

**Health Homes Webinar Series:
Health Information Technology (HIT) Basics
April 29, 2014**

Presenters: Becky Ross, KDHE Division of Health Care Finance
Leslie Banning, Amerigroup
Jeanine Meiers, Sunflower State Health Plan
Wes Wadman, United HealthCare

Moderator: Sonja Armbruster – Public Health Initiatives Coordinator, WSU Center for Community Support & Research

Sonja: This is Sonja Armbruster and I work with the Center for Community Support and Research and we have the good fortune of working with KDHE to help make sure that information is made available to Providers as we prepare for the rollout of Health Homes. Thank you all for making time today to dedicate your time to understanding more about this program. These webinars will continue to be scheduled on the last two Tuesdays of each month through the spring and are intended to highlight tools and resources that are available to potential Health Home Partners. This webinar, and all Health Homes Webinar Series Presentations are already posted on the website. The webinars from February and March are available on the KanCare website now. For each webinar, answers to questions raised during the presentations have been answered and posted. In a moment, Becky will give you a tour about how to locate materials on the KanCare website.

Just a few quick housekeeping items, all of your lines have been muted and for those of you who are speakers, you can mute your own phone, if you want, until it's your turn to talk. You should all have a question box that appears on your desktop as part of the GoTo Webinar layout. You may see a red arrow that you need to click to open up that box. This will be the method for asking questions during the presentation. You may type your questions related to today's discussion at any time and our staff will theme these and ask them of the panelists at the end of the presentation. Because of the large number of people participating, we will not be taking questions via telephone. Please limit your questions to the topic of today's webinar. Any other questions may be referred to Samantha Ferencik and her email address will appear at the end of the presentation.

Today we have several presenters. First is Becky Ross from the Kansas Department of Health and Environment, Division of Health Care Finance. She will later be joined by Leslie Banning of Amerigroup, Jeanine Meiers of Sunflower State Health Plan and Wes Wadman of United HealthCare.

Today, our purposes are to increase understanding of the basic Health Information Technology expectations and to share HIT resources that are currently available. It's also an opportunity for you all to ask questions of KDHE and the MCOs, so we look forward to your questions throughout this presentation. And with that, I pass it to Becky to get us started today. Thank you Becky.

Becky Ross: Thanks, Sonja. What you're seeing now is the front page of the KanCare website which is how you get to the Health Homes webpage. You click there on the link in the lower left hand side of the screen that says Health Homes in Kansas and that takes you to our front page where things are organized by "Consumers", "Providers", "Frequently Asked Questions" and "News and Events". The information that you are going to want to get for the most part is going to be in that "Providers box". As you see there on this "Informational Materials for Providers" page, we have the two Health Homes target populations laid out there with the draft state plan amendments, and other things that are available there. You can also get to the webinar series information as Sonja mentioned.

So let's talk about the Health Information requirements for Health Homes. Essentially, we are requiring an electronic health record of the Lead Entities and Health Home Partners for Health Home services. That is to facilitate sharing of patient information across health settings. We see this as a transformative process so we are not having hard and fast dates on this and we will talk about that in a minute.

So essentially, Health Home Partners have to commit to the use of an interoperable electronic health record. Within 90 days of becoming a Health Homes Partner, they are going to have to submit a plan to the Lead Entity that explains how they are going to implement that electronic health record. That doesn't mean it has to be up and running in 90 days; it simply means that they have to have a plan of how they're going to do it and it may take 12 months/18 months/perhaps two years for them to get down the road for implementing an electronic health record. We are not putting a hard and fast timeline; we really want folks to use this as an opportunity to get them down the road in HIT. They also, as part of that plan, have to say what their timeframe is to implement an EHR and that needs to be approved by the Lead Entity or the Managed Care Organization and then the expectation is that they will connect to one of the two certified Health Information Exchanges and that is KHIN or LACIE. Again, the time frame for doing that would have to be approved by the Lead Entity. So as a Health Home Partner, you're going to propose in your plan when you are going to get an electronic health record and implement it and when you're going to connect to one of those two HIEs.

The Lead Entity at the MCOs and the Health Home Partners have to demonstrate some other capacities around Health Information Technology. They have to be able to link services to this technology. They have to be able to facilitate communication among the various Providers, the Health Home Partner team members and the individual and family caregivers. They are also going to have to provide some feedback about their practices or allow others to provide feedback about their practices. Then they have to demonstrate that they are going to be able to report required data to both us and the Federal government in order to monitor the program.

CMS required us to think about Health Information Technology in relationship to each of the six Health Home Core Services, so I'm going to go through a set of slides here that talks about how we are tying Health Information Technology to those services. So for Comprehensive Care Management we want to see that the Health Action Plan will eventually be documented in the electronic health record, perhaps actually be part of the electronic health record so that information can be shared across the Health Home

Providers or Partners. We also want to see the use of Health Information Technology via established networks. That's one of the reasons that we want folks to connect to Health Information Exchanges. We want secure transfers of information, but we also want to make sure that Providers are updated on changes, that are current for the member and the Health Homes. Also, Health Information Technology is going to allow for that continuous monitoring of outcomes and changes in care and follow-up. You'll see that as we go through some of the other services.

For Care Coordination – again, it's going to make it easier to demonstrate documentation of the service of Care Coordination, so that you're monitoring and that you're updating that Health Action Plan; that you're incorporating treatment options, follow-up information and so forth as part of your Care Coordination activities. We had indicated that until folks are connected to the Health Information Exchanges, that the Lead Entity must provide a bi-directional electronic method for viewing and sharing data, and that's part of what the MCOs will be talking about later in this presentation.

For Health Promotion, a lot of that is going to be between the Health Home Partner or the Lead Entity and the member. So use of secure email, for example, is one way to demonstrate that you are linking to that service. Member Web Portals – all the MCO's have Member Web Portals. Health Home Partners can set up Portals as well for their Health Home members. Smartphone applications are a great way to promote Health Promotion activities for those members who have that availability. It's a great way to engage patients; there are a lot of free apps out there that you can tap into as well to help folks with their...self-management of their condition.

Comprehensive Transitional Planning – this is where HIT is going to be key because if someone goes into the hospital, it's important that the Lead Entity and the Health Home Partner are notified as soon as possible so that they can be looped into the discharge plan for that individual, which is going to be key to this Comprehensive Transitional Planning service. So Lead Entities can get that information about hospitalization. Sometimes now they are notified and they can share that, again through secure email or other secure electronic means, with the Health Home Partners which will then allow the Health Home Partners to get in touch with the member in the hospital to be looped into that Transitional Planning.

For Individual and Family Support – here's a great way to use member Portals. Ways to put information out there for members and their families to be able to use about the chronic conditions that the Health Home Partner is supporting the member on, best practices, and also ways to...for the families, for example, to link into support groups or the individual to link into support groups. So using the Portal or some mechanism on an existing website is a great way to do that, as well as the use of secure email.

And, finally, Referral to Community and Social Supports – again the Member Portals are key here to provide information, and also for sharing information with other kinds of community support. For those of you who were at the in-person meetings, you heard Sam talk about demonstrating that you have the capability to refer people to community and social supports and one way would be to show that you have a list of those types of

support services in the community. Certainly if you're doing this electronically, it's going to be a lot easier to update and a lot easier to share information with folks. So sometimes the Health Home Partner may not even be making the direct referral; they may just be helping the member or the family access those other supports through Health Information Technology.

We asked the MCOs to come together and work on some processes for Health Homes and try to be consistent. One of the first things they did was to develop a very nice table that lays out the six services and how... what they will look for...what they will look for in the way of documentation and then also how they will look to see that HIT is being included in the services. So they will all have some specific requirements that they will spell out in their document. So this table will help you get a very good idea of what they're going to be looking for.

For Comprehensive Care Management – they are going to want to see a Health Action Plan in the patient record and notes and other discussion points with members or practitioners or Providers who are working with that member. In terms of HIT, they want to see what data or reports you will use to be able to identify who was involved in the development of the Health Action Plan. They want to see that you are sharing the Health Action Plan with appropriate members and the MCO via electronic means.

For Care Coordination, again they want to see patient record entries, some sort of case notes or something that talks about what interactions you've had with the member, whether that's been a telephone conversation, an in-person meeting, or if they came in for a particular service that maybe wasn't a Health Homes service, but you're noting that that occurred because it was something that was recommended in the Health Action Plan. You would also note an ER visit, a hospital admission, any of that information that you would have and so you could do that electronically. If you have an electronic health record, obviously you could document that in the EHR, but they also want to see that you are distributing the Health Action Plan again, that you are sharing notes to the Lead Entities and MCO or with other Providers that are appropriate, that you're sharing lab results if you have them, and that you are taking information from the MCO. If they've got information that somebody went to the ER or hospital, you're taking that from their system and making use of it in yours.

So Health Promotion, they just want to see that you are documenting any activities that you engage in with the member to help them learn more about their condition and learn how to manage their condition better. They're going to be looking for any outreach activities that you have with that member, assessing their health literacy, which is going to be key. Not everybody's going to be able to understand every document that the Centers for Disease Control has about diabetes, for example. You're going to have to look for some materials that work with folks who have cognitive disabilities like for example they can't read...you're going to have to look for more creative ways to get that information to them. But in terms of HIT, the MCOs are going to be looking for evidence that you used data pulled from their system to help identify the Health Promotion needs, that you made notes about your Health Promotion interaction and any resources that you directed the person to.

Comprehensive Transitional Care – is kind of a key service where HIT is going to be really important. If someone comes out of the hospital, they need to have that discharge plan, medication reconciliation to take place, any sort of follow-up, whether it's a follow-up lab test or appointment with the Provider, so the documentation needs to include all that information. Also updating the Health Action Plan and sharing it with a new Provider who is involved. There's an example there of a physical therapist who is sees someone after a knee replacement. They need to be looped into that Health Action Plan. So in terms of using HIT for this service...to link this service, you're going to use whatever system you have whether it's the MCO system and your electronic health record to identify that the individual went into the hospital, what their discharge needs are, you're going to update that Health Action Plan, and again share it with everybody, and you're going to document any scheduling or notification to other Providers who are part of the follow-up once the member came out of the hospital.

Individual and Family Support – you're going to document their assessment of the community support needs, including any gaps, or any recommended resources. Again with the date, the time, the practitioner or service provider, the recommendations, the discussion with the family member. Again, use of HIT, you're going to share your assessment with appropriate parties, you're going to update the Health Action Plan, you're going to make some patient record entries whether that's an electronic health record or other electronic system that you might have that you're working with right now and demonstrate that you are collaborating with other practitioners, and again that can be through sharing actual data or information from your system or secure email.

And finally, Referral to Community and Social Support Systems – again the same kind of thing with documenting conversations and referrals with the family and the member about services and support needs and resources that you are referring them to. Using HIT to share that assessment that lays out what some of those needs are, updating the Health Action Plan, as well as sharing the information with other practitioners, either through your electronic system or secure email.

Sonja: OK, thank you, Becky, for that overview of the HIT process and I encourage you all, if you would like, if you have questions about what Becky has presented, go ahead and start typing those questions into the “question” box and we'll save those towards the end to assure that we have time for all of our presentations today.

First up we have Leslie Banning from Amerigroup to begin our presentation about the Amerigroup HIT Portal.

Leslie Banning: Hi, this is Leslie. Can you hear me OK?

Sonja: We sure can, thank you Leslie.

Leslie: Fantastic! Again, this is Leslie Banning with Amerigroup and I'm going to talk a little bit today about how we plan on enhancing Health Home Partner Health Information Technology capacity and Becky has just done a beautiful job of going through examples of how HIT can and should be used to document Health Home services in your medical

records. I want to talk a little bit more about how our systems will supplement the systems that many of you already have that meet the criteria as outlined in the State Plan Amendments. Again, some of you may be working on implementation of Health Information Technology and that's part of the program, but some of you may already have systems that will provide you very good knowledge and base information. So what we will be able to provide you again is supplementary.

Just a point, as we go through these slides, is that all Provider education and training will be completed once the contracting for Health Homes has been completed. All of the information that I will be sharing with you will be part of that Comprehensive Summary and Training, so much more of the detail into these systems will be shared at that time. So we will talk a little bit today about multiple systems that we plan on providing and adding additional information to in support of Health Homes.

The first is the Provider Portal. The Provider Portal provides best practices, screenings and assessment tools that are as an example. If you don't currently access a Provider Portal now, all of you should have access to that and it is a great resource. Additionally, it's going to be used to communicate Health Home related information, so again if you haven't already accessed the Provider Portal, please do so and familiarize yourself with how it's laid out and how it looks and if you have any questions, you're always welcome to contact me.

In addition to the Provider Portal as a tool, we will also be deploying Patient 360. Patient 360 is a system that organizes claims information in an organized and meaningful way to help streamline and guide member care. It's a beautiful system and shortly I will be showing you a screenshot of what the main page of that system looks like. Health Home Partners will have access to Patient 360. What it will provide to you is comprehensive medical service history including inpatient admissions, tests and procedures, pharmacy information and outpatient specialty providers. Additionally it will have service plan information, so as I go to the next slide...this is a screenshot of Patient 360 and as you'll notice it looks very busy as you look at it. Across the very top of that you will see green tabs and as you click on each one of those tabs, you will be able to drill down into that specific information.

One of the things that I want to point out as you look at the screen, at the top left hand side our Active Alerts. For those of you who are going to be working on HEDIS Alerts, you'll notice that HEDIS Alerts are closely tied to the quality measures for Health Homes and this will provide additional information on those Alerts that are either overdue or coming due. So it's a nice reminder.

Throughout this system you will notice that this is all claims-based information and although we do depend on timely filing of claims, it tends to be fairly within a 30 day range and so it gives you a very good view of current service providers, utilization of services by your members and the additional information that you may not of had in your own medical records, so again, it's supplemental information. It also provides a nice summary of the episodic viewer, which will provide you hospital inpatient stays, and other key factors in utilization and a nice summary in a chart method. So I do want to encourage providers,

even though you already may have an EMR or an EHR that provides Comprehensive Care Management Technology, do consider use of this Patient 360 as a supplement to what you are currently doing just to make sure that you have a true comprehensive view of all of the member's utilization. So going on to the next slide.

We also want to promote access to Amerigroup's Member Portal. Again the Member Portal is available to members and providers and it's a great source of Health Promotion and Health Education. It provides online connections to peer supports, which is a fantastic resource. It provides members that opportunity to speak to others who have their same conditions or who are experiencing the same types of things they are as a support system. There's going to be many of you, perhaps, that are in the more remote locations that maybe don't have local peer support in a group format or in other formats that members can attend and this provides an online connection for those folks to connect with that support. It also provides nutritional guides which is fantastic for those people who need to have specific dietary guidelines followed or simply just educated on those nutritional guidelines. It provides a personal health record that's a nice summary. Again, member access to their own health records is very empowering. It provides them the ability to access that on their own. It also has an A to Z Health Information which provides tips to address health issues and shared decision-making. Again, for providers who may have Health Promotion Activities within their own facility, this is just additional information that could be provided or used as a supplement.

This is a view of our Member Portal – the “Health A to Z”. As you can see, you can click on interactive tools, you can click on health topics or learning centers, there is a “check your symptoms” which will help someone find out what to do next and it also has a “when you need to decide” which helps them decide about surgeries, medical tests and other health related topics, just to help clarify. So again, even if this is used as talking points during Health Promotion Activities, that is what we would expect this would be used for and/or provided to members as a resource for them in their daily life.

And that is the summary of our Enhancing Health Homes Partner Health Information Technology. I'm sure at the end of the presentation, there will be information for contacting each of the MCOs and I'm always willing to answer anyone's questions if you want to contact me directly.

Sonja: Excellent, thank you Leslie for that overview and yes, the email addresses for the presenters are on the last slide and for those of you who are interested in finding that, the slide deck is already available on the KanCare website. We will transition now to the presentation from Sunflower State Health Plan. Take it away, Jeanine Meiers.

Jeanine: Thank you. Primarily today's discussion is focusing on our Provider Portal through which Providers can check the patient eligibility, as well as view and submit claims and there's a way to communicate with Sunflower through secure messaging and we'll have it specific to Health Homes so if you have a Health Home question, that will get directed to us, of course. You can see on this page, as well there's information about Care Gaps, so if there is something based from your Health Homes work with a member and you know that they need something that can be viewed through Care Gaps...you see

allergy information.

If you go to the next slide here is where you can view Clinical Information, and again like what Amerigroup said, this is claims-based. But, you can see their ER visits and occurring diagnoses, their office visits and even pharmacy activity to help stay on top of what they may need from you as a Health Home through the Six Core Services and where you can help with those pieces of their health.

The next slide there is even more information where you can access their Care Plan. At the top there are things where you can see what medications they are on and when those were filled, additional immunization information, allergy (if we have it) information and submit assessments information and again, like we were saying, view the historic patient health record information through our Portal and just use all of these pieces to help with the overall health care of the member.

There are not slides in here, but we also obviously have a Member Portal where they can view provider information, if they decide to change providers, they can see what other healthcare providers are available to them and community resources that are available to members. Caregivers of the members, so that may be a family member, can also see resources through their Member Portal to help them and be a partner with the member's health and be connected to the Health Homes Provider that is working with the family members, they can point them toward caregiver resources. There is also preventative health information through our Member Portal, a health library which has all sorts of information to help the member with taking care of themselves and understanding their own health and manage it. So that information is available through our Member Portal, as well.

At the end, I'll be happy to answer any questions that anyone may have.

Sonja: Thank you very much, Jeanine, for walking us through the Portal for Sunflower Health Plan. And last but not least, we have United HealthCare and Wes Wadman, we look forward to learning about United's plan. Thank you.

Wes Wadman: OK, thank you. We have a different approach to providing an EHR type tool for Health Homes. This application called CommunityCare™ is actually designed to be the tool to house the Health Action Plan and document all listing services and be able to be the community record that all the Providers can coordinate within the tool.

As you can see on the screenshot here, this is your main homepage. You're going to have the Enrollment screen where you see your monthly enrollment and at United we would push the New Members that would be assigned to your particular practice into that bucket. You would go in and find those members and complete the enrollment process with them. You have the ability to design "Care Teams" around each individual member so you are able to assign a Care Coordinator, the doctors and any other practitioners that you are going to be working with that particular member.

There is a "Reports" function that you can get some basic reporting information out of the tool itself. And then the "Care Plan" button is going to take you into where you actually develop the Health Action Plan. Then with "Messages", this is our secure messaging application within the tool itself, so you'll be able to send messages back-and-forth between your agency and other external providers using this tool and it is all secure.

Now the last icon on the end is called "Alerts". This "Alerts" will be hooked up to KHIN and your practice will be notified of members who enter into the ER or the hospital within 24 hours of that admit happening. We saw a big need in order to notify the agencies when these events happen quicker than clients and so this is the direction we have taken. We should have that functionality up and running by the time we start Health Home activity in July and August. Next slide please.

This is the screenshot where you are going to start building your Care Team. You will have eligible providers that will be on your left and then you select them to assign to a particular member. Next slide please.

This is the screen that starts the "Care Plan" section. Within this "Care Plan" section, as a user inside your agency, you will come in here and they will be assigned the members that they are managing and they will all appear here in this list. This is where they can view notifications, they can create a profile for this member and there's a whole host of assessments built into this tool itself. Creating progress notes and the "CCP" is the Community Care Plan and that is the actual Health Action Plan. Next please.

This view here is the Health Action Plan Summary. So you go in and you put in all of your information about the goals that the member wants, how they are doing on those goals, who it's modified by, the time and date and then the client goal priority and clinician goal priority, because we all know those usually, not usually, but sometimes they don't align together, but it's something as a clinician that you see that is important and the member doesn't. That takes a different strategy to address that with the member. This also has a printable version that 1) it can be printed and given to the member, and 2) when you go to print, you can also send it in secure messaging. So you can actually send the Health Action Plan across the community to the different Providers.

Our Care Plan Fields - as you are creating the Health Action Plan, this isn't all of them, this is just a snippet and so you're going to be addressing the needs and then we have certain domains and so we are really able to isolate what services and what needs the member has and bucket those into a deep level of analysis on that, so we can provide feedback to your particular practice on what services your clients are using the most, and maybe some education on some different areas on how to utilize the different types of services.

That's a very, very brief overview of CommunityCare™ for United. Again, if you have any other questions and want a deeper dive-in or a live demonstration, please notify us and we will be more than happy to meet with you to do that.

Sonja: Excellent, thank you so much Wes. Before we jump into Q and A, we just have just a couple more resources that Becky is going to walk us through.

Becky Ross: OK, so on this slide we are listing the contact information for our two certified State Health Information Exchanges – KHIN and LACIE. You can go there and get more information from them. They are more than willing to come out and talk with Providers about how you connect with them and what the options are and the cost. There's also a Federal HIT website and we have this link on our KanCare web page. It has a lot of good information, including sort of a step-by-step of what you ought to do as you think about implementing electronic health records, so it's a good resource for information as well.

Then, locally, here in Kansas, I want to point you to Synōvim Healthcare Solutions. They are available to provide Health Information Technology and technical assistance. They can work with your agency to assess where you are, talk about where you want to be, and help you put together a plan. They can also provide technical assistance in terms of developing an RFP if you want to put out for bids for electronic health records. They can also provide you information about various electronic health record vendors, they can help you assess those various vendors, so there are lots of things that they can help you do. They are a local company right here in Kansas who can work with you. It's basically a spinoff from the regional extension centers that were funded by the Federal government a few years ago to help Providers with electronic health records. So they are a TA group...a Technical Assistance group. They aren't going to actually provide you with the electronic health record, but if you are looking for sort of an independent source who can give you some objective technical assistance, they are a good resource.

We are also contracting with them, sort of through their parent organization, the Kansas Foundation for Medical Care, and a certain number of providers who responded to a survey that we did awhile back through them had indicated that they needed some technical assistance are getting it through this entity.

There are some providers who indicated they needed some technical assistance and now think that they don't, so we will probably have some slots available that we're actually paying for to provide the technical assistance. Again, if you're interested, contact Erin and she can let you know whether or not it's something that can be done under the contract we have with them or if it would be something you would have to contract with them separately.

Sonja: Excellent, thank you for those resources Becky and that overview. We are now at the Question and Answer portion of our presentation and - be ready MCOs - because there are many questions for you. I would like to say at the beginning there are several questions that we received about where to find the slides and if you go to the Health Homes webpage and go to the Webinar Series on the left hand side, you will see that the .pdf of the slides for today are there and that's a place where you can find the email links to the presenters for today's presentation as well.

So the first question we have is about the Provider Portal. The question was: "How frequently will the Provider Portal be updated? How recent will that information be?" "The question was specifically: Will that Provider Portal be updated about services received within 24 hours or what might the frequency of that be?"

Leslie: This is Leslie with Amerigroup. Can I clarify the question? So are we speaking about the access to the system that will show claims information or are we talking about our Provider Portal itself? I would assume that they are probably talking about our presentation of our Provider 360 and if that's what they are referring to...information in that system about member's utilization is claims-based. So it won't appear in that system until the claim has been paid. If they are referring to information that will be posted on our Provider Portal, the information will be posted to that Portal based upon Health Homes updates as frequency requires. The Health Promotion type activities that are posted there are updated as is clinically relevant, but that system is not...the system is going to house the claim information. It's a separate system altogether.

Sonja: Thank you, Leslie. So that data is generally updated when the claims are paid... is that the same for Sunflower and United?

Jeanine Meiers: This is Jeanine Meiers at Sunflower. Yeah, ours is...again, it is based on the claim as I believe they are paid. So there is a lag, I believe that it can be anywhere from about 30 to even 60 days sometimes, because it is claims-based. Now that's another great reason to...so yeah, that's why ours...there's a lag there, but everything will be updated on ours based on the claim as they are filed and the information gets fed to our Portal.

Sonja: Thank you, and Wes?

Wes: This is Wes from United. Two things: 1) at United we do have a Provider Portal where you can go in and see claims data on a member just like Amerigroup and Sunflower, so that's all the same process with lag times that they experience also because of the nature of the claims. In our Tool, it's within 24 hours that we'll be able to post information based on ER admissions.

Sonja: OK, thank you very much. We have a couple of questions that are similar, related to logging in. "Will there be an access code or password needed to access these records and how many logins or access codes will an individual at Health Home Partner have? Is it to an individual or to the agency as a whole?"

Wes: Each user will have their own access; it won't be agency based, it will be user-based.

Jeanine: Right, this is Jeanine from Sunflower and ours is the same. How it is today, so like he said, it's user-based. You have your login and your password information.

Leslie: This is Leslie with Amerigroup. All of the information related to access to all of the systems will be discussed at great length during the training and the contracting discussions. Again, it depends on which systems you are referring to. Providers have access to the Provider Portal now and Provider 360 will be provided to those Health Home Partners that are contracted with us. I could tell you internally it's simply just access to the system itself; there's no logon for Amerigroup associates who currently access the system.

It's a very, very easy system to access.

Sonja: Thank you. You also answered one of the other questions related to how difficult is the access. There is a question here related to the options for developing the Health Action Plan. "Is it on paper, in the EHR, or in the MCO Portal? How might that work? How do you envision that happening?" Let's go starting with Leslie this time and I will restate the question, "Could you clarify the options related to the Health Action Plan? Is it on paper, in electronic health record for the agency or in the MCO Portal?"

Leslie: We are wanting to be as flexible as possible for our Providers. We will offer all means of completing the Health Action Plan. Remember that the Health Action Plan is the form that the state has developed and that's the expectation for all Providers to complete that specific form. We will be willing to receive it via mail, email, fax and we are currently working on configuring this form to be available on our Provider Portal so they could be submitted electronically and automatically uploaded to our system.

Sonja: Thank you Leslie. Jeanine?

Jeanine: Sure. From the Sunflower perspective, it's...we're not requiring that the Providers submit their Health Action Plan to us so it will be on them if they are doing it by paper or if they have an EHR that they can complete it through and save it that way or if they have another means of doing it electronically and saving it to their system, then they would be able to do that and then the person would be able to help them with any questions they have of completing it and then information from it would be used for the auditing process. But they have flexibility as to how and if they want to actually complete it and store it on their system.

Sonja: Thank you, and Wes, I believe that part of your presentation illustrated the walk-through for the Health Action Plan on your Portal. Are there other options as well?

Wes: Yes. So if the agency isn't using our CommunityCare™ Platform, yeah, we are kind of following something like Sunflower's approach. However, when the Health Action Plan gets done, it needs to be documented and we prefer it in an electronic health record of some sort, either ours or the agency's. But the key is making sure that document is shareable across the community.

Sonja: Excellent, thank you.

Wes: And we do not require submission of the Health Action Plan to United.

Sonja: Another good point of clarification, thank you. Related to access to records – "how will Providers access services provided by other Providers?" So if they weren't the delivery source, how will they access those records? Will that happen through these same Portals? We will go in reverse order this time, so, Wes?

Wes: So that has two parts to that answer. 1) if you use the CommunityCare™ Platform and the other Providers are using that, then everyone has the opportunity to have input and

put in information about that member's care and treatment. That is one aspect. 2) the second aspect is a part of the requirements is being connected with KHIN or LACIE. When you're connected with either one of those agencies, you will be able to see all the activities surrounding a member by other Providers.

Sonja: OK thank you, and Jeanine?

Jeanine: Could you repeat the question just one more time making sure I understand?

Sonja: OK, so as it's written it was, "how do we access information provided by other service providers?" So, if the patient receives a service somewhere else, how would the Health Home Partner know?

Jeanine: Right. Well and again, on our Portal and given the delay, they can see that ER visits and PCP visits and such like that, so they would be able to see that Provider information and then just as United said, if they are connected with KHIN and LACIE, then they can see all that information actually quicker than even through our Portal or through the other Provider Portal.

Sonja: Thank you, and Leslie?

Leslie: OK, so I think I'm going to take a little bit of a different approach here because I'm interpreting the question a little bit differently. So on our Provider 360, Providers will be able to access current authorizations that are in place for all services for the member. They will also be able to access inpatient stays, outpatient provider information, medication, claims, etc. All of this information will help guide them into collecting whatever additional information they may need. Now our system will not provide you detailed visit summaries from those Providers; it's simply going to tell you that the service was provided. It will be the responsibility of the Health Home Partner to reach out to those Providers and ask for either records pertaining to visits or to speak to someone within that Provider's office about services being rendered to the Health Home member and coordinating care accordingly.

As it relates to the connection to HIE, your Health Information Exchanges, I think it's key to remember that Health Information Exchanges were built to gather core information data sets. They don't typically gather clinical type information or Care Summaries. So really, it would be prudent for potential Health Home Providers to really think about the care coordination and what is going to need to take place to get the information at that level.

Sonja: Thank you very much, Leslie. OK, we are going to do one last question and I think it may be for Becky and others are invited to chime in, but it's related to KHIN and LACIE. "How do we assure that our information that we present to KHIN or LACIE is compatible, like the data format requirements and etc.?" Where might we direct that question asker about resources about that?

Becky: Well again, I would reach out to KHIN and LACIE. We also have on our website under either the Stakeholder's Meeting or...I'm not sure if we still have a link called Focus Group, but KHIN and LACIE both made presentations to that group several months ago

that contained information about how you can work with them to find out if it's compatible. Generally, if you have an interoperable electronic health record, they should be able to accept information. But there are phases of things that you can do with KHIN and LACIE as well. So it was sort of phase in and they do have a secure email feature that they can make available to you. So my recommendation is that you reach out to one or both of those entities and have them sit down and talk with you and learn more about what you have and then they can tell you whether or not it's compatible.

Sonja: That's excellent, thank you, Becky. When we post the answers to the questions for today's presentation, we will find those presentations and link them in the Q and A so that those resources are right at hand. Thank you all for your good questions and thank you to our many presenters for your presentations and your answers to the questions.

This is just a reminder that this is one of many - we have additional webinars planned next month. We will be talking about Health Homes: A Member's Experience and talking about Health Promotion and then in June we will have targeted presentations for specific provider populations. You can all expect a "thank you" email and a short survey following this webinar. Your feedback is important so that we can improve the experience for future meetings. Thank you all for participating and have a great day.