



WICHITA STATE
UNIVERSITY

*CENTER FOR COMMUNITY SUPPORT
AND RESEARCH*

Health Homes Learning Collaborative

Presenter:

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November 4, 2014



Get the latest updates from KDHE and Lead Entities

Learn more about Quality Goals and Performance
Measures for the Health Homes Initiative

Purpose of the Learning Collaborative

- Bring together contracted Health Home Partners, Lead Entities, KDHE and provider Associations
- Support provider implementation of Health Homes
- In-person and electronic sessions
- Provide peer-to-peer learning and exchange of ideas vs. training





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KanCare



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UnitedHealthcare[®]

COMMUNITY & STATE

WSU Center for Community Support & Research

- Health Action Plan Webinar Series
 - Nov. 18 – 5 “As” of Smoking Cessation
 - Dec. 16 – Health Literacy
- Learning Collaborative Webcast
 - December 2, 3:00 – 4:00 p.m.
- Community of Practice Webcast
 - December 2, 1:00 – 2:00 p.m.



Health Homes Quality: Goals and Performance Measures



Background- ACA

- The requirements for quality measurement in health homes are varied
- Monitor use of HIT to improve service delivery
- Provide data to CMS for interim report to Congress
- Collect individual-level data to compare the effect of the model across Medicaid populations and against other models of service delivery

Background- ACA

- Required Data for CMS:
 - Hospital admission rates
 - Chronic disease management
 - Coordination of care for individuals with chronic conditions
 - Assessment of program implementation
 - Processes and lessons learned
 - Assessment of quality and clinical outcomes
 - Estimates of cost savings
 - Admissions to Skilled Nursing Facilities
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SMD Requirements

- November 2010-
 - Requires states to develop quality program
 - States must report on HH Core measures when released by CMS
 - Measures must capture information in two areas:
 1. Clinical Outcomes
 2. Quality of Care

SMD Requirements

- January 2013
 - Released “recommended” core measures
 - States must report on HH Core measures in addition to state-specified goals and measures
 - Core measures align with other CMS initiatives
 - Technical specifications were not yet released

Core Health Homes Measures

- Adult Body Mass Index (BMI) Assessment
- Ambulatory Care-Sensitive Condition Admission
- Care Transition – Transition Record Transmitted to Health care Professional
- Follow-Up After Hospitalization for Mental Illness

Core Health Homes Measures

- Plan- All Cause Readmission
- Screening for Clinical Depression and Follow-up Plan
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Controlling High Blood Pressure

Quality Sub-Group

- KDHE and KDADs
- KanCare Health Plan Representatives
- KUMC Partners
- Stakeholders
- Advised by Kansas EQRO

Kansas Approach

- Meet requirements
 - Learn from other States
 - Keep it simple
 - No “new” measures
 - Leverage existing metrics
 - Existing requirements for providers
 - KanCare metrics, including P4P measures
 - Health Homes Core Measures
 - Appropriate for SMI/other chronic diseases
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Health Home Goals

1. Reduce Utilization Associated with Inpatient Stays
2. Improve Management of Chronic Conditions
3. Improve Care Coordination
4. Improve Transitions of Care Among Primary Care and Community Providers and Inpatient Facilities

Core Health Homes Measures

- March 2014
 - CMS released the ‘Core Set of Health Care Quality Measures for Medicaid Health Homes Programs’
 - Outlines required data sources, collection methods and processes for reporting
 - State formed Reporting Sub-Group to incorporate the tech specs into the previously developed Health Homes Quality Goals and Measures and build a foundation for reporting.

All Health Homes Measures

- Health Homes Reporting Sub-group
 - Aligned measurement year and reporting to coincide with the approved start date of the State Plan Amendment which is June 2015 for the SMI SPA.
 - Leveraged KanCare contract P4Ps and HEDIS measures collected by the MCOs to develop tech specs for the State Goals.
 - As Lead Entities, MCOs will begin collecting this data from their Health Home Partners for State and Federal reporting purposes.
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Quality Measures- Goal 1

- 1.1. Decrease in Institutional Care Utilization
 - Language from the P4P - Members utilizing inpatient psychiatric services
- 1.2. Inpatient Utilization—General Hospital / Acute Care
 - HEDIS Code IPU – Admin – Aggregate rate of days

Quality Measures- Goal 1

1.3. Plan- All Cause Readmission

- HH Core Measure HEDIS– PCR-HH-Admin – Number of hospital stays with readmission within 30 days.

1.4. Ambulatory Care- Sensitive Cond. Ad.

- HH Core Measure – HEDIS - PQ192 Comp Admin – Number of acute care hospitalization for ambulatory care sensitive conditions
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Quality Measures- Goal 2

2.1. HBa1C Testing for Diabetes

- HEDIS Code CDC – Admin

2.2. LDL-C Screening for Diabetes

- HEDIS Code CDC – Admin for 2014
(Language from the P4P, also)

Quality Measures- Goal 2

2.3. Follow-up after Hospitalization for MI

- HH Core Measure- HEDIS– FUH – HH-Admin- Follow-up with a mental health practitioner within 7 days of discharge

2.4. Adult Body Mass Index (BMI) Assessment

- HH Core – HEDIS ABA – HH- Hybrid - Assessment and documentation of BMI for HH members by an LPN or higher.

Quality Measures- Goal 2

2.5. Screening for Clinical Depression and Follow-up Plan

- HH Core – Not a HEDIS measure but a CMS Medicare Quality Initiative measure – CDF – HH – Hybrid

Screening of members using a standardized tool and if the screen is positive, a follow-up plan is documented.

Quality Measures- Goal 2

2.6. Controlling High Blood Pressure

- HH Core – HEDIS - CBP – Hybrid – evaluation of the number of HH members whose systolic and diastolic BP is adequately controlled

Quality Measures- Goal 3

2.7 Increased Integration of Care

- Originally, this measure was based on a P4P category and evolved into a five question member survey.

*Does your HH CC talk to your doctors?
Talk to other providers? Go to your
appointments? Did you help develop your
goals? Is your health better since you
started HH services?*

Quality Measures- Goal 3

3.1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

- HH Core – HEDIS – IET – HH – Admin

Initiation of AOD treatment within 14 days of diagnosis

3.2. Tobacco Use Assessment

- HHS / Dept. Health Resources and Services Admin. (HRSA) measure of tobacco use queries.

Quality Measures- Goal 4

4.1. Inpatient Utilization—General Hospital/Acute

- Same as Goal 1, Measure 2

4.2. Care Transition- Transition Record Transmitted to Health Care Professional

- HH Core – CTR – HH- Hybrid – Not HEDIS – PCPI

4.3. Follow-up after Hospitalization for Mental Illness

- Same as Goal 2, Measure 3

Next Steps

- Fully integrate the measures into the reporting practices of the Lead Entities and Health Home Partners.
- Re-visit the measure regularly to identify implementation issues and solutions.
- Revise based on achievement and goals for continuous quality improvement.
- Celebrate successes.





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Thanks for joining us!
