



WICHITA STATE
UNIVERSITY

Health Homes Webinar Series: A Member's Experience

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Finance

May 20, 2014

Welcome!

- This week's presentation, as part of the HH Webinar Series, will explain how Health Homes might work for a hypothetical individual
- Posted on the KanCare website for future reference
- Thank you for calling in! All caller phones are muted for the duration of the presentation.
- Enter questions via "Question" box on your screen



Purposes for Today

Participants will have:

- Better understanding of Health Homes processes and potential timing of services
- Increased understanding of the roles played by the Lead Entity (LE), Health Home Partner (HHP), and Health Home members themselves
- Increased understanding of the six Core Services and how they may look in a real-life situation

Overview

- Two types of Health Homes – Serious Mental Illness (SMI) & Chronic Conditions
- Each has its own program manual that is available on the KanCare website.
- For today, we will focus on Earleen’s experience in a SMI Health Home.
 - Six Core Services are provided over the course of Earleen’s first year in a Health Home.
 - A minimum of one HH service is needed to trigger payment for the HHP in a given month.

KanCare Website

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Latest News – Upcoming Events
Meetings for Members with Serious Health Conditions
I/DD Waiver Services' Incorporation into KanCare
Open Enrollment for Members with Jan. 1 Anniversary
Important message for Members (Video)

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Delivery System Reform Incentive
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Kansas Medicaid Reform
Sect. 1115 Waiver and Comments
News
Advisory Council & Workgroups
Frequently Asked Questions

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KanCare Website

The screenshot shows the KanCare website header with the logo and navigation menu. Below the header is a banner image of a green field with the text 'Medicaid for Kansas'. The main content area is titled 'Health Home in KanCare' and contains a 'Providers' section. A red arrow points to the 'Informational Materials for Providers:' link in the left-hand menu.

Providers

Informational Materials for Providers:

- Health Home
- Provider Regional Meetings
- Approaches to Health Homes
- Payment Principles and Parameters:
- Services
- Informational Materials for Providers:**
- Stakeholder Meetings
- Health Homes Webinar Series
- Contacts

Serious Mental Illness (SMI)

- SMI State Plan Amendment
- KanCare Health Homes Program Manual – SMI
- SMI Health Homes Provider Requirements
- SMI Health Homes Services and Professional Requirements
- Target Population Estimates
- Crosswalk of DSM-IV-TR diagnoses and DSM-5 diagnoses for SMI Target Population
- KanCare Health Homes Payment

Chronic Conditions (CC)

- CC State Plan Amendment
- KanCare Health Homes Program Manual – CC
- CC Health Homes Provider Requirements
- CC Health Homes Services and Professional Requirements
- Kansas CC Health Homes Target Population
- Target Population Estimates (.xlsx)
- KanCare Health Homes Payment

Health Action Plan

Meet Earleen

Earleen is unemployed but is interested in employment

Earleen has diabetes

Earleen has COPD

Earleen is 41 years old



Earleen has bipolar disorder

Earleen has been admitted to the hospital 4 times in the past year

Things to note about Earleen:



- Earleen sees several doctors. However, she does not have a primary care physician (PCP).
- She meets the Social Security Disability eligibility criteria, receives Supplemental Security Income (SSI), and is eligible for Medicaid.
- In January 2013, she was assigned to a KanCare MCO
- Earleen is unemployed and living with her sister—both report that they are not getting along.

July: Identification

- Earleen is identified as eligible for a HH based on her bipolar diagnosis, as well as her diabetes and hospital admissions.
 - Earleen is eligible for both Health Home target populations
- Due to an existing relationship with a Community Mental Health Center (CMHC), she is defaulted into their SMI Health Home
- Earleen receives a letter in the mail notifying her of her Health Home assignment
 - Earleen does not Opt Out
 - Earleen does not request to change Health Home



July: Needs Assessment

- The HHP Comprehensive Care Coordinator reviews her medical history and does a follow-up Health Risk Assessment (HRA)
 - *Note: The HHP will be performing Care Coordination in the Health Home*
- During the HRA, Earleen learns that:
 - her HH services will be in addition to the regular health care she is already receiving.
 - she is eligible for both the Chronic Condition (CC) and Serious Mental Illness (SMI) Health Homes, and may select a different HHP if she chooses.
- Earleen decides to remain with the CMHC as her HHP as she has seen a therapist there in the past and is familiar with the agency.

August: Getting Started

With the help of her HHP Care Manager, therapist, Peer Support Specialist, and her sister, Earleen develops a Health Action Plan (HAP) to help guide her health care. –

Comprehensive Care Management

- HAP goals and health information are shared amongst Earleen’s providers – ***Health Information Technology***
- *Note: Many of these HH services can occur without the member being present.*



Health Action Plan

Create S.M.A.R.T. Goals



- HAP goals will be unique to each HH member
- HAPs should be updated as goals are met or altered (at least quarterly)
- Goals may be pursued in groups or individually
- Earleen will pursue one goal per month initially

Health Action Plan Goal #1

Goal:

Earleen will have one Primary Care Physician (PCP) overseeing her medical conditions, and see specialists at the direction of her PCP. Earleen will also attend all of her appointments with her HHP therapist.

Strategy:

Earleen's Care Coordinator will assist her to select and schedule an appointment with a PCP. Earleen will continue to see her PCP on a schedule mutually agreed upon between the two of them. The Care Coordinator will also assist Earleen in arranging non-emergency medical transportation (NEMT) for her medical appointments.

– ***Care Coordination***

August

- Earleen's HHP Care Coordinator (CC)
 - helps her select a PCP;
 - assists her in scheduling her first appointment;
 - has her sign a release to enable the CC to obtain medical information;
 - and helps her schedule NEMT through her MCO.
- Following the visit, the CC obtains information from the PCP.
- Earleen and her CC schedule weekly appointments with a therapist at her HHP.

Health Action Plan Goal #2

Goal:

Earleen will have an increased understanding of her medical conditions, her medications, and the regimens necessary to treat them. Earleen will follow the directions of her PCP and other specialists.

Strategy:

The Care Coordinator at Earleen's Health Home Partner will:

- Attend appointments with Earleen as necessary
- Assist Earleen in understanding the information given to her by her PCP and Specialists regarding her conditions and medicine.
- Assist her in accessing COPD Support Inc. online, using a computer at the local library. – **Health Promotion**

September

- The CC meets with Earleen to review the information obtained from her PCP
- Earleen and her CC adjust the HAP strategies for Goal #2 to include the following:
 - Earleen will take her glucometer to her PCP's office weekly to have glucose readings downloaded and medication adjusted based on those readings.
- The CC assists Earleen to access COPD Support Inc. at the local library.

October: Health Outcome Progress!

Earleen's progress toward her HAP goals:

- Earleen's therapist reports to her CC that her weekly visits have been beneficial and she has experienced fewer manic depressive episodes.
- Earleen states that she has learned a lot from her online class and her COPD is interfering less with her everyday activities.



Health Action Plan Goal #3

Goal:

Earleen will have increased understanding of the long-term impact of uncontrolled glucose levels, test her blood glucose levels on a regular basis, and eat a healthier diet.

Strategy:

Earleen's Care Coordinator will refer her to a Diabetes Self-Management Program (DSMP) offered at the local health department and arrange her transportation.

- Since Earleen is nervous for her first session, her Peer Support Specialist goes with her. - ***Health Promotion***

October

- The CC reviews the course information with Earleen to ensure she understands the material.
 - Earleen records her glucose levels via the secure member portal on her MCO's website or by phone with her Care Coordinator.
 - Earleen's blood glucose levels and other information is available for her Care Coordinator, Care Manager and PCP to view via the Kansas Health Information Network (KHIN).
- Earleen now feels comfortable setting up transportation through her MCO.

November

- Earleen continues to monitor and report her blood glucose levels to her PCP.
- Earleen's medication has had to be adjusted several times.
- The PCP is recommending that Earleen exercise regularly.
- The CC and Earleen adjust the HAP to include a goal of exercising regularly and a strategy of Earleen walking 15 minutes per day.

Health Action Plan Goal #4

Goal:

Earleen will exercise regularly as recommended by her PCP.

Strategy:

Earleen will walk 15 minutes per day in her neighborhood at least five days a week. Earleen's CC asks that she keep a diary tracking her weekly exercise and progress.

December: Set Back

Set Back:

- Earleen's COPD is aggravated by the cold winter weather and she is hospitalized.

Earleen's CC's Response:

- Visits Earleen in the hospital and when she is released, the CC arranges to accompany her home from the hospital and explain her doctor's orders to her.
- Ensures that Earleen attends all follow-up appointments and helps her get her prescriptions filled.
- Ensures that Earleen understands the importance of taking her medications – ***Comprehensive Transitional Care.***

TWO
STEPS
FORWARD
ONE
STEP
BACK
IS
STILL
FORWARD
PROGRESS.

January

- Earleen and her CC work to re-establish her regimen and schedule after being hospitalized.
- The CC sends Earleen's HAP to all of her providers for review.
- Despite the hospitalization, the PCP reports that her blood glucose levels are improved, and that her Hemoglobin A1c is reduced.

January: Health Outcome Progress!



Earleen's progress toward her HAP goals:

- Earleen was able to maintain her blood glucose levels within the range of normal.
- Her COPD has stabilized after her hospital stay

Health Action Plan Goal #5

Goal:

Earleen will obtain and move into safe and affordable housing in a location with access to public transportation within six months.

Strategy:

Earleen's HHP Care Coordinator will assist her to obtain affordable housing on a public transportation route.

– ***Referral to Community and Social Support Services***

February

- Earleen's CC helps her to complete a low income housing application.
- Earleen's Peer Support Specialist helps Earleen navigate the public transportation routes in the new housing area to ensure Earleen feels comfortable.

Health Action Plan Goal #5

Goal:

Earleen will become more financially independent, relying less on her sister for money and budget support.

Strategy:

Earleen's Care Coordinator will arrange for her to attend budget management classes at the local library. The Care Coordinator will also refer Earleen's sister to a support group for family members of people with mental illness.

– Individual and Family Supports

April: Health Outcome Progress!

Earleen's progress toward her HAP goals:

- Earleen was able to attend 3 of the 4 budget management classes in March.
- Earleen created her own budget and is now less reliant upon her sister.
- Earleen now feels comfortable with her budget and believes that she can afford some of the housing she has been looking into.
- Earleen's sister now has resources to help her manage Earleen's mental illness.



May and Beyond



- Earleen is now on a waiting list for housing and is budgeting for an upcoming move.
- Earleen's Care Coordinator will continue to monitor her ability to maintain the successes she has had in the last 11 months.
- Once Earleen's behavioral and physical conditions are more stable, her HHP Care Coordinator will refer her for Vocational Rehabilitation services to assist her in obtaining employment.
- Earleen will work with her various providers to continually update her HAP and goals.

Questions?

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Save the Dates! *(All sessions 12-1 p.m.)*



- May 27 – Health Promotion
- June 17 – Targeted Case Management (I/DD)



Thank you for participating!

