

Health Homes Webinar
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Planning and Preparedness Tool

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

Samantha:

Please feel free to use the chat box – we will try to correct any problems we may have.

As Sonja mentioned, we will go step by step of the PPT. (Next Slide)

The planning tool is something we are going to have you all complete. If you are planning on becoming a Health Home Partner or a subcontractor with a Health Home Partner, you need to fill out this tool. Send it to me by April 1st if you want to be a Health Home Partner by July 1st. Now, you can become a Health Home Partner anytime. Many of you won't be ready by July 1st and that's fine. But keep these dates in mind if you are shooting for July 1st, try to get it in by April 1st for full consideration. The third bullet point, I'd like to draw your attention to, is how you can actually access the tool online. If you go to the main KanCare website, under 'Policies and Reports', there is a link for 'Health Homes in Kansas'. Now this is the main Health Homes page. There is lots of information here. I encourage you to look around look under the 'Consumer' section as well. There might be useful information for the people you serve. We have 'Frequently Asked Questions', 'News and Events'. For today, we will look at the 'Providers' box. Click on 'Providers' box. Along the side you will see black links. The one you need is 'Informational Materials for Providers'. You will see the first three bullet points on the screen right are for the Preparedness and Planning Tool that we are going over today. We have two different versions of Microsoft Word. That's just because not everyone has access to newest version. You don't need to send to me in both versions, just one. Just this morning we added a final black link that says 'Webinars'. If you ever want to know about upcoming webinars, or go back to past webinars, click on that link and all the information will be provided there. (Next Slide)

Purpose of the tool: The tool has several purposes. One specific audience it's for is the provider and the other is the MCO. So with the regard to the provider; we hope this tool will become a conversation starter. We want it to help you get you talking and thinking about becoming a Health Home Partner. It should help you create a roadmap. It should help you understand the ability to support progress toward becoming a Health Home Partner. It should help you assess your strengths and challenges. And most importantly, it should help you set and prioritize goals toward becoming a Health Home Partner. (Next Slide)

Purpose of the tool for MCOs: Its importance is assisting in evaluating, supporting and contracting with potential Health Home Partners. It's not designed to determine whether a potential Health Home Partner is accepted or rejected. It's a roadmap, a conversation starter, and baseline to access were you are. (Next Slide)

How to use the tool: It's going to be best if you answer the questions in the tool with an honest assessment of where you are and where you need to be. You get no points, so it's not scored. So, you can't circle 'yes' thinking you are getting ahead of the game. You need to really think about where you

are and try to give it your best honest evaluation. Some pre-work will be helpful. If you can collect information about your population served currently, how often they are served, how many people you serve, what do they look like, what are the characteristics they share? Also think about your infrastructure. What does your agency look like? How is it set up? Are there particular factors that make it unique - that would make it a Health Home Partner and make it succeed? We encourage you to have leadership from all levels of the organization involved. Discuss results with the team. If there is not a consensus, that's ok. Just start the conversation. Again, identify your goals and next steps and how you are going to move forward. (Next Slide)

Understanding the Population: So, this is what you will see on your first page of the tool, asking about your general population. Number 1 we ask for the most prevalent top five diagnoses in the population you serve. It's important to remember that Health Homes are not for everyone. We are asking for these diagnoses, to gauge whether you are the right fit to become a Health Home Partner. Remember, Health Homes are for people with serious mental illnesses, diabetes, asthma and certain other chronic conditions. Just because you don't have the first five - asthma, diabetes, serious mental illness - that's ok. But it's useful for the MCOs to know who you serve and how often. Questions 2 and 3 are related to how many people you serve and how often. I'm not going to hit every line of this tool, as that would take a long time. But I think this gives you a good idea of what kind of information you need to collect before you get into the meat of the tool. (Next Slide)

Comprehensive Care Management: Now we are going to get in the core services that are going to be provided by a Health Home Partner. Comprehensive Care Management. The best way to describe this is you are going to help make a plan to help guide a member, their doctors and their other providers. So question number 1 reflects this, "Do you provide Comprehensive Care Management through knowledge of the medical and non-medical service delivery system within and outside of the member's area?" "Yes or No." Question 2, "Do you provide Comprehensive Care Management through effective cultural, linguistic, and disability appropriate communication with the member, family members/support persons, guardians, and service providers?" "Yes or No." And for Comprehensive Care Management, when you look at these first two questions and the whole set of questions; do you have the knowledge to perform the service? Do you have the ability to perform this service across the diverse population? They are 'yes' or 'no' questions. You may feel like you need to go beyond 'yes' or 'no' and explain yourself and that's fine. I do ask for examples later on in the tool. And if you need to attach additional documents, that is fine. We encourage more rather than less information at this time. (Next slide)

This box you are going to see repeated time and time again because that it's important. As I said when I first picked up the phone, even if you are planning on subcontracting for one or two of the core services you need to fill out this tool. Let's say you know you want to become a Health Home Partner, but you know you are going to have to subcontract for some of the services. This is where you are going to tell us about your plans about subcontracting. And you will notice the second line down, "If subcontracting for this service, please attach appropriate documentation." So, if you have formalized paperwork that shows exactly who is going to be doing what, include that. If not, that is fine but if you can, tell me who have been in conversations and who is doing what. Let us know that you are pursuing this and who you really see yourself going forward with as a certain subcontractor. The final two boxes, where it says score...again, this is not a score to judge you, this is a self-assessment. Zero to 10, how ready are you right now? And the final box, "What is your greatest obstacle to overcome in order to improve?" Feel free to tell me here - maybe you need extra staff, maybe you need extra training. Whatever it might be, let us know and maybe we can work with the MCOs to see if this is something we can help you

overcome. (Next Slide)

Care Coordination: Second core service, Care Coordination. It's making sure the member is getting the right services at the right time. Obviously, it's a little more in depth than that, but for those just getting started, think of it in those terms. So, Question 1, "Do you provide Care Coordination that is timely, addresses needs, improves chronic conditions, and assists in the attainment of the member's goals?" "Yes or No." "Do you provide Care Coordination that supports adherence to treatment recommendations, engages members in chronic condition self-care, and encourages continued participation in Health Home care?" "Yes or No." Again, thinking about what I said, right services at the right time. For example, there is a diabetic you are working with and the doctor says they have need to see an eye specialist. Follow up should be done quickly and the Health Home Partner should make sure it's done timely and that all follow up care is taken care of. Hope that makes sense. (Next slide)

As I said before, you are going to see this box over and over again. Please take the time to fill it out each time. If you aren't subcontracting for this, that is ok, just answer 'no'. But if you are, please provide the information we need to see where you are. (Next Slide)

Health Promotion: Third core service is Health Promotion. This is just teaching your member about their condition and how they can help themselves be healthier. Questions 1-5 are going to drill into that deeper. Question 1: "Do you provide Health Promotion that encourages and supports healthy ideas and behavior, with the goal of motivating members to successfully monitor and manage their health?" "Yes or No." For example, you've got a diabetic member – perhaps you need to tell them about healthy eating habits, healthy recipes, put them in contact with someone that can put them on an exercise plan. Things like that. Questions 1-5 should help you know if you are ready to do this kind of work. (Next slide)

Again, the subcontracting and scoring slide. Just remember to fill this out every time for me. (Next Slide)

Comprehensive Transitional Care: How I would explain this...this is going to help the member when they are discharged from a hospital or care facility. Obviously, it's much more than that, but it's a good place to start if you aren't familiar with this. Question 1: "Do you provide Comprehensive Transitional Care timeframes related to appointments and discharge paperwork?" "Yes or No." Question 2: "Do you provide Comprehensive Transitional Care follow-up appointment information?" "Yes or No." So, we know follow up care is important. We also know when you don't take care of yourself when you leave the hospital you are likely to wind up back in the hospital. We want to prevent that. So, one of the things we hope the Health Home Partner will do is make that transition as smooth and successful as possible. And that's what we are trying to get at here. (Next Slide)

You are probably tired of this slide, but please make sure you fill it out when you come to it in the tool. (Next Slide)

Member and Family Support: This is really about providing the member and their family support. I think it's important to focus on communication here. Are you going to help them reach their health goals by working with their family and their other providers and all care providers involved? Question 1: "Do you provide Member and Family Support that is contingent on effective communication with member, family, guardian, other support persons, or caregivers?" "Yes or No." "Do you provide Member and Family Support that involves accommodations related to culture, disability, language, race,

socio-economic background, and non-traditional family relationships?" "Yes or No." I think on this one the important thing to recognize is we have a great deal of diversity in some of the groups we work with. We want to be sensitive to that and we want to make sure we provide communication that is happening in an acceptable way. Can you provide these services? Question 1-6 will walk you through that. (Next slide)

Again the subcontracting slide. (Next Slide)

Referral to Community and Social Support Services: Final core service, 'Referral to Community and Social Support Services'. This is making sure that the member gets the other services and supports they need to stay in their home, be successful and be as healthy as they can be. Question 1: "Do you provide Referral to Community and Social Supports through knowledge of the medical and non-medical service delivery system within and outside of the member's area?" "Yes or No." "Do you provide Referral to Community and Social Supports through engagement with community and social supports?" "Yes or No." If you are going to focus on two things – focus on knowledge and engagement. Perhaps you have a list of community resources that you can direct your members to. Or you can work with other providers who are working with this member so they know everything that is available to them. (Next slide)

Again the subcontracting slide. (Next Slide)

Health Homes Information Technology: I know we are using acronyms here. So bear with us. We are really asking if you have an interoperable electronic health records you are using. It's ok if you answer 'no'. Questions 1-3 below are going to gauge where you are and help the MCOs know what they need to help you move forward. Question 1: "Do you currently have the capacity to submit a plan, within 90 days of contracting as a Health Home Partner, to implement the EHR?" We are asking if you have a plan. Can you commit to making a plan in 90 days? Question 2: "The State expects Health Home Partners to achieve full implementation of the EHR within a timeline approved by the Lead Entity." "Provide an estimate of how long it may take you to meet this expectation: 12 months/18 months/ 24 months (circle one)?" Think about this honestly, how long is it going to take? What do you need to make it there? Question 3: "The State expects Health Home Partners to have the capacity to connect to one of the certified State HIEs, KHIN or LACIE." "Provide an estimate of how long it may take you to meet this expectation: 12 months/18 months/24 months?" Circle the one that most relates to your timeline. (Next Slide)

Health Homes Provider Standards: Not going to walk through each one of these. I will give you the broad strokes here. Health Home Providers must meet State licensing standards or Medicaid Provider certification and enrollment requirements as one of the following. Do you meet these standards? You might circle 'no' to most of these. You might circle 'yes' to most of these. But please go through carefully and choose the appropriate response. (Next slide)

Health Homes Partners must enroll or be enrolled in the KanCare program and agree to comply with all KanCare program requirements. "Are you enrolled in the KanCare Program?" "Yes or No." "Do you agree to comply with all KanCare program requirements?" "Yes or No." Question 3: "Health Home Partners must have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls. Does your leadership fit the description above?" "Yes or No." Please provide some brief examples. (Next slide)

“Health Home Partners must have the capacity to accompany enrollees to critical appointments, when necessary, to assist in achieving Health Action Plan goals. Do you have the capacity to accompany enrollees to critical appointments?” “Yes or No.” You kind of get the idea here. These are ‘yes’ or ‘no’ questions. We do ask for brief examples and we hope you give those in either the boxes or an attached document. (Next slide)

Health Homes Partner and Lead Entity Joint Standards: Again, I’m not going to go over each of them, but I do want to point out just a few. Question 1: “The Lead Entity and the Health Home Partner jointly must provide 24-hour, seven days a week availability of information and emergency consultation services to enrollees. Do you have staff and procedures in place to ensure this availability?” “Yes or No.” The other questions in this section are similar with ‘yes’ or ‘no’ questions and we do ask you to give examples and we ask you to provide those. (Next slide)

This is just more of the same, ‘yes’ or ‘no’ questions. If you have specific questions about these I will circle back, but I want to make sure we have time to get through the tool. We will move on for now. (Next slide)

This is an important one. And I do want to read through a little of this. “The Lead Entity and the Health Home Partner jointly must demonstrate their ability to perform each of the following functional requirements. Can you do the following?” “Please provide a brief example to support your answer to each. If you respond ‘No’, please explain where you are in your process and describe your current abilities.” I think it’s very important to know that it’s ok to say ‘no’ but please tell us where you are and what it would take to move you forward. Question 1: “Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines?” “Yes or No.” Can you provide these services in Number 1? But you might also want to tell us about the clinical practice guidelines you are using so that everyone is kind of on the same page about what you are doing and why. (Next slide)

Questions? Turning back to Sonja and she will introduce the MCO representatives. Thank you everyone.

Sonja:

Thank you Samantha and thank you for the questions waiting in the cue. On the line today, we have Leslie Banning from Amerigroup, Dr. Katherine Friedebcach from Sunflower State Health Plan and I’m not sure if we have Ben Pierce on the line from United and if you are there, you can let me know. We are thankful for everyone that can be here to help answer questions. We just have a few so if you have a question that you have on your mind, I encourage you to type into the text box because some of those questions might be helpful to your peers. The first questions are about the very beginning of the tool. The question says: “Do you want to know individuals seen in the target population or all by the agency?” So, for that first page of the tool related to the five diagnoses and the total number of encounters, etc., is that just within the target population or is it the entire group by the agency? And that totally is a question back to you, Samantha.

Samantha:

Alright, this is Samantha, we want your whole agency. We want to know the whole population you are serving. And again you might not list anywhere in the top five, someone with, let’s say, asthma. But that’s ok, tell us about the people you are serving right now and think about it you’re willing to expand

your service base as well. I hope that answers your question but, again, always feel free to send me an email or contact me directly and I'll be happy to go into more detail if that's needed.

Sonja: And another question read: "How do Community Mental Health Centers determine all the primary care diagnoses in our catchment area?" And so, I'm wondering if that's an interpretation of those first five diagnoses question and is that clarification of the first five diagnoses within one's own population? Or within the catchment area itself? (Pause) So Samantha, if I read the tool, my assumption is that you are asking for the top five diagnoses within the agency's population. (Pause) Did we lose Samantha?

Samantha:

Can you hear me? We've got this alarm going off and things are kinda getting screwy. You are correct in your assumption. It is the diagnoses for your agency.

Sonja:

Ok. And one more from the first page, related to questions 2 and 3. Is that the total clients served? Or just those who would be served who would qualify as a Health Home client? You're wanting data about...

Samantha:

We are asking for the total clients served. Now, if you are able to break it down...again, more information is better than less...but we're asking for the total of the client base that you are serving right now. (Pause)

Sonja:

Ok. So we have a couple of other questions. One is, "Define substance use disorder provider". So that was one of the yes or no boxes on that long list of providers. So what constitutes the 'substance use disorder provider'?

Samantha:

So, what I need to do here is refer you to the website. Ask you to look in the State Plan Amendment, which is located under 'Informational Materials for Providers'. We also have documents that say 'Provider Requirements', 'Provider Standards' – these are things that we have defined in other places. Some of these I'm not going to be able to give you a verbatim definition right now. But, go ahead and look at those other documents, look at the State Plan Amendment, and if you still have questions, give me a call and I'll be happy to walk you through it, ok?

Sonja:

Excellent! Thank you, Samantha. Another question that we have is related to...oh yeah...related to diagnoses, the top five diagnoses...do you want those grouped? So, for example, all depression diagnoses together rather than separated out by various variations?

Samantha:

(Ok.) I've just been handed a note that I need to evacuate. So, Sonja, I'm gonna have to hand it over to you. I'm very sorry everyone, I'm really not sure what's happening here in Topeka but, um, I'm very sorry.

Sonja:
No, you're fine!

Samantha:
You are welcome to contact me directly if you have questions. Sonja, I'm going to give it back to you, ok?

Sonja:
That's fine. We are happy to take those questions. So, again, for those of you who have joined the call perhaps a little bit later, this is Sonja Armbruster of the Center for Community Support and Research and we are helping host these webinars and this was certainly an interesting unforeseen circumstance. But, we do, we are capturing questions on the website that will be answered and those answers will be posted on the KanCare website within our Health Homes and for all of you who are registered on the call, we'll be sending the answers to those questions.

There is a question on the call that asks, "When can we get an idea of payment rates?" And, we have planned for this call just to answer questions about the Preparedness and Planning Tool. There is some information about rates available on the website now, but those are the rates, those are the dollars that KDHE will be paying per member, per month in the SMI SPA with the...to the KanCare providers, to the three MCOs. So, in a future call, we'll have additional information about the answers to the payment rates. We just want to acknowledge that we received that question.

Another question was mentioning the subcontractors must fill out the application: "If we are going to subcontract with an agency that is contracting with the MCO for prevention services only, the tool does not seem to apply". So, that's a great question and the answer is...answer each of those questions as fully as is appropriate for you. So, for example, if you are considering providing health promotion services only, then you would simply answer 'no' to the other five – the other five of the six core areas. So, it's not an application. It's a tool for beginning a conversation between the individual Health Home Provider partner and the MCO who they will be subcontracting with.

(You want to advance to the next slide?) Just wanted to announce that we'll be saving the date for the other topics that we are planning to provide an overview for. So, the other topics that will be coming up...next week we will be talking about the Program Manual and some of the other documents. Many of those documents you can see on the website now. March 18 we will be talking about Member Assignment and the Referral Process. And, March 25, the payment structures for the two SPAs. April 22, the Health Action Plan: Step by Step and April 29, HIT.

Another question that's come in, "Where can we get details on what it means to have an 'interoperable EHR'?" I believe that is defined in a document on the website now and we will have the answer – a clear answer for that – posted with the answers for all of the questions for today's webinar...unless there is a MCO rep on the call who would like to take an answer for that. Again, the question was, "What's the definition of an 'interoperable EHR'? (Pause) So, for the two MCOs that I know are registered and on the call, a similar question that has been asked is, "I assume the MCOs have an EHR. Will it be the preference of the MCO that the Health Home Partner use their EHR?" Would either of you be willing to comment on that? Is there a preference related to EHRs?

Dr. Katherine Friedebach:
Hi, this is Dr. Friedebach, and I think the answer to that question is evolving. I think at this point, the MCOs are pretty aligned in we want to (cough) ...Health Information Technology where it's available and

that's probably going to, in some ways, be Health Home Partner specific. So, if the Health Home Partner doesn't have an EHR but would benefit from using one of the MCO portals, then that may be a starting point that we evolve from. So, I think the Health Information Technology utilization question is one that probably allows us to define where our starting point is and how we may evolve and transform from there. But, to my knowledge there hasn't been a definite direction on what that needs to look like from day one.

Bill Downham:

This is Bill Downham from United. Ben is out today but I'll take this. We, as Dr. Friedebach had mentioned, we also are evolving in the way we are going to approach this. We do have a web-based platform that we use as we are in the process of using it in some other types of circumstances. I don't know that we would necessarily require that our platform be used and that's part of what's evolving, to make sure that we track the appropriate information. So, as we meet with the providers, those will be discussions we would have and create whatever opportunity that might be effective to help in managing information.

Sonja:

Thank you, both, for that clarification there...that this is an evolving process and that there will be additional information coming forward related to those two things. Ok. This is the majority of the questions that have been asked. There are a couple of others that are going to be Samantha specific and I'm sure that she would have been very happy to answer them if they hadn't evacuated their building. So, we will get the answers as quickly as possible. The answers...the webinar itself will be posted online on KanCare's website either later today or tomorrow for any of your colleagues who have not had any...who have not been on the line. If you have any specific questions, we encourage you to direct them to Samantha Ferencik and her email address is up upon the screen right now and she'll be happy to help answer any questions. Thank you all for being on the call. In about an hour, you are going to get an evaluation and we encourage you to fill that out so that we can develop a better webinar for the next time. Thanks so much!