



WICHITA STATE
UNIVERSITY

*CENTER FOR COMMUNITY SUPPORT
AND RESEARCH*

Health Homes Stakeholder Meeting

June 3, 2014

WSU Hughes Metroplex

PARTICIPANTS – Please sit according to your service region (see table signs).

Purposes of the Day

- Provide an update on progress since March Stakeholder Meeting
- Gain information from the Lead Entities regarding updated processes and ongoing support
- Provide resources related Health Information Technology, Health Promotion, and Professional Development opportunities
- Gain increased understanding of how Health Home services and processes will work



Health Homes Progress Update

Becky Ross, KDHE DHCF
Samantha Ferencik, KDHE DHCF



Health Home Network and PPTs

- 118 Preparedness and Planning Tools Received
 - CMHCs: 23%
 - FQHCs: 9%
 - CDDOs & Community Service Providers for people with I/DD: 42%
 - Local Health Departments & Home Health Agencies: 19%
 - Other: 7%



Network Coverage

Though not all providers will become Health Home Partners, we have interested providers in every county.

Many providers did not indicate their desired target population. However, among those that did:

- 37 expressed interest in serving both target populations
- 17 expressed interest in serving the CC population
- 6 expressed interest in serving the SMI population

Health Homes Updates

- State Plan Amendments for both target populations (SMI and CC) were submitted to Centers for Medicare and Medicaid Services (CMS)
- Onsite MCO “Readiness” Reviews completed
- 1115 Waiver



Lead Entities



Leslie Banning
Health Homes Manager
KSHealthHome@amerigroup.com



Overview

- Philosophy and Spirit of Health Homes
- Amerigroup's Vision for Health Homes
 - Integrative model
 - Movement from acute care to chronic disease management
 - Individual providers to team care
- Management of the Core Services
 - Expectations
 - Documentation

What Is a Health Home?

An integrated, person-centered, physical and behavioral ***service delivery system*** aimed at populations with complex, chronic conditions (fueled by the exchange of health information, evidence-based practices and intense care coordination) intended to improve outcomes by **reducing fragmented care** and promoting **patient-centered care**.

What Does a Health Home Address?



A Health Home addresses physical and mental health issues and conditions while coordinating with community supports and services.

Premise for Health Homes

- Connects mind and body
- Enhances care through team organization
- Promotes member engagement and enhanced self-care
- Mobilizes and coordinates primary medical services, specialists, behavioral health, and long-term services and supports, increasing efficiencies and improving patient outcomes:
 - Increases health status and quality of life
 - Reduces premature mortality
 - Enhances service quality
 - Reduces hospital inpatient admits/length of stays
 - Reduces emergency department utilization
 - Reduces redundancy in tests and procedures
 - Reduces costs

Amerigroup's Health Home Point of View

- A managed care organization (MCO) provides end-to-end care coordination. Collaborating with a Health Home partner streamlines and connects the delivery of health care services
- The preferred HHP model includes co-located physical and behavioral health services with a co-located care manager
- If not co-located, relationships are established to achieve a holistic and shared approach (team-based care) through the use of health information technology
- All Providers of care and support are included in the care planning process to decrease fragmented care and to assist in addressing identified gaps in care

Roles and Responsibilities

Health Home	Amerigroup
Outreach and engagement	Identify members from data files for health home
Biopsychosocial assessment, personal health plan	Benchmarks, expected outcomes
Outpatient physical and behavioral health services —assessment and health plan	Provide sample clinical guidelines — pathways to manage members with chronic conditions
Wellness visits and health promotion	Monitor health screenings completed
Chronic condition management: acute episodes of care, education and self-management (chronic care)	Monitor care for chronic conditions, duplication of test and procedures, ER/inpatient admissions
Case management; refer to community/social supports	Communicate with Health Home
Individual and family support	Respite services, value-added benefits
Care coordination between all providers	Vendor services, Ancillary services
Facilitate transitions in care	Utilization management
Monitor members over time — registries to track	QA/QI reporting

Managing Core Services

- Contracting with HHP specifies which of the core Health Homes services will be provided by the HHP and/or a sub-contractor, and which will be provided by Amerigroup
- Defining documentation standards
- Reviewing Health Action Plans
- Promotion of collaboration, coordination, and communication through the use of Health Information Technology (HIT)
- Providing oversight and support

Managing Members – Complex Case Management

- Members identified by Amerigroup in the highest “risk” category will be managed by the Health Plan in the complex case management program.
- If the above identified members wish to participate in a Health Home, only HH services and supports supplemental to complex case management as provided by the Health Home Partner will be available to assure compliance with NCQA requirements related to complex case management.

Managing Members – Complex Case Management

- For members who are enrolled in a Health Home and whose utilization subsequently places them in the highest “risk” category, Amerigroup will follow one of the following ...
 - Amerigroup will provide complex case management and the Health Home will supplement by providing comprehensive care management (and/or other) Health Home Services
 - Amerigroup will provide all complex case management services
 - Amerigroup will engage in a delegation agreement with the assigned Health Home to monitor all complex case management activity accordingly



Hierarchy of Six Core Services

Hierarchy	Service	SMI Codes	CC Codes
HHP contracted for one service	Health Promotion	S0280 U1 HE	S0280 U1
HHP contracted for two services	Comprehensive Care Management	S0280 UC HE	S0280 UC
HHP contracted for three services	Referral to Community and Social Support Services	S0281 U8 HE	S0281 U8
HHP contracted for four services	Individual and Family Support	S0280 U8 HE	S0280 U8
HHP contracted for five services	Comprehensive Transitional Care	S0281 U1 HE	S0281 U1
HHP contracted for all six services	Care Coordination	S0281 UC HE	S0281 UC

Documenting Health Home Core Services

Service	Documentation
Comprehensive Care Management	Health Action Plan (HAP) in the patient record; assessment notes in the patient record with date and time (including duration), discussion points with the member or other practitioners, indication that the Plan was shared with all other treating practitioners and others involved in providing or supporting care.
Care Coordination	Patient record entries with date, time, practitioner providing the service, referral, follow-up or coordination activity with the member, treating practitioners and others involved in providing or supporting care. Patient record note could denote an ER visit, hospital admission, phoning member with lab results, discussing a consult with another treating practitioner, etc.
Health Promotion	Health promotion activities document activities to engage member in care, including outreach, assessment of member's health literacy, summary of health education and resources provided.

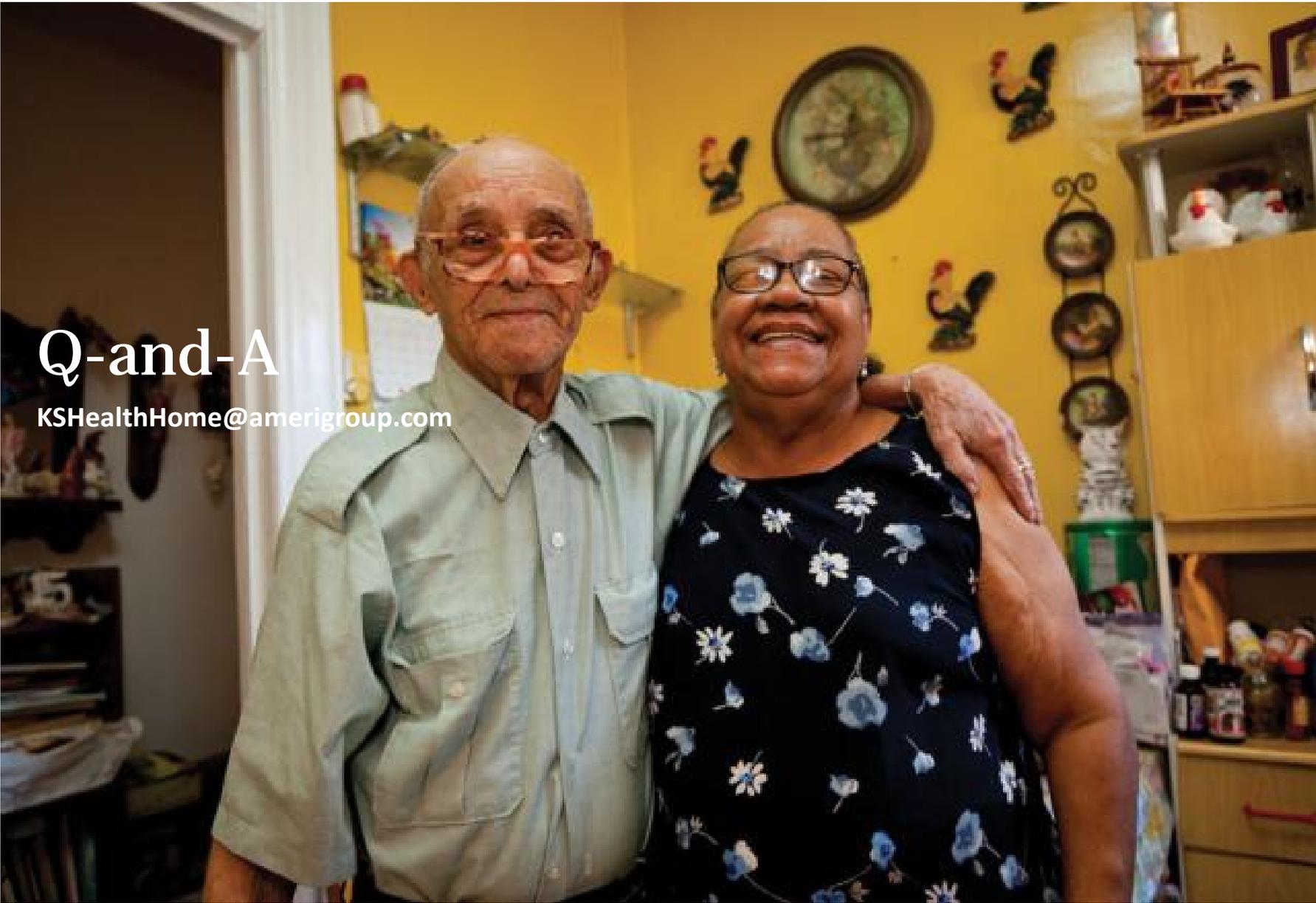


Documenting Health Home Core Services

SERVICE	DOCUMENTATION
<p>Comprehensive Transitional Care</p>	<p>Documentation in the Patient Record as to medication reconciliation and other key treatments or services with other health systems/places of service. Documentation should include date, time, practitioner from the HHP and what specific elements of the Health Action Plan, or the Plan itself, were shared and with what other health system or place of service and to achieve which specific Health Action Plan goal. Attention to the appropriate providers to address the follow-up care is extremely important; e.g., transmission of the Health Action Plan to a physical therapist who will be treating a member post knee replacement.</p>
<p>Individual and Family Support</p>	<p>Documentation of the assessment of psycho social or community support needs including the identified gaps and recommended resources or resolutions to address the gaps. Date, time, practitioner, service recommendations and discussion with the member, family (or other support persons), and/or guardian should all be included.</p>
<p>Referral to Community and Social Support Service</p>	<p>Documentation in the member record of the date, time and contact at a referral source and/or the date and time that a referral follow through or discussion was convened to address the gaps from the Individual and Family Support assessment process.</p>

Establishing Health Action Plan

- Meet with enrollee (face to face)
- Complete a comprehensive assessment
- Identify unmet needs, health literacy (member-centric)
- Establish Health Action Plan goals and action steps
- Ensure collaboration/integration of care between all providers of care and/or support, using HIT
- Submit to Amerigroup for review and oversight
- Revisions to HAP as needed and/or required



Q-and-A

KSHealthHome@amerigroup.com





Sunflower Health Plan Health Home Program



- **Mission Statement:** To improve health outcomes across the state of Kansas by encouraging the expansion, strengthening, and integration of local health care delivery systems as they provide exceptional health home services.
- **Philosophy:** The most powerful health home innovations come from direct service providers.
- **Program Highlights:**
 - Low Administrative burden
 - Autonomy to make changes relevant to your community
 - Technical assistance and data to help support your progress

- **Our health home program will facilitate:**
 - Patient Centeredness
 - Community Permanence & Relevance
 - Increased health literacy
 - Improved health outcomes
 - Integration of services
 - Population management
 - Cultures of continuous improvement
 - Utilization of health information technology

What lies ahead for our health home partners?



- Health homes is journey **NOT** a destination
 - Continuous learning & improvement
 - Must be more than standard practice
 - Patient-centered Strategy & Innovation
- 2014 Getting Started
 - Getting acquainted with
 - enrollees
 - SHP Health Home Program & team
 - Other Health Home Partners in region

(continued...)



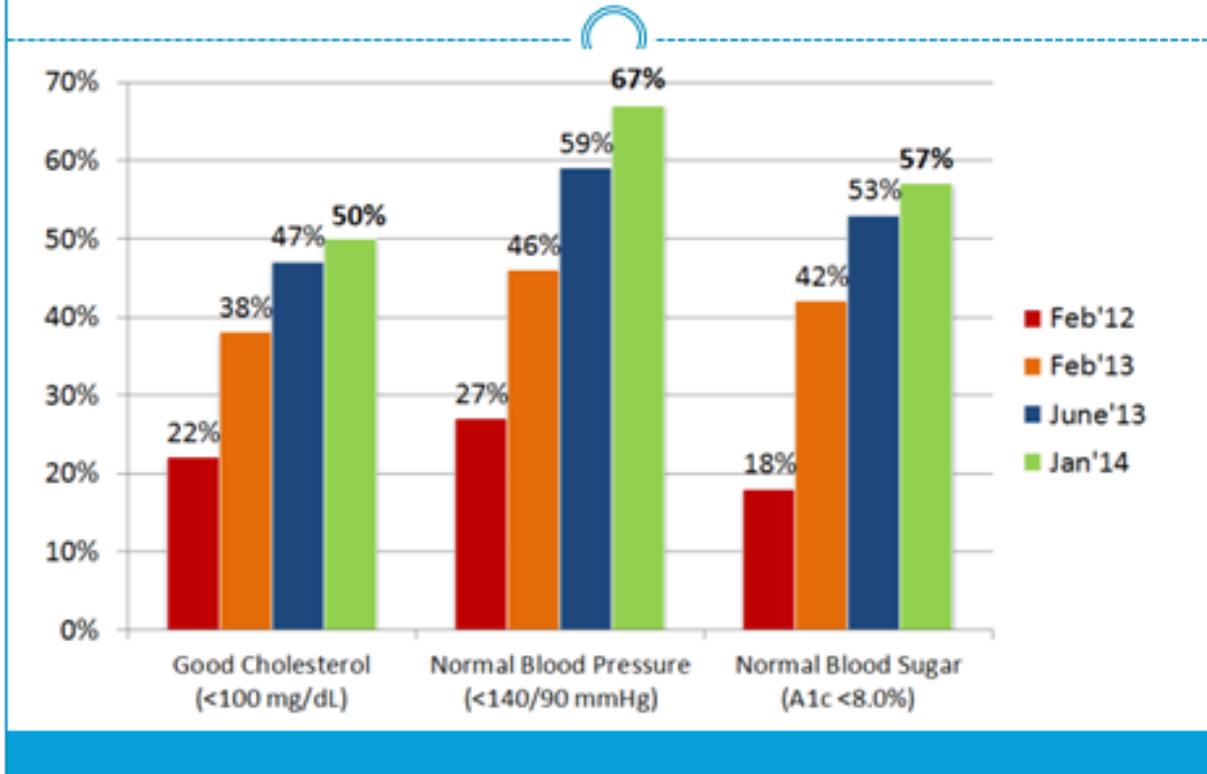
What lies ahead for our health home partners? (continued...)



- Operational and Educational meetings
- Evaluating health status & needs of population
 - HAP
 - 2014 report submissions
- Considering Innovations to reach Health Home Goals
 - Huddling, open access, hospital/ER follow up, etc.
- Evaluating adequacy of staffing



24 Month Health Outcomes for Behavioral Healthcare Home Adults with Diabetes



KanCare Health Homes Quality Goals & Measures



- Reduce Utilization associated with inpatient stays
 - Members utilizing inpatient psychiatric services
 - Inpatient Utilization – General hospital/Acute (HEDIS)
 - All Cause Re-admission
 - Ambulatory Care – Sensitive Condition Admission
- Improve Management of Chronic Conditions
 - A1c testing
 - LDL screening
 - F/u after Hospitalization for Mental Illness
 - Adult Body Mass Index (BMI) Assessment
 - Screening for Clinical Depression and Follow-up Plan
 - Controlling High Blood Pressure

(continued...)



KanCare Health Homes Quality Goals & Measures (continued...)



– Improve Care Coordination

- Increased Integration of Care
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Tobacco Use Assessment

– Improve Transitions of Care

- Inpatient utilization – General hospital/Acute Care (HEDIS)
- Transition Record Transmitted to Health Care Professional within 24 hours of discharge
- F/u after Hospitalization for Mental Illness



Process – Member assignment



- Sunflower will determine which members are eligible based on the claims-based data as defined by the state.
- Member assignment to a Health Home will be based on the following factors:
 - Existing Health Home Partner relationships
 - Same family indicator
 - Geographic location
 - Health Home capacity
 - Member condition (if a member qualifies for both SMI and CC the member will be assigned to a Health Home based on which one has more claims)
 - Age range



Process – Referrals



- Provider referrals –
 - There are referral forms that providers will be able to send to the plan. These forms will be available after the program starts.
 - The referral forms will be reviewed by our Health Home team with approved referrals being assigned to a contracted Health Home provider.
 - Providers will receive notification of whether or not their referral was approved or denied.



Process – Member changes



- Member changes –
 - All members will have a choice of Health Home providers with change requests handled through member services.
 - When a member changes Health Homes the member listing for providers (available through the portal) will be updated.



Process – Claims



- Providers will submit claims using the S0280 and S0281 billing codes.
- Health Home claims will be processed the same as other claims.
- Health Home claims should only include Health Home services.
- Providers will submit claims for every Health Home service provided for tracking purposes.
- The rates will be calculated based on the member's Health Home type and cohort.



Process – Claims (continued...)



- Claims submitted for Health Home services from a HHP other than the HHP assigned to the member will be denied.
- Providers should check spenddown status prior to performing services.



Process – Claims (continued...)



- **Modifiers matter:** All Health Home claims must include the appropriate modifier.

Core Services	Type = Serious Mental Illness	Type = Chronic Condition
Comprehensive care management	S0280 UC HE	S0280 UC
Care coordination	S0281 UC HE	S0281 UC
Health promotion	S0280 U1 HE	S0280 U1
Comprehensive transitional care	S0281 U1 HE	S0281 U1
Patient and family support	S0280 U8 HE	S0280 U8
Referral to community and social support services	S0281 U8 HE	S0281 U8



Key Health Home Program Contacts



- Sunflower Health Home Correspondence:
 - E-mail: LEN_SFSHPHEALTHHOME@centene.com
 - Phone: 913-333-4612
 - Fax: 866-241-6416
- Leadership Team:
 - Health Home Clinical Project Manager: Dorothy Keller, RN
 - Health Home Operational Project Manager: Jeanine Meiers
 - Provider Relations: Bryan Swan



Resources



- Health Home Program Team
- Regional Meetings
- Provider Portal
- Nursewise
- Nurtur
- Cenpatico Behavioral Health
- Provider Relations
- LifeShare Management Group



UHC Kansas Health Homes

Contact Information

E-Mail

Health Homes Mailbox

UHC KS Health Homes - uhckshealthhomes@uhc.com

All In Model –

You have the training, tools, capacity, and capability to perform all 6 services on day 1

- Control over maximum panel size and population served
- Data and application training support from UHC
- Includes models where the Health Home Partner subcontracts with other providers for services
- PMPM Payment –**MAX**

Partial Service Model –

You can perform at least 3 services on day 1

- Control over maximum panel size and population served
- Data and application training support from UHC
- UHC assistance in identification of potential subcontractor partners
- PMPM Payment –**MIX**

Demonstration Model –

You are a health home provider, but UHC covers staffing, admin, and day to day work

- Members assigned to your practice
- No initial up front staffing cost
- UHC demonstrates scope of work, systems, processes etc.
- Data and application training support from UHC when ready to take over services
- PMPM Payment – **NOMINAL**

Preparation

Before the contract is signed:

- United reviews and assesses the submitted Preparedness & Planning Tool
- A joint meeting is conducted to review the providers PPT, answer questions, discuss alignment with the United model and assessment tool is provided
- We jointly estimate the provider's capacity and service area by county
- UHC tools are introduced
- The provider completes the assessment
- UHC reviews the completed assessment and agrees that the provider can move forward with contracting, or determines that some areas are deficient and need to be reworked

Execution

After the contract is signed:

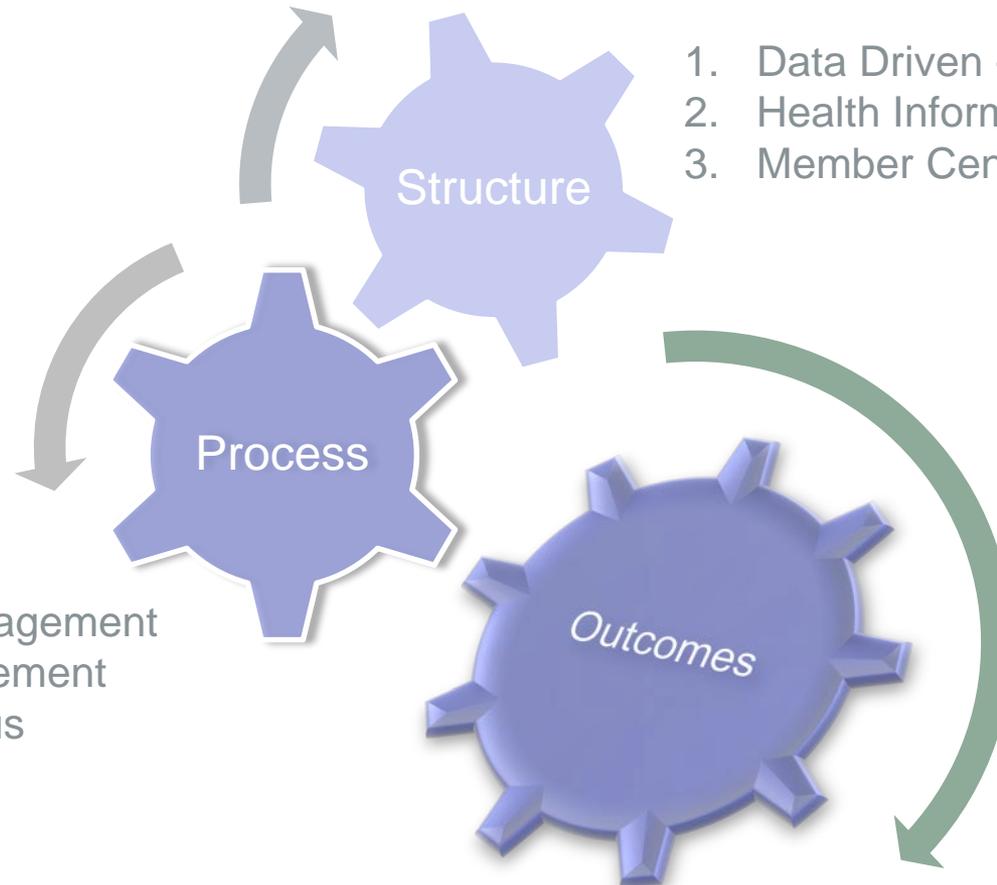
- Clinical Consultant and RN Care Manager is assigned to each practice and introduced to staff and leadership
- Policies/processes are finalized
- Training on UHC tools
- Processes of patient engagement and care coordination are started with coaching and trouble-shooting with UHC team assigned
- Oversight and support provided as needed
- August 1 – Begin submission of provided services to UHC
- September
 - Assessment of first month with adjustments as needed
 - Joint Operating Committee (JOC) schedule begins

Training Schedule

More detailed information will be available on www.uhccommunityplan.com in the coming weeks. Training session design will be similar to the DD training program.

- Training expected to occur each Tuesday beginning June 17th and ending August 26th 2014
- Expected to occur each Tuesday and will last 1.5 hours
- Times will vary each Tuesday to allow for differing schedules
- Representatives from United provider advocate teams for physical, behavioral, and HCBS provider types will attend
- Representatives from United will be attend to support the clinical aspects of the program
- Content will include billing, policies and procedures, website tools and resources, and many other topics for Health Homes
- All providers are encouraged to attend

Provider Oversight and Support



1. Data Driven - Headlights
2. Health Information Exchange
3. Member Centric

1. Care Team Engagement
2. Member Engagement
3. Population Focus

1. Continuous quality improvement
2. Evidence based interventions
3. Reporting – Tail Lights

Monitoring/Remediating

Our contract requires a Joint Operating Committee (JOC) which ensures:

1. Provider is meeting the expectations of Care Coordination model and data sharing/reporting.
2. Reports are shared with the provider monthly with collaboration around improvement of process and results.
3. Collaboration with providers to seek a satisfactory resolution to data sharing or performance expectations.
4. Providers who elect to use independent tools that cannot/do not provide data to UHC on expected processes will need to provide a corrective action plan or be subject to removal from the Health Home network.
5. Providers who fail to meet the expectations of care coordination will need to provide a corrective action plan or be subject to removal from the Health Home network.
6. UHC reserves the right to deliver services to members directly until a replacement health home partner can be identified.

Clinical Model of Care Coordination



Six Core Services	Example Requirements	Expectations	Measure
Comp. care Management	Member assessment for complex care needs and development of Health Action Plan; indication that plan was shared with multidisciplinary care team.	Assessments performed on all Health Home members within 30 days of enrollment and annually.	% members assessed within req. time frame <i>% of patients with a face-to-face encounter with a care coordinator in last 30 days</i>
Care coordination	Facilitate completion of activities between and among members of the community based care team assuring interactive participation with whole person plan of care.	PCP visits q 90 days for members. Behavioral health visits q 90 with leading behavioral health condition.	% members with no PCP visits % PCP visits every 90 days % behavioral health visits every 90 days
Health promotion	Documented assessment of health promotion needs and addition of problems to health action plan including obesity, health literacy assessment, educational discussions	All members will have their BMI recorded at least annually, All members receive information on health promotion including gaps in care for chronic illness.	% members with BMI on record % members with preventive measures complete (no gaps in care)
Comprehensive transitional care	Coordination of services across various providers, with a transition of place or level of care. Ensure PCP visit within 7 days of inpatient or emergency room visits	PCP -visit is provided within 7 days of any discharge from ED or inpatient service.	% PCP follow up visit within 7 days of ER visit % PCP follow-up within 7 days of inpatient discharge
Individual & family support	Assessment of individual and family psych-social or community support needs including gap identification and plan development; documentation regarding services for member of family	Document HAP for all members including goals w/ time frames Individuals name a primary caregiver.	<i>% of patients who have goals with timeframes</i> <i>% of patients with substance abuse disorders in active treatment programs</i> <i>% patients who identified a primary caregiver</i>
Referral to comm / social support services	Management of referrals including transparency of tracking when referrals are made, completed, reported and changes to plan of care resulting from referrals.	All referrals are tracked for completion of visit, completion of referral report or CDC and follow-up by PCP visit.	% referrals completed by evidence of report tracking
Use of HIT	Documentation and information sharing through community based health information exchange – required for all services above	Use of UnitedHealth Care tools for care coordination.	If using an independent system must provide access to United to that system and provide data field extracts.



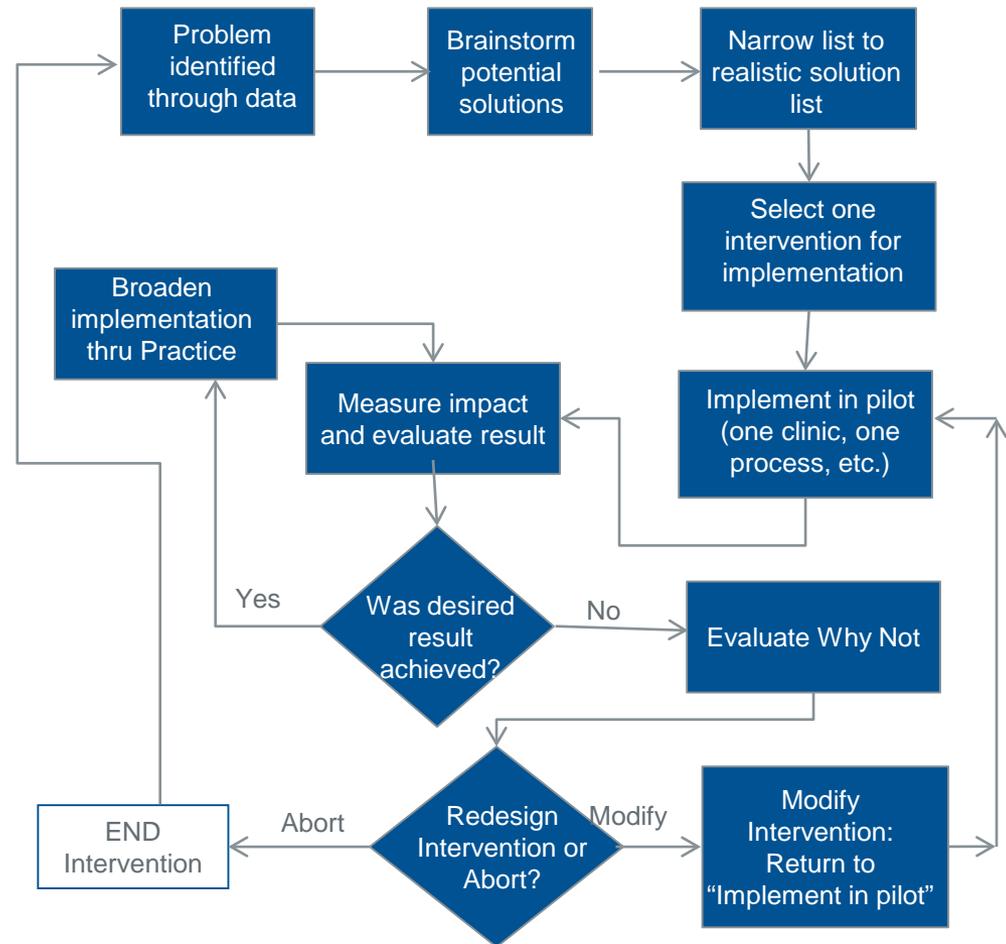
KS Health Home Program Monthly HHP JOC Update

Agenda

- I. Introductions
- II. JOC Charter
- III. Results Update
 - Enrollment
 - Care Management
 - Care Coordination
 - Care Transitions
 - Referral Management
 - Individual Patient Support
 - Family/Caregiver Support
- IV. Next Steps

Continuous Quality Improvement Program

- The Health Home Partner and UHC Community Plan will implement data driven quality improvement initiatives as a part of the collaboration of the Joint Operation Committee (JOC) meetings.
- Each initiative is driven on the identification of an opportunity for improvement through review of process and outcome metrics.
- Barriers identified form an excellent place to begin dialogue around how to improve a process.



Lunch!



Dr. Teresa Shireman

A stylized, light-colored illustration of a plant with several leaves and a cluster of small, round buds or flowers, positioned on the left side of the slide against a dark brown background.

BRINGING US BACK: WHY HEALTH HOMES ARE IMPORTANT

TARGET SUBGROUPS: BASELINE DATA

*Theresa I. Shireman, PhD, Professor
University of Kansas School of Medicine
Department of Preventive Medicine & Public Health*

June 3, 2014

Health Homes Stakeholder Meeting

Wichita, KS

General Methods: Cohorts

- Target subgroups
 - Chronic conditions (not in SMI subgroup)
 - Diabetes + at risk
 - Asthma + at risk
 - Serious mental illness (SMI)
- Cohorts from FY 2012
 - Used for prior data presentations
 - Looked back to FY 2011 and forward to FY 2013 using same individuals

General Methods: Measures

- All analyses pulled through Data Analytic Interface (DAI)
- Includes fee-for-service (FFS) and managed care (MC) encounter claims
- Measures
 - Co-occurring conditions: claims based diagnosis codes
 - Risk factors: claims based diagnosis codes
 - Expenditures: reimbursed amounts reported on FFS & MC claims

A stylized, monochromatic illustration of a plant with several large, pointed leaves and a cluster of small, round buds or flowers on the left side. The illustration is rendered in a dark brown color against a lighter brown background.

DIABETES TARGET SUBGROUP

Diabetes Health Home Target Population

- Primary diagnosis code = 250xx
- No evidence of serious mental illness (non-SMI)
- Pulled data through DAI (Data Analytic Interface)
 - Prevalent persons with diabetes during FY 2012
 - Children = 1,096
 - Adults = 18, 521
 - Fee-for-service (FFS) & managed care (MC) encounter claims
 - FY 2011
 - FY 2012
 - FY 2013

Health Care Expenditures: Diabetes cohort

	FY 2011	FY 2012	FY 2013
Number	17,026	18,916	16,726
Net pay—FFS, mean	\$14,641	\$14,678	\$8,353
Net pay—MC, mean	\$678	\$1,237	\$7,273
Net pay total, mean	\$15,319	\$15,915	\$15,626
PMPM, mean	\$1,372	\$1,511	\$1,426
Age, mean yrs	56.1	57.7	58.6
Months elig, mean	11.0	10.9	10.9

Net pay = amount reimbursed for paid claims

FFS = fee-for-service, MC = managed care

PMPM= per member per month & includes FFS and MC net payment amounts

Diabetes cohort: PMPM by year and age groups

Age Group	FY 2011	FY 2012	FY 2013
<= 5 yrs	\$1,319	\$1,753*	\$833
5 to <= 12 yrs	\$649	\$869	\$801
12 to <=18 yrs	\$783	\$980	\$847
18 to <= 40 yrs	\$1,234	\$1,374	\$1,430
40 to < = 65 yrs	\$1,427	\$1,558	\$1,393
> 65 yrs	\$1,449	\$1,545	\$1,561

Net pay = amount reimbursed for paid claims

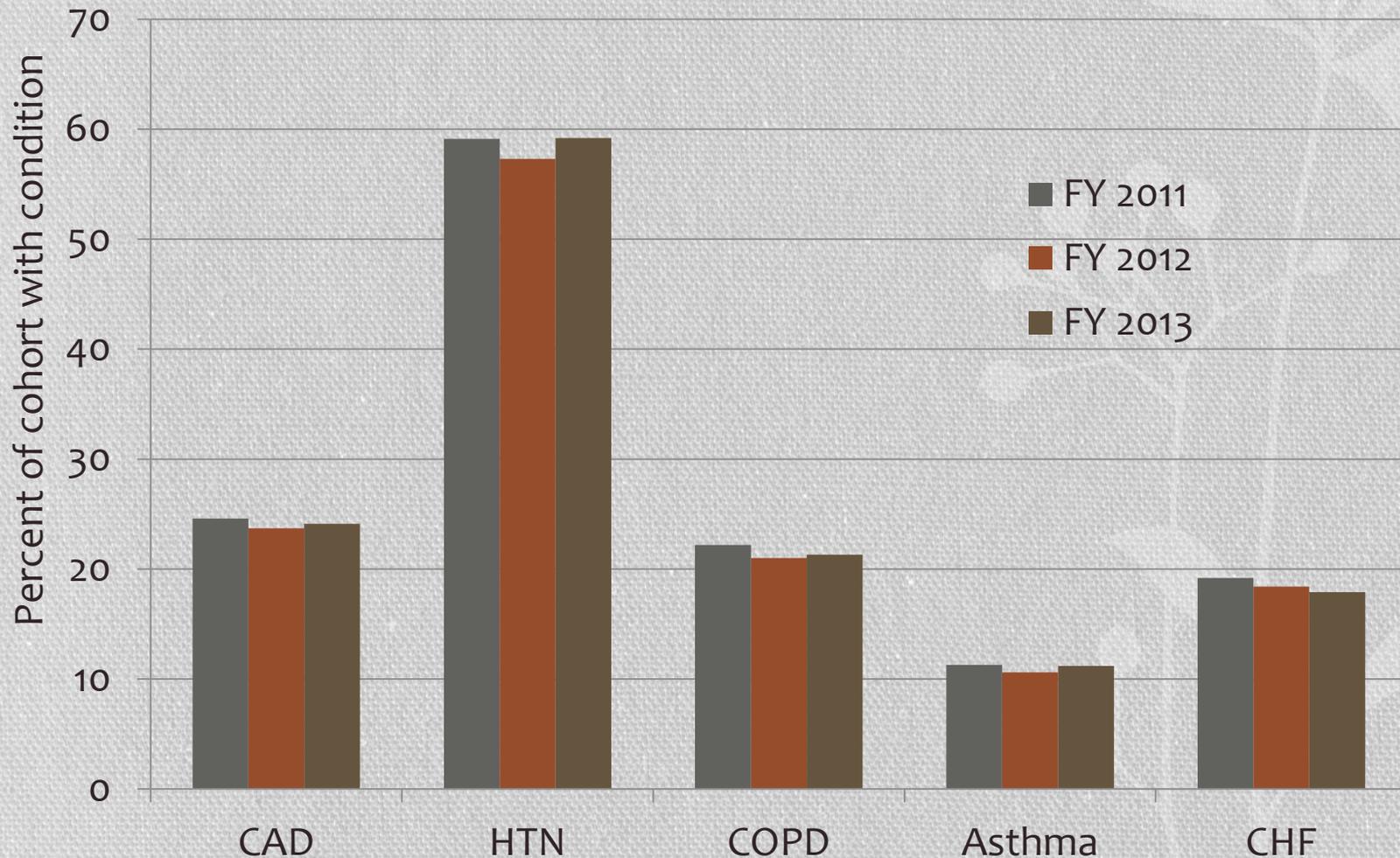
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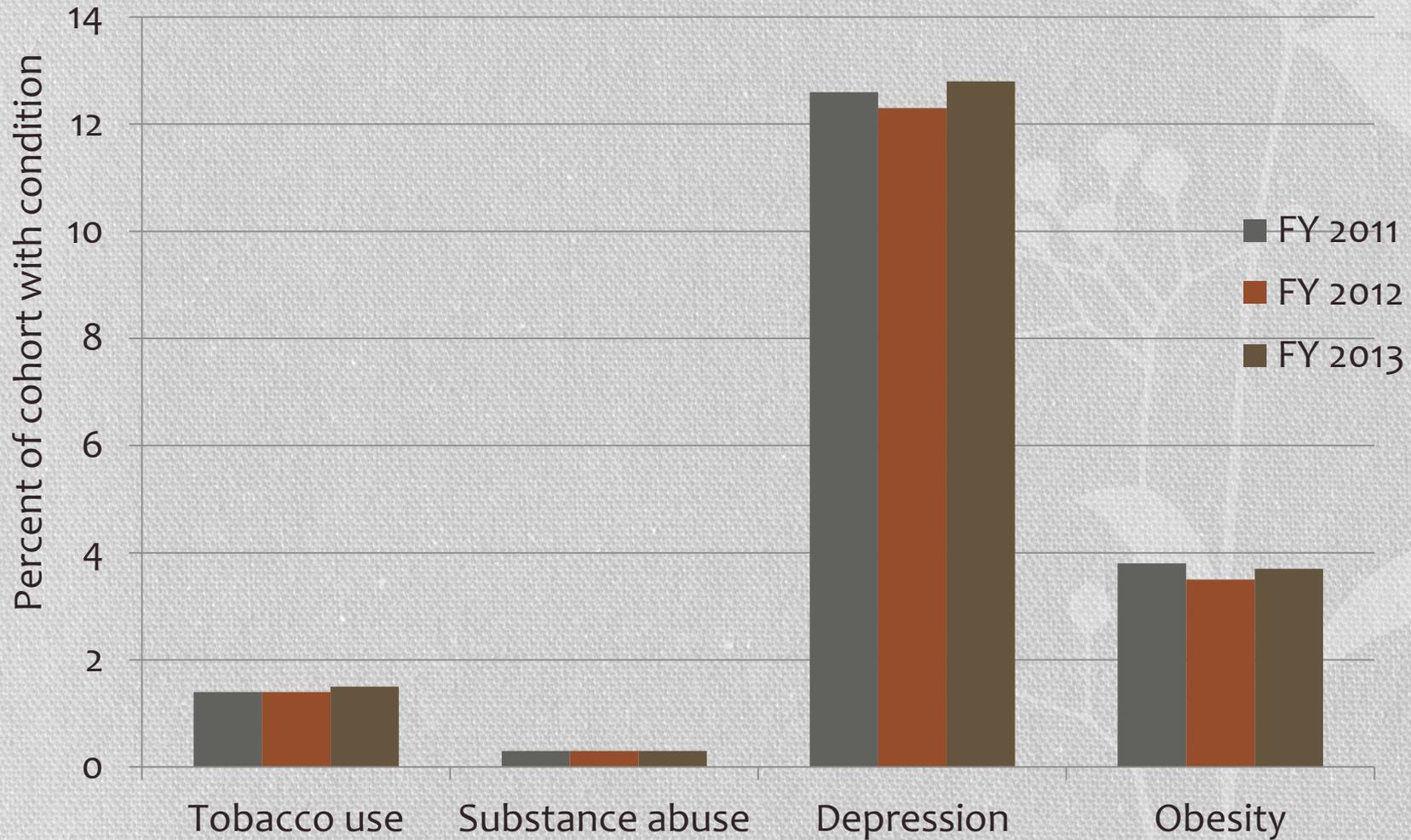
* PMPM—FY 12 for < 5 yrs: 2 cases with PMPM > \$100,000 removed

		At risk for 2nd condition (either set would qualify the individual)	
Primary condition	Case Identification criteria	Non-claims risk factors	Claims-based risk factors
Diabetes or pre-diabetes or metabolic syndrome	<p>Claims (2+ prior 12-24 months):</p> <ul style="list-style-type: none"> ICD9 codes = 250.xx; 648.0; 648.8; 790.29; 277.7 Medications = oral or injectable diabetes medications <p>Primary care referral:</p> <ul style="list-style-type: none"> Chart-supported diagnosis 	<p>Other chronic conditions:</p> <ul style="list-style-type: none"> Hypertension Coronary artery disease Depression Overweight/obese: <ul style="list-style-type: none"> Adult: BMI \geq 25 kg/m² Child: age-adjusted Substance abuse: alcohol, drugs <p>Current smoker or exposure to secondhand smoke</p> <p>Uncontrolled diabetes (HbA1c or glucose tests)</p>	<p>Missed quality of care indicator:</p> <ul style="list-style-type: none"> No HbA1c prior 12 months No LDL cholesterol prior 12 months No HDL/Triglyceride level prior 12 months <p>> 1 ED visit for diabetes or diabetes-related complication in prior 12-18 months</p> <p>> 1 hospital admission for diabetes or diabetes-related complication in prior 12-18 months</p> <p>Top 25th percentile of Lead Entity's risk score for persons with primary condition</p> <p>Other chronic conditions (2+ diagnosis codes from claims past 12-24 months):</p> <ul style="list-style-type: none"> Hypertension Coronary artery disease Depression <p>Non-compliance in taking medication regularly</p>

Diabetes Cohort: Co-occurring condition prevalence

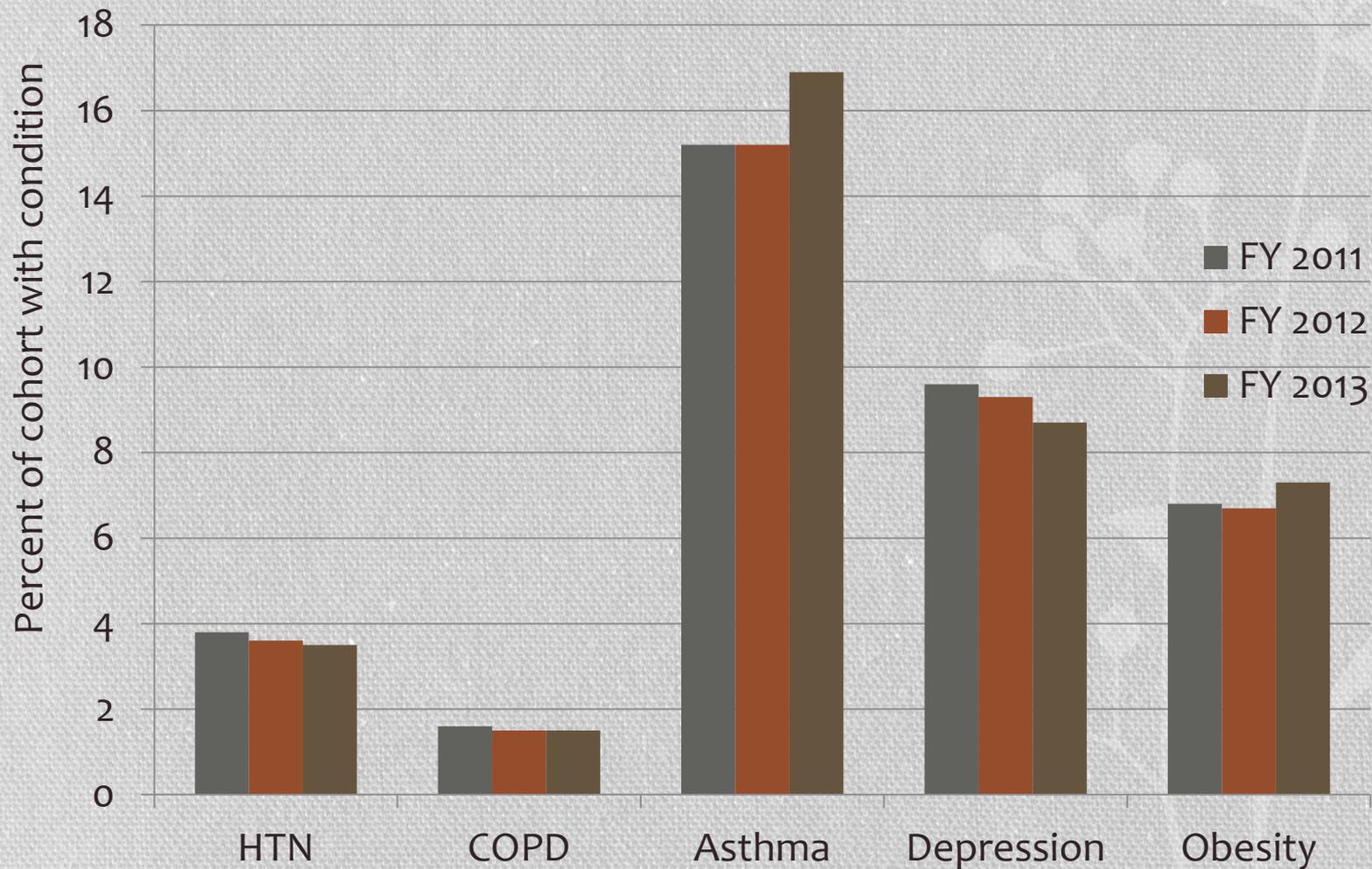


Diabetes cohort: Risk factor prevalence



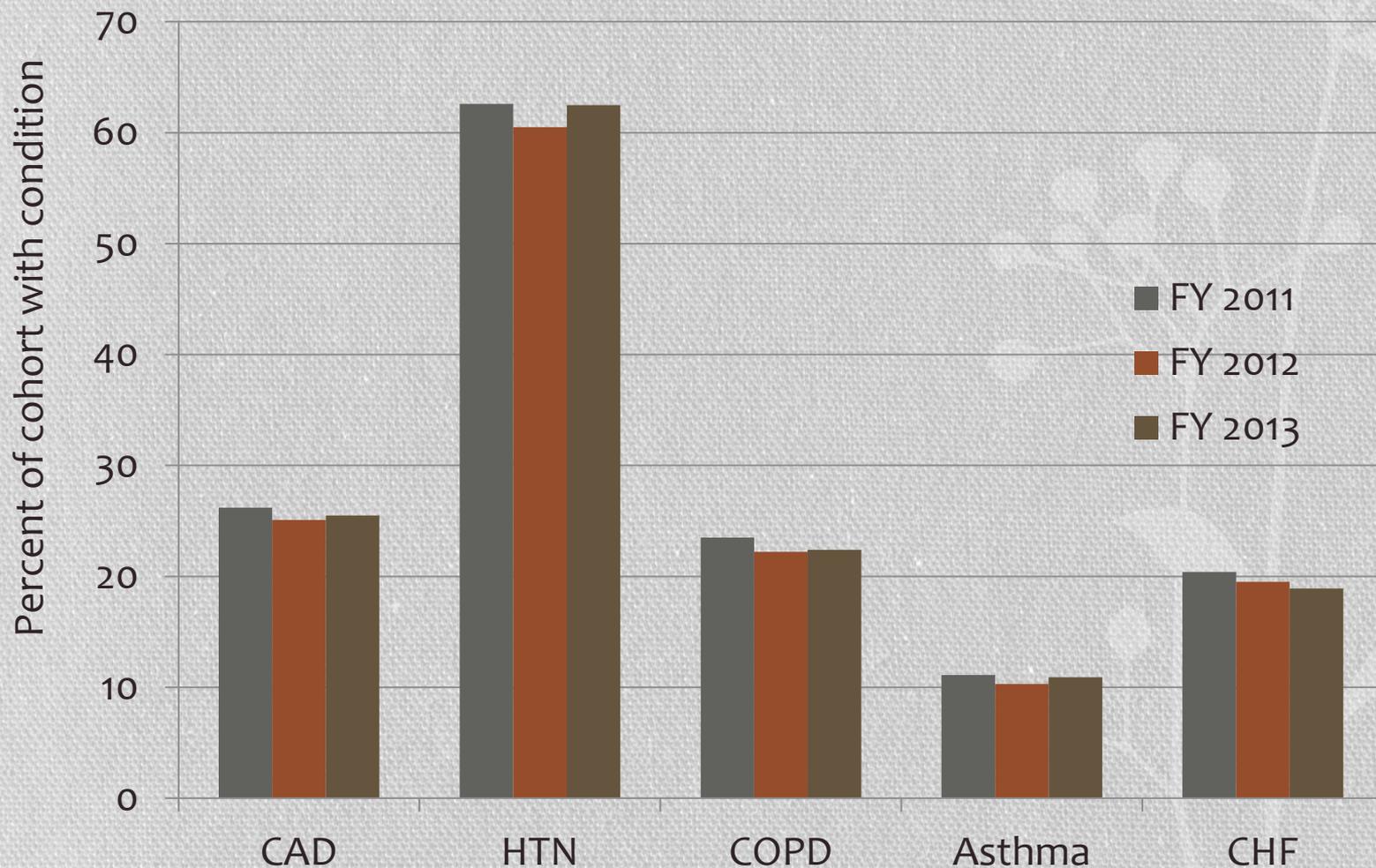
Diabetes cohort:

Co-occurring conditions: age \leq 18 yrs

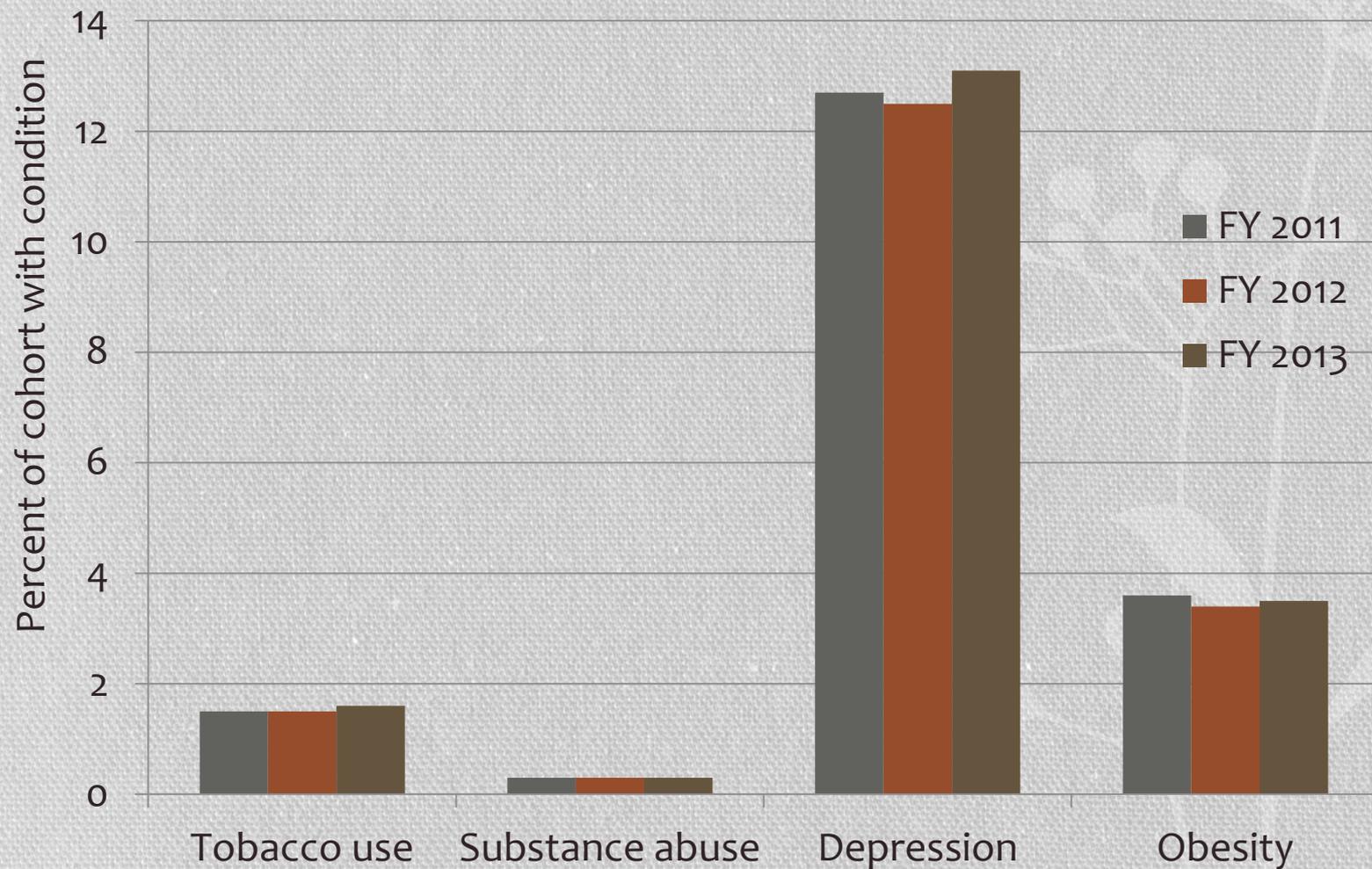


Diabetes cohort:

Co-occurring conditions: Age > 18 yrs



Diabetes cohort: Risk factors: Age > 18 yrs





ASTHMA TARGET SUBGROUP

Asthma Health Home Target Population

- Primary diagnosis code = 493xx
- No evidence of serious mental illness (non-SMI)
- Pulled data through DAI (Data Analytic Interface)
 - Prevalent persons with asthma during FY 2012
 - Children = 14,812
 - Adults = 3,794
 - Fee-for-service (FFS) & managed care (MC) encounter claims
 - FY 2011
 - FY 2012
 - FY 2013

Health Care Expenditures: Asthma cohort

	FY 2011	FY 2012	FY 2013
Number	17,186	18,806	17,584
Net pay—FFS, mean	\$3,853	\$3,578	\$2,037
Net pay—MC, mean	\$1,756	\$2,858	\$3,242
Net pay total, mean	\$5,609	\$6,436	\$5,280
PMPM, mean	\$539	\$572	\$477
Age, mean yrs	14.0	14.9	15.5
Months elig, mean	10.8	11.4	11.1

Net pay = amount reimbursed for paid claims

FFS = fee-for-service, MC = managed care

PMPM= per member per month & includes FFS and MC net payment amounts

Asthma cohort: PMPM by year and age groups

Age Group	FY 2011	FY 2012	FY 2013
<= 5 yrs	\$477	\$362	\$264
5 to <= 12 yrs	\$277	\$328	\$300
12 to <=18 yrs	\$360	\$398	\$355
18 to <= 40 yrs	\$813	\$1,505	\$967
40 to < = 65 yrs	\$1,369	\$1,402	\$1,398
> 65 yrs	\$1,310	\$1,290	\$1,339

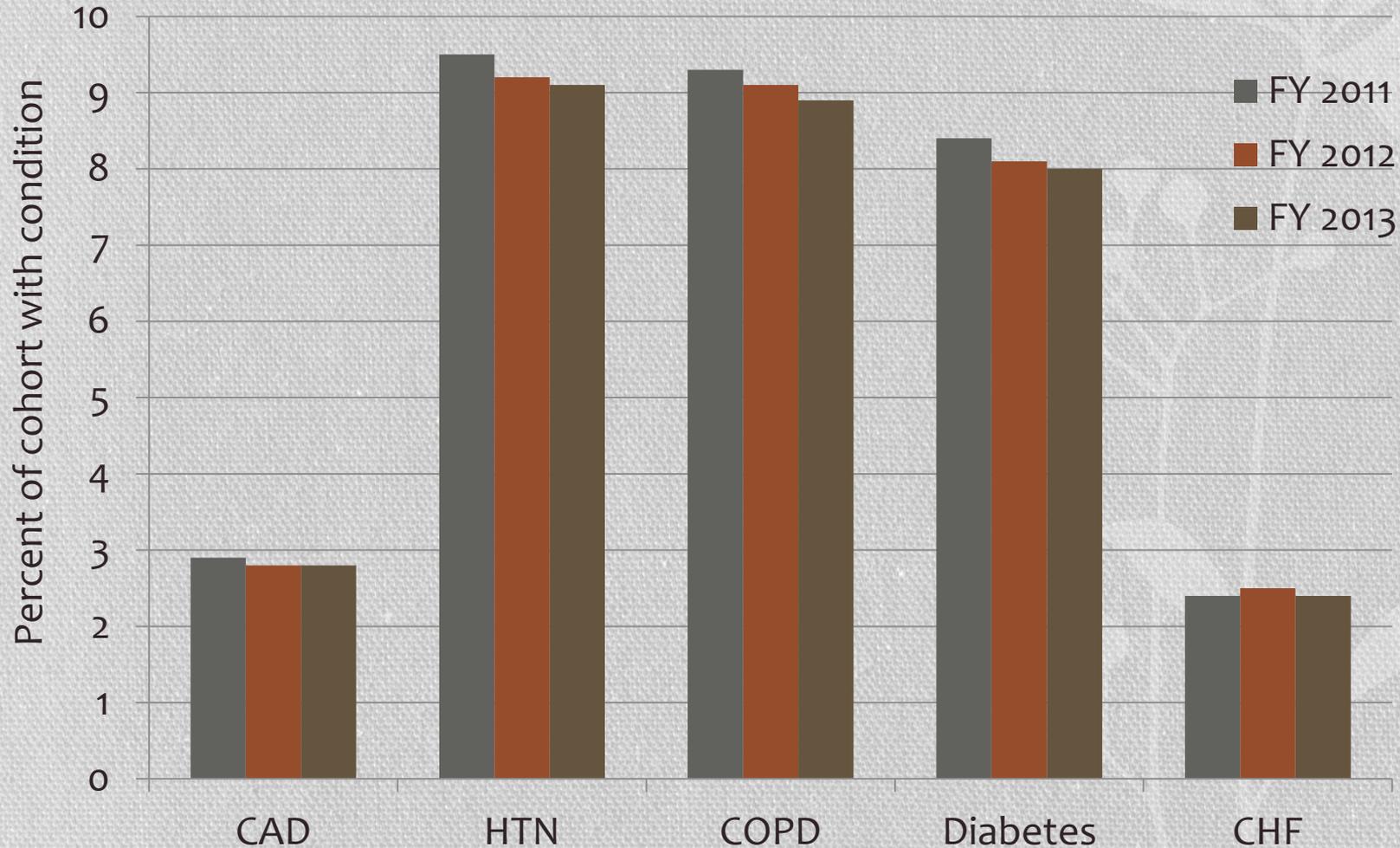
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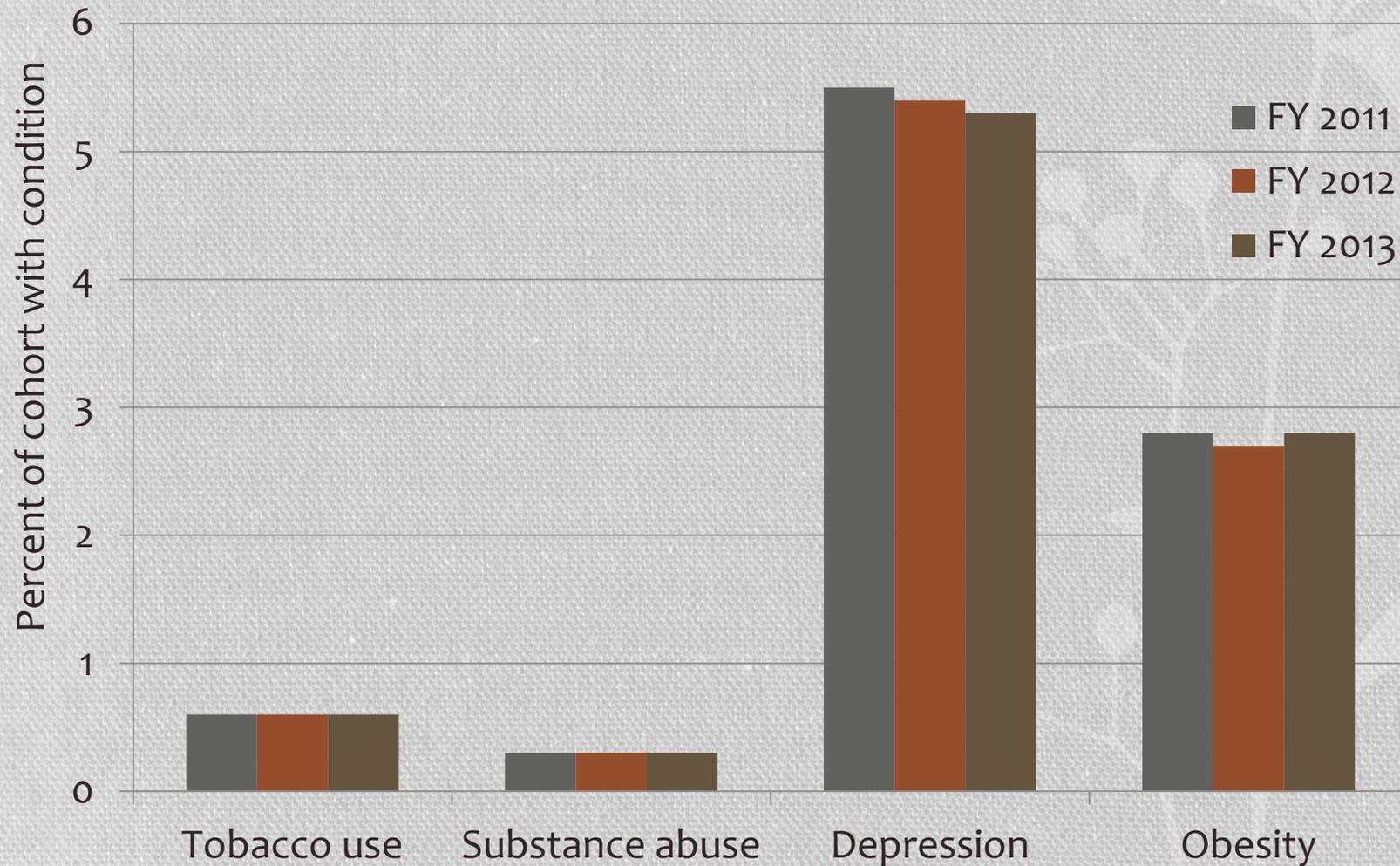
PMPM= per member per month & includes FFS and MC net payment amounts

		At risk for 2 nd condition (either set would qualify the individual)	
Primary condition	Case Identification criteria	Non-claims risk factors	Claims-based risk factors
Asthma	<p>Claims (2+ prior 12-24 months):</p> <ul style="list-style-type: none"> ICD9 codes = 493.xx <p>Primary care referral:</p> <ul style="list-style-type: none"> Chart-supported diagnosis 	<p>Other chronic conditions:</p> <ul style="list-style-type: none"> Hypertension Overweight/obese: <ul style="list-style-type: none"> Adult: BMI \geq 25 kg/m² Child: age-adjusted Substance abuse: alcohol, drugs <p>Current smoker or exposure to secondhand smoke</p> <p>Environmental exposures:</p> <ul style="list-style-type: none"> Air pollution Industrial or chemical toxins Dust mites, pets Mold Pollen 	<p>Missed quality of care indicator:</p> <ul style="list-style-type: none"> No evidence of inhaled steroid RX in last 12 months Evidence of >1 rescue medication prior 6 months <p>≥ 1 ED visit for asthma or asthma-related complication in prior 12-18 months</p> <p>≥ 1 hospital admission for asthma or asthma-related complication in prior 12-18 months</p> <p>Top 25th percentile of Lead Entity's risk score for persons with primary condition</p>

Asthma cohort: Co-occurring condition prevalence



Asthma cohort: Risk factor prevalence





SMI TARGET SUBGROUP

Health Home SMI Definition

- Schizophrenia (295.xx)
- Bipolar and Major Depressive Disorders (296.xx)
- Delusional Disorders (297.xx)
- Psychosis NOS (298.xx)
- OCD (300.3, 301.4)
- Personality Disorders (301.0, 301.2, 301.22, 301.83)
- PTSD (309.81)

Health Care Expenditures: SMI Cohort

	FY 2011	FY 2012	FY 2013
Number	32,280	35,387	32,068
Net pay—FFS, mean	\$12,518	\$12,700	\$8,361
Net pay—MC, mean	\$4,095	\$4,261	\$7,596
Net pay total, mean	\$16,613	\$16,961	\$15,956
PMPM, mean	\$1,461	\$1,523	\$1,410
Age, mean yrs	34.8	35.6	36.5
Months elig, mean	10.9	10.9	10.9

Net pay = amount reimbursed for paid claims

FFS = fee-for-service, MC = managed care

PMPM= per member per month & includes FFS and MC net payment amounts

PMPM by year and age groups: SMI cohort

Age Group	FY 2011	FY 2012	FY 2013
<= 5 yrs	\$631	\$766	\$793
5 to <= 12 yrs	\$1,238	\$1,340	\$1,193
12 to <=18 yrs	\$1,240	\$1,147	\$897
18 to <= 40 yrs	\$1,279	\$1,330	\$1,186
40 to < = 65 yrs	\$1,673	\$1,755	\$1,647
> 65 yrs	\$2,418	\$2,588	\$2,817

Net pay = amount reimbursed for paid claims

FFS = fee-for-service, MC = managed care

PMPM= per member per month & includes FFS and MC net payment amounts

Summary

- Quick snapshot of the target subgroups across 3 years
 - Expenditures
 - Chronic conditions & risk factors (asthma & diabetes)
- Health action plans/comprehensive assessments
 - Critical for identifying AT RISK populations
- Further baseline measures... to be continued
 - Quality of care metrics
 - E.g., diabetes quality
 - ED utilization
 - Hospital admissions
 - Re-admissions

- Questions? Comments? Suggestions?
 - Contact information:
 - Theresa Shireman, PhD
 - 913-588-2382
 - tshireman@kumc.edu
- 

Tools You Can Use

HIT Requirement

Implementation of an Electronic Health Record (EHR) will be required of all Lead Entities and Health Home Partners to facilitate the sharing of patient information across health settings.



State and Federal HIT Resources

Kansas Health Information Network (KHIN):

Laura McCrary, Ed.D., Executive Director - lmccrary@khinonline.org
<http://www.khinonline.org/>

Lewis and Clark Information Exchange (LACIE):

Mike Dittmore, Executive Director - mike.dittmore@lacie-hie.com
<http://www.lacie-hie.com/>

Federal HIT website:

<http://www.healthit.gov/>

Including how to implement EHRs:

<http://www.healthit.gov/providers-professionals/ehr-implementation-steps>

Independent HIT Resource

Synōvim Healthcare Solutions, Inc.

Erin Patrick, RHIA, Technical and Quality Services Manager –
info@synovim.org or erin.patrick@synovim.org

Address: 2947 SW Wanamaker Drive, Topeka, KS 66614

Main: 785-273-3031

Website: www.synovim.org

What is “Health Promotion”?

- Engaging HH members by phone, letter, HIT, community “in reach” and outreach
- Assessing member’s understanding of their health status and motivation to engage in self-management
 - How important is their health status?
 - How confident is the member about changing behaviors?
- Assisting in the development of recovery plans
- Linking members to resources based on member needs and preferences
- Assisting in the development of skills and confidence that will enable the member to manage their needs independently

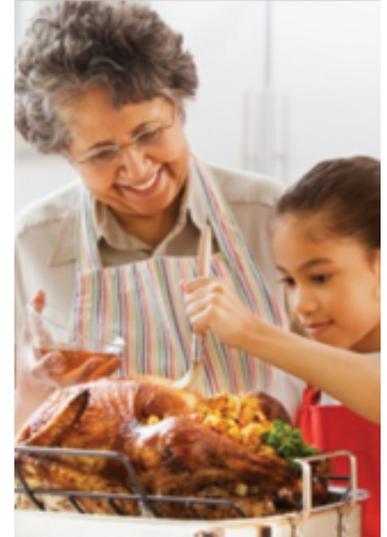
Health Promotion Activities

- Encourage and support healthy ideas and behaviors with the goal of motivating members to successfully monitor and manage their health
- Place strong emphasis on self-direction and skill development
 - Engage members, family members/support persons, and guardians in making health service decisions that assist in the evaluation of risks and benefits of recommended treatment



Self-Management Workshops

- Chronic Disease-Self Management (CDSMP)
- Diabetes Self-Management (DSMP)
- Tomando Control de su Salud (culturally adapted Spanish CDSMP)



Why Self-Management?

- Increased exercise.
- Better coping strategies and symptom management.
- Better communication with their physicians.
- Improvement in their self-rated health, disability, social and role activities, and health distress.
- More energy and less fatigue.
- Decreased disability.
- Fewer [self-reported] physician visits and hospitalizations.

Workshop Overview

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
Overview of self-management and chronic health conditions	•					
Making an action plan	•	•	•	•	•	•
Using your mind to manage symptoms	•		•		•	•
Feedback/problem-solving		•	•	•	•	•
Difficult Emotions		•				
Fitness/exercise		•	•			
Better breathing			•			
Pain			•			
Fatigue			•			
Nutrition				•		
Future plans for health care				•		
Communication				•		
Medications					•	
Making treatment decisions					•	
Depression					•	
Working with your health care professional						•
Working with the health care system						•
Future plans						•



Find a KOHP Workshop

<http://my.calendars.net/kohp>

KOHP Workshops and Trainings

[Calendars Net](#)

Kansans Optimizing Health Program

Navigate: < Year < Month < 2 Wks < Week Today Week > 2 Wks > Month > Year >
 Display: [Year](#) [Month](#) [Week](#) [Day](#) [Block](#) [List](#) [Condensed](#) [Abs](#) [Slide](#) [Calendars:](#) [Search](#)
 Add Events: [Daily](#) [Duration](#) [Periodic](#) [Administrator:](#) [This Calendar](#)

May 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
18 May	19 10:00a -12:30p DSMP Workshop-Wichita 1:00p -3:30p CDSMP-Kansas City 2:30p -5:00p CDSMP-Colby 5:45p Group Walk With Ease-Topeka	20 10:00a -12:00p Tomando Control Workshop-Wichita 1:00p -3:30p CDSMP-Leavenworth 6:00p -8:30p CDSMP-Hays	21 9:00a -4:30p CDSMP Leader Training-Manhattan	22 9:00a -4:00p CDSMP Leader Training-Manhattan 9:00a -4:30p CDSMP-Manhattan	23	24
25	26 10:00a -12:30p DSMP Workshop-Wichita 1:00p -3:30p CDSMP-Kansas City 5:45p Group Walk With Ease-Topeka	27 10:00a -12:00p Tomando Control Workshop-Wichita 1:00p -3:30p CDSMP-Leavenworth 6:00p -8:30p CDSMP-Hays	28 9:30a -11:45p CDSMP Workshop-Newton	29 9:00a -4:30p Tomando Control Leader Training-Garden City 2:00p -4:00p CDSMP Workshop-Hugoton	30 9:00a -4:30p Tomando Control Leader Training-Garden City	31
1 Jun	2 9:00a -4:30p DSMP Leader Training-Wichita 10:00a -12:30p DSMP Workshop-Wichita 1:00p -3:30p CDSMP-Kansas City 5:45p Group Walk With Ease-Topeka	3 9:00a -4:30p DSMP Leader Training-Wichita 10:00a -12:00p Tomando Control Workshop-Wichita 1:00p -3:30p CDSMP-Leavenworth 2:00p -4:00p Stepping On-Wichita 6:00p -8:30p CDSMP-Hays	4 9:30a -11:45p CDSMP Workshop-Newton	5 9:00a -4:30p Tomando Control Leader Training-Garden City 2:00p -4:00p CDSMP Workshop-Hugoton	6 9:00a -4:30p Tomando Control Leader Training-Garden City	7
8	9 9:00a -4:30p DSMP Leader Training-Wichita 9:30a -12:00p CDSMP-Overland Park 10:00a -12:30p DSMP Workshop-Wichita 1:00p -3:30p CDSMP Workshop-Topeka 5:45p Group Walk With Ease-Topeka	10 9:00a -4:30p DSMP Leader Training-Wichita 10:00a -12:00p Tomando Control Workshop-Wichita 1:00p -3:30p CDSMP-Leavenworth 2:00p -4:00p Stepping On-Wichita 6:00p -8:30p CDSMP-Hays	11 9:30a -11:45p CDSMP Workshop-Newton	12 2:00p -4:00p CDSMP Workshop-Hugoton	13	14

Health Systems

Kansas Tobacco Quitline:

KanQuit!

1-800-QUIT-NOW (784-8669)

KSquit.org

Quit Coaches



- ✓ Highly trained in cognitive behavioral coaching
- ✓ Over 50% have 3+ years of prior counseling experience
- ✓ Undergo ongoing quality control
- ✓ Receive more than 270 hours of training and evaluation

Text2QuitSM

THE NEWEST WAY TO KEEP YOUR HANDS BUSY.

We now offer Text2Quit, a new feature that will help you set a Quit Date, manage urges, play craving games, and track your quit weeks before and months after you stop using tobacco. Doing these things increases your odds of staying quit, and now they're right at your fingertips.

Text2Quit sends tailored text messages to your supported mobile device when you need them and keeps your Quit Coach[®] in the loop of your progress. Enroll in the program today to take advantage of this exciting new feature.

1-800-QUIT-NOW
(1-800-784-8669)



QuitNow Mobile App

- Visit www.quitforlife.com
- Download at Apple App Store
- Simply designed app to help current smokers (not designed to help smokeless tobacco users).
- App has two states:
 - Pre-quit: Will prompt user to set a quit date within 30 days and then motivate them by providing access to a variety of evidence-based tools.
 - Post-quit: Will actively support 14 days after quit date.
- App is free
- Users will get a chance to learn about the Quitline and will be prompted to call.

KanQuit! Website



[Enroll Now](#)

[About the Program](#)

[Common Questions](#)



Josh Quit. Now He Can Help You.

If you have tried to quit before, try something different. Quit Coaches like Josh Walker can help you become an expert in living tobacco free with The 4 Essential Practices to Quit For Life.

[ENROLL ONLINE NOW ▶](#)

Already Enrolled?

[Log In Now »](#)



0 1 0 3 2 0

Lives Helped Counter

You can quit. We'll show you how.

We understand that quitting is about more than just not smoking. When you join our program, a Quit Coach® will help you become an expert in living without tobacco using "The 4 Essential Practices to Quit For Life," principles based on 25 years of research and experience helping people quit tobacco.

[Learn More About the Kansas Tobacco Quitline »](#)



[Participant Testimonials](#)

Thinking About Quitting?

Download our free e-book and learn how to make quitting manageable.

[Download e-book »](#)

Refer A Friend

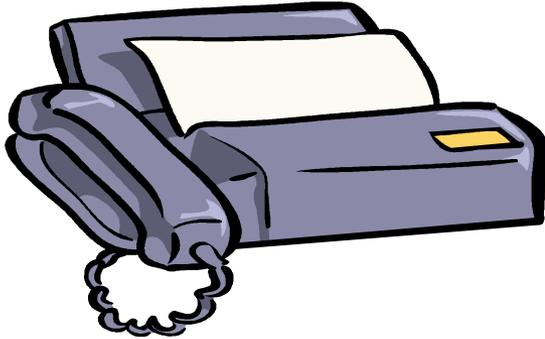


[Refer a friend to this](#)

KSquit.org

- Offers participants interactive features, information and social forums.
- Site blends information with social interaction and self-management tools.
- Information and tools on Web Coach support participants throughout the quitting process - from making the decision to quit to preventing relapse.
- Use Web Coach to:
 - Reinforce and increase motivation to quit
 - Talk with Quit Coaches and peers who are quitting in discussion forums
 - Prepare for quit date
 - Track money saved
 - Build and print a quit plan
 - Manage stress and avoid weight gain

Fax Referrals



- Health care provider completes a simple referral form and faxes to the Quitline
- The Kansas Tobacco Quitline makes 5 contacts to the patient/client and the service delivery protocol begins
- Patient/client will receive the same intake, assessment, and offer of services

Bureau of Health Promotion Resources

Kansans Optimizing Health Program:

Ariel Capes, Health Educator – acapes@kdheks.gov
<http://www.kdheks.gov/arthritis/kohp.htm>

Kansas Tobacco Quitline

Matthew Schrock, Cessation Coordinator – mschrock@kdheks.gov
www.KSquit.org.

Physical Activity Nutrition and Obesity Program

Anthony Randles – arandles@kdheks.gov
<http://www.kdheks.gov/bhp/pan/index.htm>

Additional Resources

The Community Guide

<http://www.thecommunityguide.org/index.html>

Million Hearts

<http://millionhearts.hhs.gov/index.html>

YMCA Diabetes Prevention Program

<http://www.ymcawichita.org/diabetes-prevention>

CDC Chronic Disease Prevention & Health Promotion

<http://www.cdc.gov/chronicdisease/>

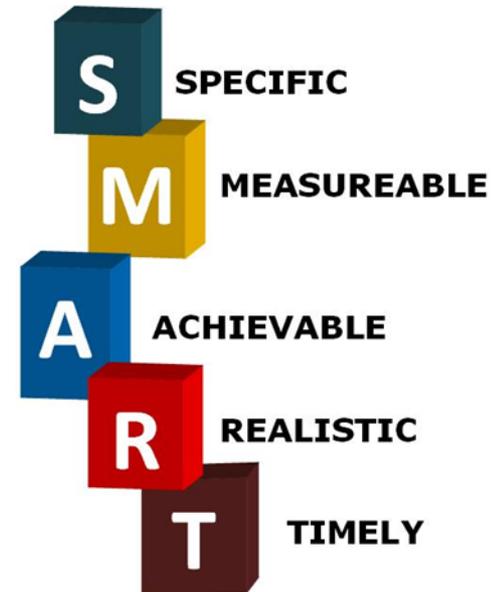
Learning Collaborative

- Learning Collaborative research report
- For contracted HHPs only – will include webinars, conference calls, and regional in-person meetings.
- NOT training – opportunity for peer-to-peer learning
- Participation expectation outlined in Health Homes manuals
- Start with a conference call in Late August and webinar in September

Healthy Living Grant

- Funded by Kansas Health Foundation for two years
- Training for Care Coordinators/Managers on how to write effective Health Action Plans
- Four-part webinar series, repeated three times
- In-person opportunities to strengthen learning

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



Putting It All Together

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.

Small Group Discussion

- At your table, choose a member profile from back of handout.
- Based on what you know, use YELLOW Post-its to map activities that might be experienced by the member.
- Use the COLORED Post-its to map processes “behind the scenes” that are happening during the same time.
- Consider resources needed by the member/family, what was shared, and what is available in your area.

What's next?

Closing Thoughts

**Thank you for
participating!**

