



WICHITA STATE  
UNIVERSITY

# Health Homes Webinar Series: Preparedness & Planning Tool

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# Agenda

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Step-by-step review of the Preparedness & Planning Tool  
– Samantha Ferencik, KDHE DHCF

Q & A – Samantha & MCO Representatives

# Preparedness & Planning Tool

# Preparedness & Planning Tool

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- Completed by all potential Health Home Partners (HHP)
- Submitted to KDHE by April 1 for July 1 launch date
- To follow review of the actual form, visit [http://www.kancare.ks.gov/health\\_home/providers\\_materials.htm](http://www.kancare.ks.gov/health_home/providers_materials.htm)

# KanCare Website

**KanCare**  
AD ASTRA PER ASPERA

**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)

**About Us   News   Workgroups/Council   I/DD   Health Plans   Contact Us**

**Medicaid for Kansas**

Search

KanCare Consumer Assistance: 1-866-305-5147

**Consumers**

- Benefits & Services
- Apply for Medicaid/KanCare
- Choosing a KanCare Health Plan
- Events
- Frequently Asked Questions
- ...More

**Providers**

- Become a KanCare Provider
- Frequently Asked Questions
- Events
- KanCare Health Plan Information
- Pharmacy
- Provider Billing Information

**Policies & Reports**

- Medical Assistance Reports
- KanCare Quality Measurement
- Health Homes in KanCare**
- Readiness Activities
- Delivery System Reform Incentive
- Annual and Quarterly Reports

**About Us**

- What is KanCare?
- 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 homepage. At the top left is the KanCare logo with the motto "AD ASTRA PER ASPERA". To the right of the logo is a navigation menu with links for "About Us", "News", "Workgroups/Council", "I/DD", "Health Plans", and "Contact Us". Below the navigation is a large banner image of a green field with the text "Medicaid for Kansas". Underneath the banner is the heading "Health Homes in KanCare". There are four main content areas: "Consumers" (with a photo of a diverse group of people), "Providers" (with a photo of healthcare professionals and a red arrow pointing to it from the right), "FAQs" (with a photo of "FAQ" written on a chalkboard), and "News and Events" (with a photo of a booth at a conference). At the bottom of the page is a footer with copyright information and links for "Contact Us", "Privacy Notice", "Records Request", "KDHE", "KDADS", and "Webmaster".

# 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
- Approaches to Health Homes
- Payment Principles and Parameters:
- Services
- Informational Materials for Providers:**
- Stakeholder Meetings
- Contacts

- Preparedness and Planning Tool Instructions
- Preparedness and Planning Tool - for MS Office 1997-2003
- Preparedness and Planning Tool - for MS Office 2007 & Above
- Kansas Health Homes: Quick Facts
- Frequently Asked Questions from Providers
- Chronic Conditions (CC) Health Homes Provider Requirements
- Chronic Conditions (CC) Health Homes Services and Professional Requirements
- SMI Health Homes Provider Requirements
- SMI Health Homes Services and Professional Requirements
- Chronic Conditions State Plan Amendment
- Serious Mental Illness State Plan Amendment
- Providers Slide Show
- Health Home Herald Newsletter

# Purpose of the Tool: For Providers

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- Understand ability to support progress toward becoming a HHP
- Assess strengths & challenges in undertaking different approaches to integration
- Set & prioritize goals toward becoming a HHP

# Purpose of the Tool: For MCOs

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- Assist in evaluating, supporting and contracting with potential HHPs
- NOT to determine whether “accepted” or “rejected”
- Roadmap to working with potential HHPs

# How to Use the Tool

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- Answer based on an honest analysis of current practices and processes
- Pre-work:
  - Who you serve and how often
  - The infrastructure of what makes your organization unique
- Leaders from all levels of the organization
- Discuss results as a team
- Identify goals & next steps

# Understanding your Population

## 1. General Population

**1. Most prevalent (top five) diagnoses:**

- 1.
- 2.
- 3.
- 4.
- 5.

**2. Total number of individuals seen in past 12 months:**

**3. Total number of visits to the whole organization in past 12 months:**

**4. Where individuals who are served by the organization live (i.e. counties, cities/towns, areas within a city):**

**5. Based on the physical health information available to you, percentage of your population with multiple chronic conditions (MCC)? For example, SMI and diabetes or diabetes and coronary heart disease.**

**6. Percentage of your population who do not have either a primary care provider (PCP) or a regular source of behavioral health care, if applicable?**

**7. Do you know the total number of individuals seen in your organization who visited the emergency department within the last year? If so, how many? What was the total number of visits?**

# Kansas Health Homes Service Definitions

- Comprehensive Care Management

**Critical components of Comprehensive Care Management include:**

1. 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/No
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/No
3. Do you provide Comprehensive Care Management through ability to address other barriers to success, such as low income, housing, transportation, academic and functional achievement, social supports, understanding of health conditions, etc.?	Yes/No
4. Do you provide Comprehensive Care Management through monitoring and follow-up to ensure that needed care and services are offered and accessed?	Yes/No
5. Do you provide Comprehensive Care Management through routine and periodic reassessment and revision of the HAP to reflect current needs, service effectiveness in improving or maintaining health status, and other circumstances?	Yes/No

# Kansas Health Homes Service Definitions

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- Comprehensive Care Management

Do you/will you subcontract for this service?	Answer:
If subcontracting for this service, please attach appropriate documentation, if applicable	
Please rate your existing level of readiness with regard to the provision of Comprehensive Case Management. (0-10 with 10 being a high level of readiness)	Score:
What is your greatest obstacle to overcome in order to improve? (i.e. additional training for staff, a required change of agency culture, reorganization of agency processes?)	

# Kansas Health Homes Service Definitions

- Care Coordination

**Critical components of Care Coordination include:**

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/No
2) Do you provide Care Coordination that supports adherence to treatment recommendations, engages members in chronic condition self-care, and encourages continued participation in HH care?	Yes/No
3) Do you provide Care Coordination that involves coordination and collaboration with other providers to monitor the member's conditions, health status, and medications and side effects?	Yes/No
4) Do you provide Care Coordination that engages members and family/support persons/guardians in decisions, including decisions related to pain management, palliative care, and end-of life decisions and supports?	Yes/No
5) Do you provide Care Coordination that implements and manages the HAP through quality metrics, assessment survey results and service utilization to monitor and evaluate intervention impact?	Yes/No
6) Do you provide Care Coordination that creates and promotes linkages to other agencies, services, and supports?	Yes/No

# Kansas Health Homes Service Definitions

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- Care Coordination

Do you/will you subcontract for this service?	Answer:
If subcontracting for this service, please attach appropriate documentation, if applicable	
Please rate your existing level of readiness with regard to the provision of Care Coordination. (0-10 with 10 being a high level of readiness)	Score:
What is your greatest obstacle to overcome in order to improve? (i.e. additional training for staff, a required change of agency culture, reorganization of agency processes?)	

# Kansas Health Homes Service Definitions

- Health Promotion

**Critical components of Health Promotion include:**

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/No
2) Do you provide Health Promotion that places a strong emphasis on self-direction and skills development, engaging members, family members/support persons, and guardians in making health services decisions using decision-aids or other methods that assist the member to evaluate the risks and benefits of recommended treatment?	Yes/No
3) Do you provide Health Promotion that ensures all health action goals are included in person centered care plans?	Yes/No
4) Do you provide Health Promotion that provides health education and coaching to members, family members/support persons, guardians about chronic conditions and ways to manage health conditions based upon the member's preference?	Yes/No
5) Do you provide Health Promotion that offers prevention education to members, family members/support persons, guardians about proper nutrition, health screening, and immunizations?	Yes/No

# Kansas Health Homes Service Definitions

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- Health Promotion

Do you/will you subcontract for this service?	Answer:
If subcontracting for this service, please attach appropriate documentation, if applicable	
Please rate your existing level of readiness with regard to the provision of Health Promotion. (0-10 with 10 being a high level of readiness)	Score:
What is your greatest obstacle to overcome in order to improve? (i.e. additional training for staff, a required change of agency culture, reorganization of agency processes?)	

# Kansas Health Homes Service Definitions

- Comprehensive Transitional Care

The transition/discharge plan includes, but is not limited to, the following elements:

1) Do you provide Comprehensive Transitional Care timeframes related to appointments and discharge paperwork?	Yes/No
2) Do you provide Comprehensive Transitional Care follow-up appointment information?	Yes/No
3) Do you provide Comprehensive Transitional Care medication information to allow providers to reconcile medications and make informed decisions about care?	Yes/No
4) Do you provide Comprehensive Transitional Care medication education?	Yes/No
5) Do you provide Comprehensive Transitional Care therapy needs, e.g., occupational, physical, speech, etc.?	Yes/No
6) Do you provide Comprehensive Transitional Care transportation needs?	Yes/No
7) Do you provide Comprehensive Transitional Care community supports needed post-discharge?	Yes/No
8) Do you provide Comprehensive Transitional Care determination of environmental (home, community, workplace) safety?	Yes/No

# Kansas Health Homes Service Definitions

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- Comprehensive Transitional Care

Do you/will you subcontract for this service?	Answer:
If subcontracting for this service, please attach appropriate documentation, if applicable	
Please rate your existing level of readiness with regard to the provision of Comprehensive Transitional Care. (0-10 with 10 being a high level of readiness)	Score:
What is your greatest obstacle to overcome in order to improve? (i.e. additional training for staff, a required change of agency culture, reorganization of agency processes?)	

# Kansas Health Homes Service Definitions

- Member and Family Support

Member and family support:	
1) Do you provide Member and Family Support that is contingent on effective communication with member, family, guardian, other support persons, or caregivers?	Yes/No
2) 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/No
3) Do you provide Member and Family Support that promotes engagement of members, family/support persons and guardians?	Yes/No
4) Do you provide Member and Family Support that promotes self-management capabilities of members?	Yes/No
5) Do you provide Member and Family Support that involves ability to determine when members, families/support persons, and guardians are ready to receive and act upon information provided, and assist them with making informed choices?	Yes/No
6) Do you provide Member and Family Support that involves an awareness of complexities of family dynamics, and an ability to respond to member needs when complex relationships come into play?	Yes/No

# Kansas Health Homes Service Definitions

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- Member and Family Support

Do you/will you subcontract for this service?	Answer:
If subcontracting for this service, please attach appropriate documentation, if applicable	
Please rate your existing level of readiness with regard to the provision of Member and Family Support. (0-10 with 10 being a high level of readiness)	Score:
What is your greatest obstacle to overcome in order to improve? (i.e. additional training for staff, a required change of agency culture, reorganization of agency processes?)	

# Kansas Health Homes Service Definitions

- Referral to Community & Social Support Services

Referral to community and social support services involves:	
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/No
2) Do you provide Referral to Community and Social Supports through engagement with community and social supports?	Yes/No
3) Do you provide Referral to Community and Social Supports through establishing and maintaining relationships with community services providers, e.g., Home and Community Based Services (HCBS) providers, the Aging & Disability Resource Center (ADRC), faith-based organizations, etc.?	Yes/No
4) Do you provide Referral to Community and Social Supports through fostering communication and collaborating with social supports?	Yes/No
5) Do you provide Referral to Community and Social Supports through knowledge of the eligibility criteria for services?	Yes/No
6) Do you provide Referral to Community and Social Supports through identifying sources for comprehensive resource guides, or development of a comprehensive resource guide if necessary?	Yes/No

# Kansas Health Homes Service Definitions

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- Referral to Community & Social Support Services

Do you/will you subcontract for this service?	Answer:
If subcontracting for this service, please attach appropriate documentation, if applicable	
Please rate your existing level of readiness with regard to the provision of Referral to Community and Social Support Services. (0-10 with 10 being a high level of readiness)	Score:
What is your greatest obstacle to overcome in order to improve? (i.e. additional training for staff, a required change of agency culture, reorganization of agency processes?)	

# Health Homes Health Information Technology

1. Do you use an interoperable EHR?	Yes/No
<p>If answering "No" above,</p> <p>1) Do you <u>currently</u> have the capacity to submit a plan, within 90 days of contracting as a HHP, to implement the EHR?</p> <p>2) The State expects HHPs 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:</p> <p>3) The State expects HHPs 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:</p>	<p>Yes/No</p> <p>12 months/ 18 months/ 24 months</p> <p>12 months/ 18 months/ 24 months</p>

# Health Homes Provider Standards

**1. 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?**

- |  |        |
|--|--------|
| 1) Center for Independent Living   | Yes/No |
| 2) Community Developmental Disability Organization   | Yes/No |
| 3) Community Mental Health Center  | Yes/No |
| 4) Community Service Provider – for people with intellectual / developmental disabilities (I/DD) | Yes/No |
| 5) Federally Qualified Health Center/Primary Care Safety Net Clinic                              | Yes/No |
| 6) Home Health Agency  | Yes/No |
| 7) Hospital – based Physician Group  | Yes/No |
| 8) Local Health Department   | Yes/No |
| 9) Physician – based Clinic  | Yes/No |
| 10) Physician or Physician Practice  | Yes/No |
| 11) Rural Health Clinics   | Yes/No |
| 12) Substance Use Disorder Provider  | Yes/No |

# Health Homes Provider Standards

**2. Health Homes Partners must enroll or be enrolled in the KanCare program and agree to comply with all KanCare program requirements.**

- |  |        |
|--|--------|
| 1) Are you enrolled in the KanCare Program?                      | Yes/No |
| 2) Do you agree to comply with all KanCare program requirements? | Yes/No |

**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.**

- |   |        |
|---|--------|
| 1) Does your leadership fit the description above?<br>Please provide some brief examples: | Yes/No |
|---|--------|

**4. Health Home Partners must provide appropriate and timely in-person care coordination activities. Alternative communication methods in addition to in-person such as telemedicine or telephonic contacts may also be utilized if culturally appropriate and accessible for the enrollee to enhance access to services for members and families where geographic or other barriers exist.**

- |  |        |
|--|--------|
| 1) Do you provide appropriate and timely in-person care coordination activities? | Yes/No |
| 2) Do you utilize alternative communication methods?                             | Yes/No |

# Health Homes Provider Standards

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**5. Health Home Partners must have the capacity to accompany enrollees to critical appointments, when necessary, to assist in achieving Health Action Plan goals.**

1) Do you have the capacity to accompany enrollees to critical appointments?

Yes/No

**6. Health Home Partners must agree to accept any eligible enrollees, except for reasons published in the Kansas Health Homes Program Manual.**

1) Do you agree to accept any eligible enrollees except for reasons published in the Kansas Health Homes Program Manual?

Yes/No

**7. Health Home Partners must demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers to collaborate with the HHP on care coordination and hospital / ER notification.**

1) Do you demonstrate such engagement and cooperation?  
Please provide some brief examples:

Yes/No

# Health Homes Partner and Lead Entity Joint Standards

<b>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.</b>	
1) Do you have staff and procedures in place to ensure this availability?	Yes/No
<b>2. The Lead Entity and the Health Home Partner jointly must ensure access to timely services for enrollees, including seeing enrollees within seven days and 30 days of discharge from an acute care or psychiatric inpatient stay.</b>	
1) Do you have staff and procedures in place to ensure that enrollees will be seen within seven days of an acute care or psychiatric inpatient stay?	Yes/No
2) Do you have staff and procedures in place to ensure that enrollees will be seen again within 30 days of an acute care or psychiatric inpatient stay?	Yes/No
Please provide some brief examples:	
<b>3. The Lead Entity and the Health Home Partner jointly must ensure person and family-centered and integrated health action planning that coordinates and integrates all his or her clinical and non-clinical health care related needs and services.</b>	
1) Do you have staff and procedures in place to ensure that this health action planning will be achieved?	Yes/No

# Health Homes Partner and Lead Entity Joint Standards

<b>4. The Lead Entity and the Health Home Partner jointly must provide quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves health literacy.</b>	
1) Do you have staff and procedures in place to ensure that quality-driven services are provided to address health disparities?	Yes/No
2) Do you have staff and procedures in place to ensure that quality-driven services are provided to address and improve health literacy?	Yes/No
3) Do you have staff and procedures in place to ensure that quality-driven services are provided to address health disparities?	Yes/No
4) Do you have staff and procedures in place to ensure that cost-effective services are provided to address and improve health literacy?	Yes/No
5) Do you have staff and procedures in place to ensure that culturally competent services are provided to address health disparities?	Yes/No
6) Do you have staff and procedures in place to ensure that culturally competent services are provided to address and improve health literacy?	Yes/No
<b>5. The Lead Entity and the Health Home Partner jointly must establish a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers.</b>	
1) Have you established such a data-sharing agreement?	Yes/No

# Health Homes Partner and Lead Entity Joint Standards

**6. 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.**

- |   |        |
|---|--------|
| 1) Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines?  | Yes/No |
| 2) Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders?   | Yes/No |
| 3) Coordinate and provide access to mental health and substance abuse services?   | Yes/No |
| 4) Coordinate and provide access to chronic disease management, including self-management support to individuals and their families?  | Yes/No |
| 5) Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate?  | Yes/No |
| 6) Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level? | Yes/No |

# Health Homes Partner and Lead Entity Joint Standards

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**7. The Lead Entity and the Health Home Partner jointly must demonstrate the ability to report required data for both state and federal monitoring of the program.**

1) Do you have the staff and procedures in place to report this required data?

Yes/No

# Questions?

# Contact Information

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

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- Feb 25 – Program Manual & Documents List
- Mar 18 – Member Assignment & Referral Process
- Mar 25 – Payment Structures for SPA 1 & 2
- Apr 22 – Health Action Plan: Step by Step
- Apr 29 – Health Information Technology Basics

**Thank you for  
participating!**