



WICHITA STATE
UNIVERSITY

CENTER FOR COMMUNITY SUPPORT
AND RESEARCH

Health Homes Stakeholder Meeting

Please sit with people from
your region or cross-discipline



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AND RESEARCH*

Health Homes Stakeholder Meeting

March 21, 2014

Purposes of the Day

- Introduce the Chronic Conditions SPA and Payment Methodology
- Discuss how MCOs will connect and engage with potential HHPs
- Look at resources available to potential HHPs and procedural details in development
- Envision what a Health Home will look like through lessons learned in other states and ideas of our own



Health Homes Update



CONSUMER TOUR

- The HH Consumer Tour ran March 3-12. Teams of 2-3 staff from KDADS and KDHE were sent to 16 venues across the state for 32 presentations
- Though the tour was marketed and designed with consumers in mind, we also had the opportunity to speak with many interested providers across the state.
- Though many providers took an active role in helping get their consumers to the meetings the turnout was lower than we expected.

CONSUMER TOUR TURNOUT

HH Member Tour	1:00pm	6:00pm
Winfield 03/03/14	0	0
Dodge City 03/03/14	4	0
Wichita 03/03/14	7	5
Pittsburg 03/04/14	11	0
Great Bend 03/04/14	6	4
Garden City 03/04/14	1	0
Colby 03/05/14	13	2
Chanute 03/05/14	3	1
Concordia 03/05/14	3	2
Hays 03/06/14	17	4
Salina 03/06/14	6	3
Emporia 03/06/14	1	1
Olathe 03/11/14	15	2
Wyandotte County 03/11/14	0	0
Topeka 03/12/14	8	1
Atchison 03/12/14	10	0

CONSUMER TOUR

- Despite the turnout, the meetings produced good discussions and the question and answer times were very productive.
- Additionally, the Tour gave us an opportunity to speak with members of the media across the state through both radio and television news sources. A KOAM TV 7 in Pittsburg, WIBW in Topeka and KVOE in Emporia

CONSUMER FEEDBACK

- Strong opposition to Care Coordination being performed over the phone
- Perception that MCOs were not as knowledgeable on Health Homes as local providers expected
- Still confusion regarding 6 Core Services vs. All other services
- Generally positive reception overall however.

GENERAL ACCOMPLISHMENTS

- Identified the second target population, approximately 38,000 people who have asthma or diabetes and are at risk for a second chronic condition, including hypertension, substance use disorder, coronary artery disease, or depression
- Deployed the Preparedness and Planning Tool to help providers assess their readiness to become HHPs
- Deployed a provider survey through Kansas Foundation for Medical Care to prioritize providers for assistance in planning to implement electronic health records (EHR)
- Transferred responsibility to WSU's Center for Community Support and Research (CCSR) for convening and facilitating the Health Homes Focus Group, now called the Health Homes Stakeholders Meeting
- Scheduled, through CCSR, twice monthly webinars for providers interested in becoming HHPs to be held from February through June 2014

GENERAL ACCOMPLISHMENTS

(CONTINUED)

- Developed a network adequacy report format for the health plans to report their progress in establishing networks of Health Homes, beginning April 15, 2014
- Created a referral form for providers and hospitals to use to refer potential Health Homes members to the MCOs
- Created an HH informational brochure for consumers
- Secured funding from the Sunflower Foundation and REACH Foundation to support the Health Homes Learning Collaborative beginning July 2014
- Published a draft Program Manual for SMI Health Homes
- Issued tribal notification to the four recognized American Indian tribes
- Scheduled and sent invitations for six day-long provider train sessions across the state

FORMS COMPLETED

- Health Action Plan
- Health Homes Referral Form
- Health Homes Refusal Form
- Health Homes Opt Out
- Health Homes Assignment Letter
- Preparedness and Planning Tool

FORMS STILL BEING DRAFTED

- Health Homes Discharge Form(s)
- Program manual for chronic conditions (CC)
Health Homes
- Reporting requirements

SMI PAYMENT

Level Rate	
Level 1	\$117.21
Level 2	\$153.51
Level 3	\$185.17
Level 4	\$327.48
<i>Average</i>	\$171.79

PRESENTATIONS MADE

- 54 Presentations made across the state since July, 2013
- Due to time constraints and important issues related to implementing Health Homes, we will be unable to accommodate additional requests for presentations in the coming months.

Target Populations

State Plan Amendment #1

Target Population:

- Individuals (adults & children) with a severe mental illness (SMI)
- Includes anyone with a primary diagnosis of one or more of the following:
 - Schizophrenia
 - Bipolar and major depression
 - Delusional disorders
 - Personality disorders
 - Psychosis not otherwise specified
 - Obsessive-compulsive disorder
 - Post-traumatic stress disorder

State Plan Amendment #2

Target Population:

- People who have asthma or diabetes (including pre-diabetes and metabolic syndrome) who also are at risk of developing:
 - Hypertension
 - Coronary artery disease
 - Depression
 - Substance use disorder
 - Being overweight or obese (Adult: BMI \geq 25; Child: age-adjusted)

OR...

State Plan Amendment #2



- Current smoker or exposure to second-hand smoke
- Environmental exposures
- Missed quality of care indicator:
 - No evidence of inhaled steroid prescription in last 12 months
 - Evidence of more than one rescue medication in the prior 6 months
- One or more ER visit for asthma or asthma-related complication in the prior 12 months
- One or more hospital admission for asthma or asthma-related complication in the prior 12 months
- In the top 25th percentile of Lead Entity's risk stratification for persons with primary condition

State Plan Amendment #2



- Current smoker or exposure to secondhand smoke
- Uncontrolled diabetes (as demonstrated by HbA1c or glucose tests)
- Missed quality of care indicator:
 - No HbA1c, LDL cholesterol, or HDL/Triglyceride level in the prior 12 mo.
- One or more ER visit for diabetes or diabetes-related complication in the prior 12 months
- One or more hospital admission for diabetes or diabetes-related complication in the prior 12 months
- In the top 25th percentile of Lead Entity's risk stratification for persons with primary condition
- Non-compliance in taking medication regularly

Health Homes Rate Development



Health Homes Payment and Principles Parameters

Basic Payment Structure

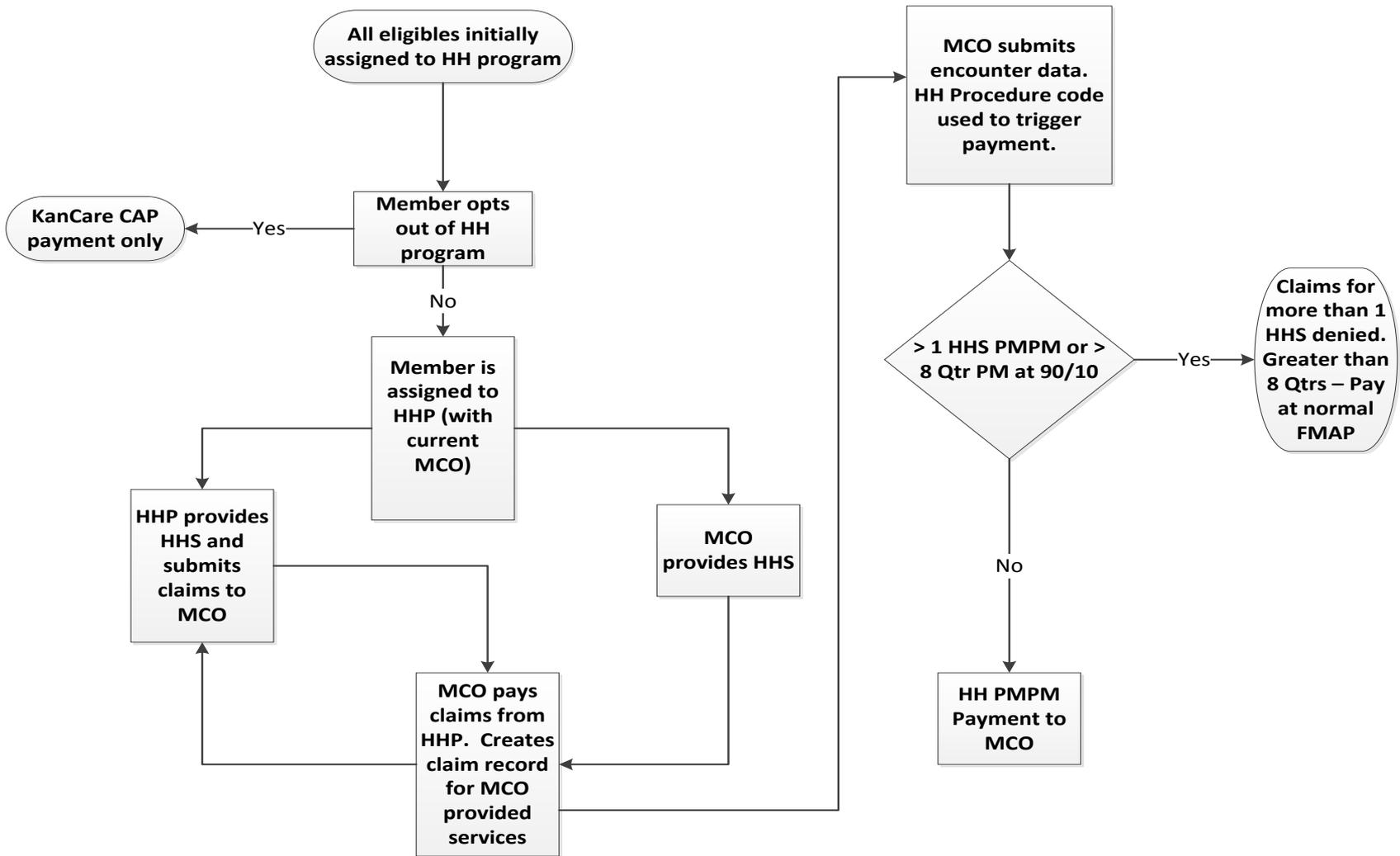
- The state will pay each MCO a per member per month payment for each member enrolled in a health home who received a service.
- MCO will contract with HHP to provide services. Some services may be provided jointly as negotiated in their contracts.
- The state approves any non-PMPM payment arrangements. *Review Requested PMPM Rates. (Selected Sample Review)*

Health Homes Payment and Principles Parameters

Payment Principles

- State PMPM payments to the MCOs will be adequate to ensure quality services
- MCO payments to HHPs will be adequate to ensure sustainability and quality of services
- State health home payments to the MCOs will be actuarially sound
- Will not duplicate payment for Care Management Services

Health Homes Payment



Rate Development Objectives

- Develop payment methodology for KanCare health homes program and the State Plan Amendment
- Determine how and what payment rate for health home services will be made to KanCare MCO's
- *Review As Necessary MCO and health home partner payment arrangements*
- Collaborate with actuaries to develop rates
- Adequate – Sustainable – No Duplication

Rate Development

- Identify Target Population
- KanCare Rate Cohorts
 - Cohort Assignment
 - Comprehensive Care Management
- Stratify Target Population
- Professional Costs
- Mix of Staffing Professionals
- Service Utilization
- Assign non-medical load/PMPM

Rate Development

- Target Population
 - *CC – Approximately 38,000*
- KanCare Rate Cohorts
 - Assigned to at least 1 of the 54 rate cohorts
 - CCM 45/54 rate cohorts

Rate Development

- Stratify Target Population
 - SFY 10 to SFY 12 Base Data
 - Utilization of Services
 - Specific Only to Target Population
 - 45 Rate Cohorts to 4 *Levels*

Rate Development

- *Professional Costs (3 Professions)*
 - *Physician, Nurse Care Coordinators, Social Worker*
 - Allocation of Professional Resources
 - Physician – Member Visits
 - Nurse Care Coordinators, Social Worker, % of Time/Service by Level

Rate Development

- Professional Costs (continued)
 - Determine Cost of Professionals
 - Physician Per Visit (CCM/CTC/Health Promotion)
 - Nurse Care Coordinator, Social Worker, Annual Compensation
 - Bureau of Labor Statistics – Kansas Specific
 - Includes Burden Rate

Rate Development

- Mix of Staffing Professionals
 - Physician - Member Visits
 - Consistent for CCM, HP, CTC
 - *Nurse Care Coordinator, Social Worker,*
 - *Varies by Service –*
 - *CCM/CTC – 10% Social Worker – 90% Nurse Care Coordinator.*
 - *CC/HP – 30% Social Worker – 70% Nurse Care Coordinator*
 - *IFS/RTCSS – 70% Social Worker – 30% Nurse Care Coordinator*

Rate Development

- Service Utilization
 - Nurse Care Coordinator, Social Worker,
 - Hours Per Member Per Month – Varies by Level
 - Use of Average Hourly Rate as Determined from Professional Costs/Mix of Professionals
 - *Rate Varies by Service*
 - *CCM/CTC – \$56.52*
 - *CC/Health Promotion – \$52.79*
 - *IFS/RTCSS – \$45.31*
 - Physician
 - Visits Per Member
 - Varies by Service – CCM/CTC/HP

Rate Development

- Non-Medical Load
 - Burden Rate In Professional Costs
 - *Administration – 10%*

Rate Development

- Identify Target Population
- KanCare Rate Cohorts
 - Cohort Assignment
 - Comprehensive Care Management
- Stratify Target Population
- Professional Costs
- Mix of Staffing Professionals
- Service Utilization
- Assign non-medical load/PMPM

Draft Rate Table

Health Home Rate Summary

Level	Visits/Year Physician	Cost/Visit Physician	Hours/Month All Other Staff	Cost/Hour All Other Staff	Total Cost	Admin	Admin PMPM	Final Premium
Level 1	1.75	\$103.57	1.55	\$53.15	\$97.48	10.00%	\$10.83	\$108.31
Level 2	2.00	\$106.25	2.05	\$53.97	\$128.35	10.00%	\$14.26	\$142.61
Level 3	2.75	\$111.36	3.00	\$54.03	\$187.62	10.00%	\$20.85	\$208.46
Level 4	3.50	\$114.29	6.25	\$55.33	\$379.13	10.00%	\$42.13	\$421.25

NEXT STEPS

- Rate Approval Steering Committee/CMS
- Rate Methodology Into SPA
- Operationalize Payment Structure



www.kancare.ks.gov



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Enrollment

Automatic assignment with opt-out

- a. Amerigroup will auto-enroll Medicaid eligible members using claims data to determine those members with a qualifying diagnosis
- b. Amerigroup assigns members to Health Home Partner while considering:
 - 1) Geographic area of residence
 - 2) Current Health Service Providers
 - 3) Availability of a Health Home Partner
- c. Amerigroup mails assignment/enrollment letters to members and providers
- d. Members can choose to opt-out of Health Home participation, accept Health Home assignment, decline and/or request a different Health Home



Health Home Referrals

- **Providers or community partners can complete a KanCare Health Home Referral Form**

Referral Forms include:

- Member information
 - Diagnosis of a qualifying condition
 - Presence of other health risk factors
 - History of high health service utilization
 - Quality of Care Indicators
 - Provider contact information
- **Members can self-refer by calling 1-800-600-4441**



Health Home Delivery System (Financial)

- Defines four levels with a Case Rate
- MCO may provide some of the health home services for certain waiver populations
- Health Home Partners strongly encouraged to provide the following Health Home core services: Care Coordination, Comprehensive Transitions in Care and Health Promotion
- HHP uses Code S 0281 to submit a Health Home service. Payment is provided for each enrollee who received at least one of the six core services by the HHP (PMPM)

Health Action Plan

- Meet with enrollee
- Complete a comprehensive assessment including reconciliation of medications
- Identify unmet needs from a holistic prospective— physical health, mental health, substance use, social, financial, spiritual and cultural
- Establish Health Action Plan goals and action steps
- Ensure collaboration/integration of care between all providers of care and/or support

Program Activities: Roles and Responsibilities

Health Home	MCO
Outreach and engagement	Identify members from data files for health home
Biopsychosocial assessment, establish personal health plan inclusive of safety, advanced directive	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	Comprehensive care management — communicate with health home on social supports
Individual and family support	Respite services, value-added benefits
Care coordination between physical health and behavioral health; primary care and specialists	Vendor services Ancillary services
Facilitate transitions in care	Utilization management
Monitor members over time — registries to track	QA/QI reporting

HIT: Member 360

George >

Currently Enrolled Alerts Exist No OHI

Provider QA
WELLPOINT

Member Care Summary Claims Utilization Care Management Episodic Viewer Lab Reports

Date Range Mar 12, 2012 to Sep 12, 2014

Update

Source	Description	Type
HEDIS	Diabetes- HbA1c Testing - Pending	Alert
HEDIS	Diabetes- LDL Screening - Pending	Alert
HEDIS	Diabetes- HbA1c > 9 - Pending	Alert
HEDIS	Diabetes- HbA1c between 8-9 - Pend...	Alert
HEDIS	Diabetes- LDL < 100 - Pending	Alert
HEDIS	Diabetes- Medical Attention for Neph...	Alert

Immunizations & Preventive Health		
Date	Service	Provider
07/19/2013	Pneumococcal polysacchari...	Jersey City Medical Ctr

Lab Results			
Date	Type	Value	Acuity
07/05/2013 12:33	Hemoglobin A1C	6	No lab acuity p...
07/05/2013 12:33	LDL	157	No lab acuity p...
07/05/2013 12:33	HDL	65	No lab acuity p...
07/05/2013 12:33	Total Cholesterol	241	No lab acuity p...
07/05/2013 12:33	Blood creatinine	0.7	No lab acuity p...
05/21/2013 00:00	T4, FREE	1.3	Normal
05/21/2013 00:00	PROTEIN, TOTAL	6.2	Normal

Inpatient			
Admit Date	Discharge Date	Facility Name	Primary Diag
08/07/2013	08/12/2013	Jersey City Medical Ctr	Chronic airway obstruct...
08/07/2013	08/08/2013	Jersey City Medical Ctr	Chronic airway obstruct...
07/19/2013	07/24/2013	Jersey City Medical Ctr	Chronic bronchitis with...
06/08/2013	06/10/2013	Jersey City Medical Ctr	Other dyspnea and res...
06/08/2013	06/10/2013	Jersey City Medical Ctr	Chronic obstructive ast...
04/29/2013	05/01/2013	Jersey City Medical Ctr	Obstructive chronic bro...
02/19/2013	02/21/2013	Jersey City Medical Ctr	Chronic airway obstruct...

Emergency Department			
Date	Facility Name	Primary Diagnosis	
06/08/2013	Liberty Emergency Medical As...	Other dyspnea and respirator...	
04/29/2013	Liberty Emergency Medical As...	Obstructive chronic bronchitis...	
02/19/2013	Liberty Emergency Medical As...	Chronic airway obstruction, n...	

Pharmacy		
Date	Medication/Strength	Prescriber
01/01/2014	FOLIC ACID TAB 1MG	Elamir, Mazhar
12/30/2013	METOCLOPRAM TAB 10MG	Elamir, Mazhar
12/30/2013	LACTULOSE SOL 10GM/15	Salah-eldin, Alaa
12/30/2013	ALFUZOSIN HCL ER 10 MG...	Elamir, Mazhar
12/30/2013	MINTOX SUS	Elamir, Mazhar
12/30/2013	OMEPRAZOLE CAP 20MG	Elamir, Mazhar
12/30/2013	IPRATROPIUM SOL 0.02%I...	Elamir, Mazhar

Authorizations						
Auth Number	Start Date	End Date	Place of Service	Referred To Provider	Status	
C01228606	08/07/2013	08/12/2013	Inpatient Hospital	Jersey City Medical Ctr	Discharged	
C01228191	08/07/2013	08/08/2013	Inpatient Hospital	Jersey City Medical Ctr	Void	
103658934	07/19/2013	01/18/2014	Outpatient Hospital	Senior Spirit Of Jersey City Adult Medic...	Complete	
C01191978	07/19/2013	07/24/2013	Inpatient Hospital	Jersey City Medical Ctr	Discharged	
103647282	07/16/2013	07/16/2013	Patient's Home	Loving Care Agency	Complete	
103629058	07/03/2013	08/03/2013	Ambulance-Land	Ostrich Medical Transportation	Complete	
C01110310	06/08/2013	06/10/2013	Inpatient Hospital	Jersey City Medical Ctr	Disallowed	

Office Visits		
Date	Provider	Primary Diagnosis
07/15/2013	Raginsky, Boris	Other peripheral vascular...
07/03/2013	Elamir, Mazhar E	Shortness of breath
06/19/2013	Elamir, Mazhar E	Essential hypertension, be...
06/14/2013	Salah-eldin, Alaa A	Acute gastritis without men...
05/20/2013	Lala, Vinod R	Diabetes mellitus without...
04/26/2013	Fatah, Nail A	Asthma, unspecified with st...
04/17/2013	Elamir, Mazhar E	Cough

Home Mods and Equipment Claims		
Date	Provider	Service

Other Claims		
Date	Provider	Service
08/08/2013	Quality Home Care Providers	O2 conc 1 del port 85%>0...
07/30/2013	Senior Spirit Of Jersey City	Day Care Services Adult P...

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Q-and-A

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United Healthcare – Health Homes Update

March 21, 2014

How to Engage UHC on Health Homes

E-Mail

Health Homes Mailbox

UHC KS Health Homes - uhckshealthhomes@uhc.com

Preparedness and Planning Tool

Complete the Preparedness and Planning Tool – UHC will respond after receipt of the tool from the state.

KS Health Homes Program Key Features

1. MCO Integration into Health Home model
 - The MCOs serve as advisors and SMEs in Care Management
 - Assist in HIT development
 - Payment pass-through from state
 - MCO Determine Eligibility and HH Assignment within some guidelines

2. MCO mandate to provide services
 - MCO must provide 6 core services in the absence of a Health Home Partner

3. Mandated TCM participation in Health Homes
 - Guarantee of revenue to TCM participating in Health Homes

4. Reimbursement
 - Single code for all 6 services
 - Per Member Per Month(PMPM) Payment to Health Home Partners
 - Payment to MCO in arrears based upon encounter activity

Timeline

3-21-2014 Stakeholder Meeting

4-1-2014 Preparedness and Planning Tool “Due Date”

7-1-2014 Go Live

July 2014 Letters mailed to members, HH assignments made, opt out letters received.

8-1-2014 Health Home Services Begin

Post 8-1-2014 Ongoing support, education, development activities for Health Home Partners that are not ready on day 1.

What Do We Already Know?

UHC has experience in many states with Health Homes already

We work in WA, NY, and TN on similar programs

Simple is Good – Is there any way to reduce the administrative burden?

UHC performs many of the 6 core services, or services like them today

UHC has dedicated training staff for our internal care management teams

We have more capacity to absorb risk than individual provider practices

We, the MCOs, will be paid after the fact based upon an encounter

How Do We Best Support Providers?

Category	Provider Concern	UHC Goals for Provider Support
Member	<i>Health Outcomes</i>	<i>Help members live healthier lives</i>
	<i>Existing Relationship</i>	<i>Make smart matches to Health Homes by identifying existing relationships</i>
	<i>Benefit</i>	<i>Help educate members on why Health Homes make sense for them</i>
Revenue	<i>Reimbursement Level</i>	<i>Sustainability</i>
	<i>Membership</i>	<i>Member Choice - Multiple Health Home Options</i>
	<i>Up Front Investment</i>	<i>Risk Reduction</i>
Change	<i>New Program, Systems, Process</i>	<i>Create Tools for Provider Use</i>
	<i>Fatigue - KanCare and DD Implementation</i>	<i>Help promote consistent, current, and timely payment to providers</i>
	<i>New Staff</i>	<i>Demonstrate what the job is.</i>
Operations	<i>Capacity</i>	<i>Ensure Member Access and Provider Capability - Support a Range Health Home Providers</i>
	<i>Claims</i>	<i>Simplify and Streamline Payment Process</i>
	<i>3 MCOs to Work With</i>	<i>Make it Easy to Work With Us</i>

UHC Proposed Model

All In Model –

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

- 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

- Comprehensive Care Management, Care Coordination and Comprehensive Transitional Care
- Data and application training support from UHC
- Does not allow for subcontract models
- UHC assistance in identification of potential subcontractor partners
- PMPM Payment –**MIX**

Demonstration Model –

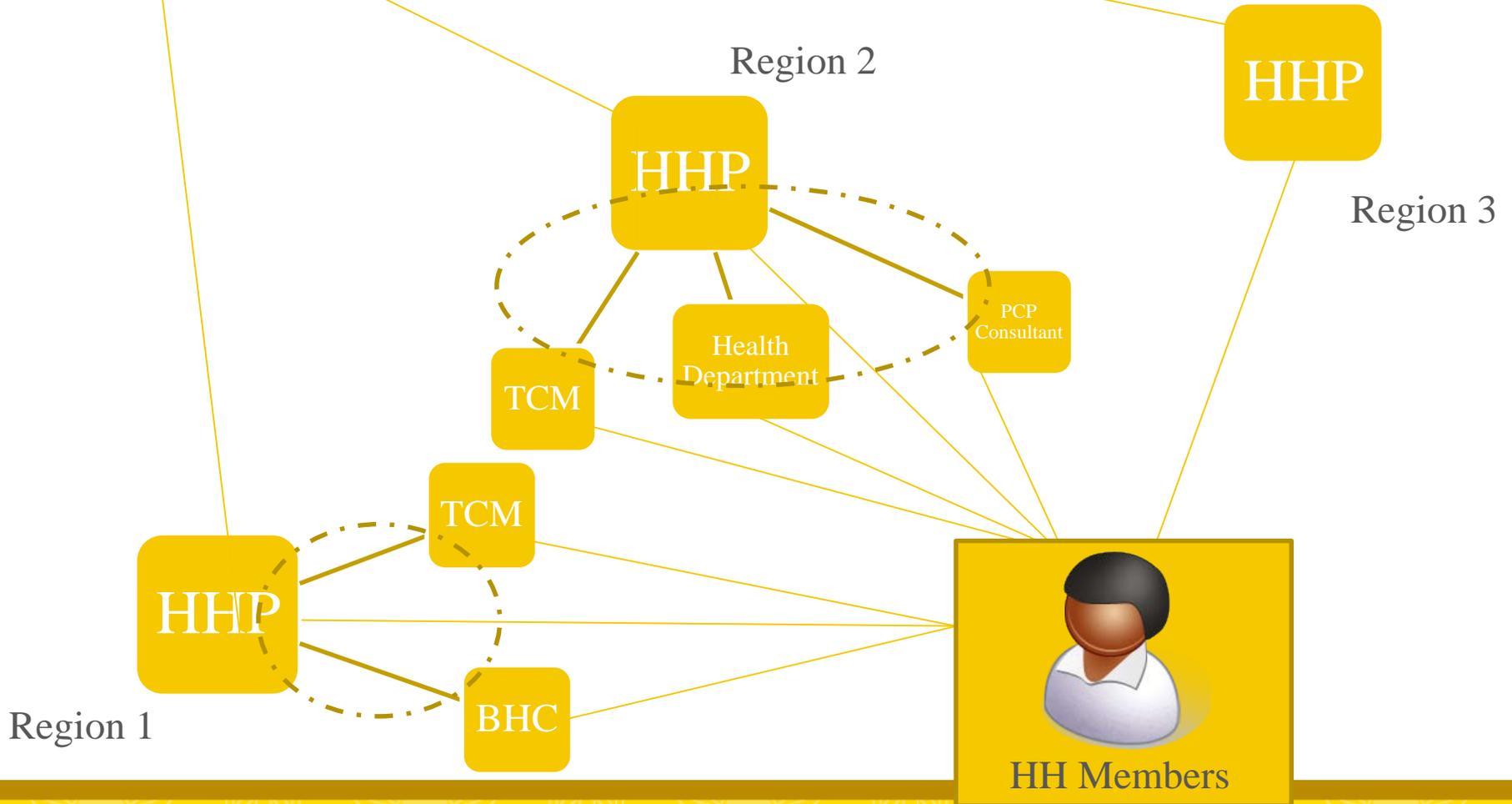
You are a health home provider, but UHC covers staffing, admin, and day to day work

- 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**

Sunflower Health Plan

Health Home Program

- Enrolled in KanCare program & agree to comply with KanCare program
- Must meet State licensing standards or Medicaid provider certification and enrollment requirements as one of the following:
 - Center for Independent Living, Community Developmental Disability Organization, Community Mental Health Center, Community Service Provider- for people with I/DD, Federally Qualified Health Center/Primary Care Safety Net Clinic, Home Health Agency, Hospital-based Physician Group, Local Health Department, Physician-based clinic, Physician or Physician Practice, Rural Health Clinics or Substance Use Disorder Provider
- Leadership Commitment to Continuous Process Improvement & Patient Centeredness
- Provide 6 core services
 - Directly or through contracted providers



- **Team of Professionals**

- **Physician:** MD/DO (minimum 1)
- **Nurse Care Coordinators:** RN, APRN, BSN or LPN (minimum 1)
- **Care Coordinator (SW):** (minimum 1)
 - BSW or BS/BA in a related field or MH TCM or an IDD TCM or a substance use disorder person centered CM
- **Behavioral Health Professionals:** psychiatrist (must employ or contract)
 - Other Behavioral Health Professional: “May be a licensed clinical psychologist, a licensed clinical psychotherapist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, a licensed professional counselor, licensed clinical additions counselor, a licensed specialist social worker or a licensed master social worker or a registered nurse who has a specialty in psychiatric nursing and is employed by, or under contract with the HHP.”

- Comprehensive Case Management
 - Health Action Plan http://www.kancare.ks.gov/health_home/download/Health_Home_Action_Plan.doc
- Care Coordination
 - Dedicated care coordinator responsible for overall management of HAP
- Health Promotion
- Comprehensive Transitional Care
 - Facilitate transition of treatment plans among service providers and facilities
- Individual & family support
- Referral to community & social support services

Lead Entities

- Evaluate, select & support providers
- Provide infrastructure & tools to support HHP
 - Portal
 - Health Home Program team
- Sharing member level data
 - Gaps in care, medications, ER/IP utilization
- Develop & offer learning activities
- Assure HHP commits to the use of an interoperable HER through the following:
 - Submission of a plan to the LE, within 90 days of contracting as a HHP, to implement the EHR
 - Full implementation of the HER within a timeframe approved by the Lead Entity
 - Connection to one of the certified state HIE, KHIN or LACIE, within a timeframe approved by the Lead Entity
- Audits & Data Analysis to facilitate the HHP transformation
 - HAP evaluation
 - Review of PDSA
 - Utilization of Portal

Provider Portal



SunFlower State Health | Currently sharing | Give Control | Stop Sharing

https://support.sunflowerstatehealth.com/careconnect/memberDetails?displayMedicaidId=

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SunFlower State Health Provider Tools

Coordination of Benefits

Claims

Age [Redacted] Phone Number [Redacted]

Member # [Redacted]

Address [Redacted]

Eligibility History

Start Date	End Date	Product Name
Mar 1, 2014	Dec 31, 9999	TANF
Aug 1, 2013	Feb 28, 2014	TANF

[more](#)

[View PCP History](#)

Name	Start Date	End Date
[Redacted]	Mar 1, 2014	Dec 31, 9999
[Redacted]	Aug 1, 2013	Feb 28, 2014
[Redacted]	Apr 13, 2013	Jul 31, 2013
[Redacted]	Apr 1, 2013	Apr 12, 2013

[Care Gaps](#)

Due for blood lead test on or before 2nd birthday

[Allergies](#)

None On File

[View Clinical Information](#)

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https://support.sunflowerstatehealth.com/careconnect/memberDetails?displayMedicaidId=...

SunFlower State Health Provider Tools

[View Clinical Information](#)

Three Most Recent ER Visits

Primary Diagnosis	Date	Facility/Provider
DIAPER OR NAPKIN RASH	09/16/2013	THE UNIVERSITY OF KANSAS HOSPITAL
FEVER NOS	08/28/2013	THE CHILDRENS MERCY HOSPITAL MO
FEVER NOS	07/28/2013	THE CHILDRENS MERCY HOSPITAL MO

Top 5 Most Occurring Diagnosis

- ROUTINE INFANT/CHILD HEALTH CHECK
- FEVER NOS
- OTH SPEC CONDS ORIG PERINTL PERIOD
- SINGLE LIVEBORN HOSP W/O C-SEC
- NB FEEDING PROBLEMS

Recent Pharmacy Activity

- FLUCONAZOLE SUS 10MG/ML
- MAPAP LIQ 160/5ML
- MUPIROCIN OIN 2%

Three Most Recent Inpatient Admissions

None On File

Three Most Recent Office Visits

Primary Diagnosis	Date	Facility/Provider
ROUTINE INFANT/CHILD HEALTH CHECK	01/16/2014	[REDACTED]
ROUTINE	01/16/2014	[REDACTED]
ROUTINE	01/16/2014	[REDACTED]

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Provider Portal



Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Coordination of Benefits

Claims

Visits Medications Immunizations Labs Allergies

Fill Date	Drug Name	Dose	Quantity	Dispensing Pharmacy
10/08/2013	FLUCONAZOLE SUS 10MG/ML	10 MG/ML	35	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
10/08/2013	MAPAP LIQ 160/5ML	160 MG/5ML	118	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
10/08/2013	MUPIROCIN OIN 2%	2 %	22	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
09/17/2013	NYSTATIN CRE 100000	100000 UNIT/GM	30	WALGREENS #7550
09/17/2013	NYSTATIN SUS 100000	100000 UNIT/ML	60	WALGREENS #7550
06/10/2013	DEEP SEA SPR 0.65%	0 %	44	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
06/10/2013	MAPAP LIQ 160/5ML	160 MG/5ML	118	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
05/03/2013	SIMETHICONE DRO 40/0.6ML	40 MG/0.6ML	30	CHILDRENS MERCY WEST PHARMACY/THE CORDEL

Done

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- Preparedness & Planning Tool

- http://www.kancare.ks.gov/health_home/download/Preparedness_and_Planning_Tool.doc
- Key Elements of Tool
 - The population you serve
 - 6 core services you provide
 - Presence of EHR & HIT use
 - Provider standards
 - KanCare Participation
 - Organizational leadership
 - Open panel
 - Community coordination
 - Health Home Partner standards

What Comes Next?



- Provider tool acknowledgement letter/fax
- SHP Health Home Program team reviews
 - Available health home partners
 - Regional characteristics
- Provider Regional Meetings in 4/2014
- Association outreach- ongoing
- SHP HHP regional calls scheduled after 4/30/2014
- Health home member letter sent on 7/1/2014
- Health home program begins 8/1/2014

- Sunflower Health Home Correspondence:
 - E-mail: LEN_SFSHPHOMEHEALTH@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

Provider Relations



A dedicated Sunflower Health Plan Provider Relations Representative can provide:

- ✓ Health Home core services information
- ✓ Health Home rate cell information
- ✓ Demographic information updates
- ✓ New practitioner credentialing information
- ✓ Policy and procedures clarification
- ✓ Contract clarification
- ✓ Membership roster information
- ✓ Claims dispute and resolution information

Contact Provider Relations at 877-644-4623



Provider Relations



Providers can contact Sunflower Health Plan through:

Secure web portal – www.SunflowerStateHealth.com

Phone – 877-644-4623

Fax – 888-453-4316

Lunch!



Small Group Discussion

Based on what you heard this morning:

- What insights do you have? What did you learn?
- What challenges/opportunities do you see?
- What else do you need to know?

Health Homes Resources



FORMS COMPLETED

- Health Action Plan
- Health Homes Referral Form
- Health Homes Refusal Form
- SMI Program Manual
- Health Homes Opt Out
- Health Homes Assignment Letter
- Preparedness and Planning Tool

FORMS STILL BEING DRAFTED

- Health Homes Discharge Form(s)
- Program manual for chronic conditions (CC)
Health Homes
- Reporting requirements

IMPORTANT DATES FOR PROVIDERS

- April 1, 2014– date to return Preparedness and Planning Tool (PPT) to be eligible for July 1, 2014 implementation
 - Providers can become a Health Home Partner at any time after July 1, 2014, but submitting the Tool by April 1st will ensure you receive full consideration to come in at implementation
 - April 2-9, 2014 – Provider Tour
 - July 1, 2014 – Implementation
-

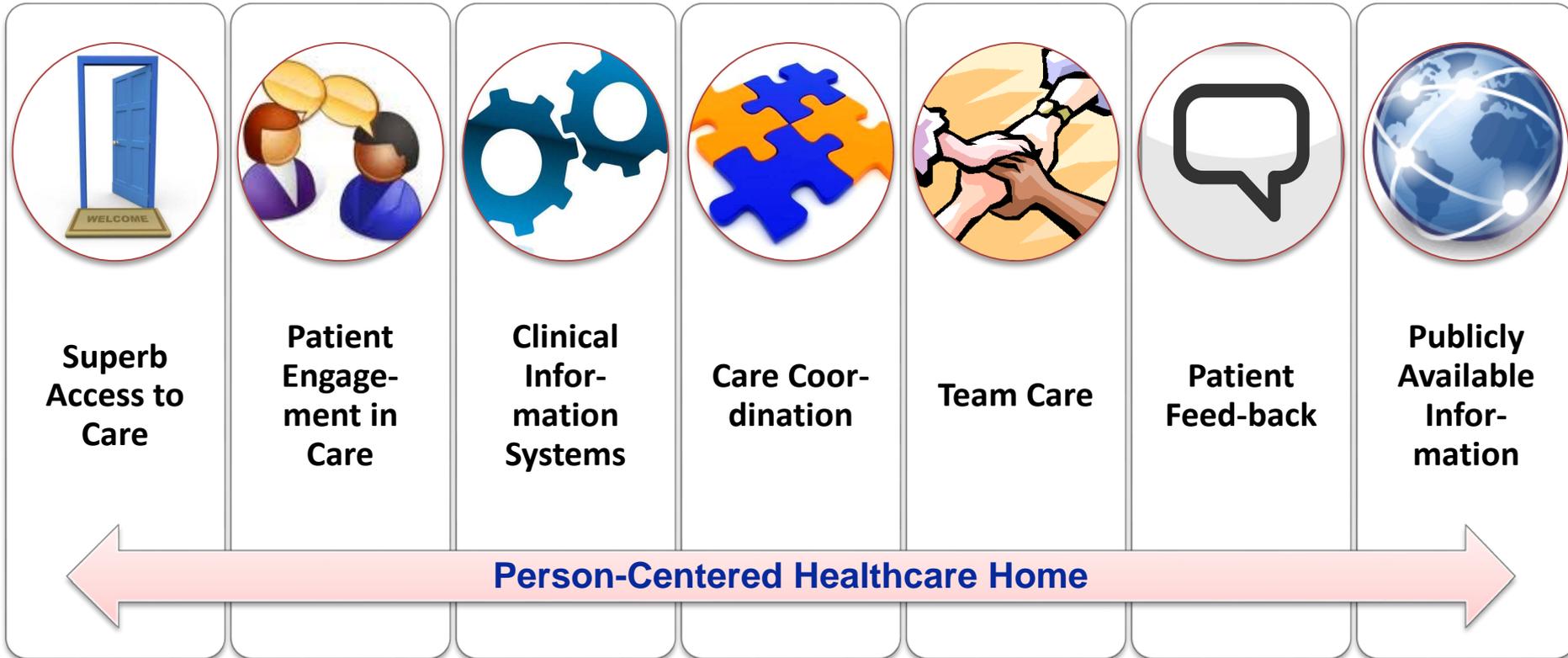
ACCESSING THE PPT

- Completing the PPT is the first step towards contracting to be a HHP
- The PPT and instructions are available at:
http://www.kancare.ks.gov/health_home/providers_materials.htm
- Other important documents like the Program Manual and both SPAs can be accessed from this page as well.
- If you have specific questions related to the PPT please contact Samantha Ferencik
sferencik@kdheks.gov

OTHER IMPORTANT RESOURCES

- Health Homes Webinar Series:
http://www.kancare.ks.gov/health_home/providers_webinar_series.htm
- Webinars will provide instructions and answer questions related to important documents and forms. All past webinars will be archived at the above address.
- Upcoming topics include:
 - Payment Structures for both SPAs
 - HIT Requirements
 - Health Action Plan

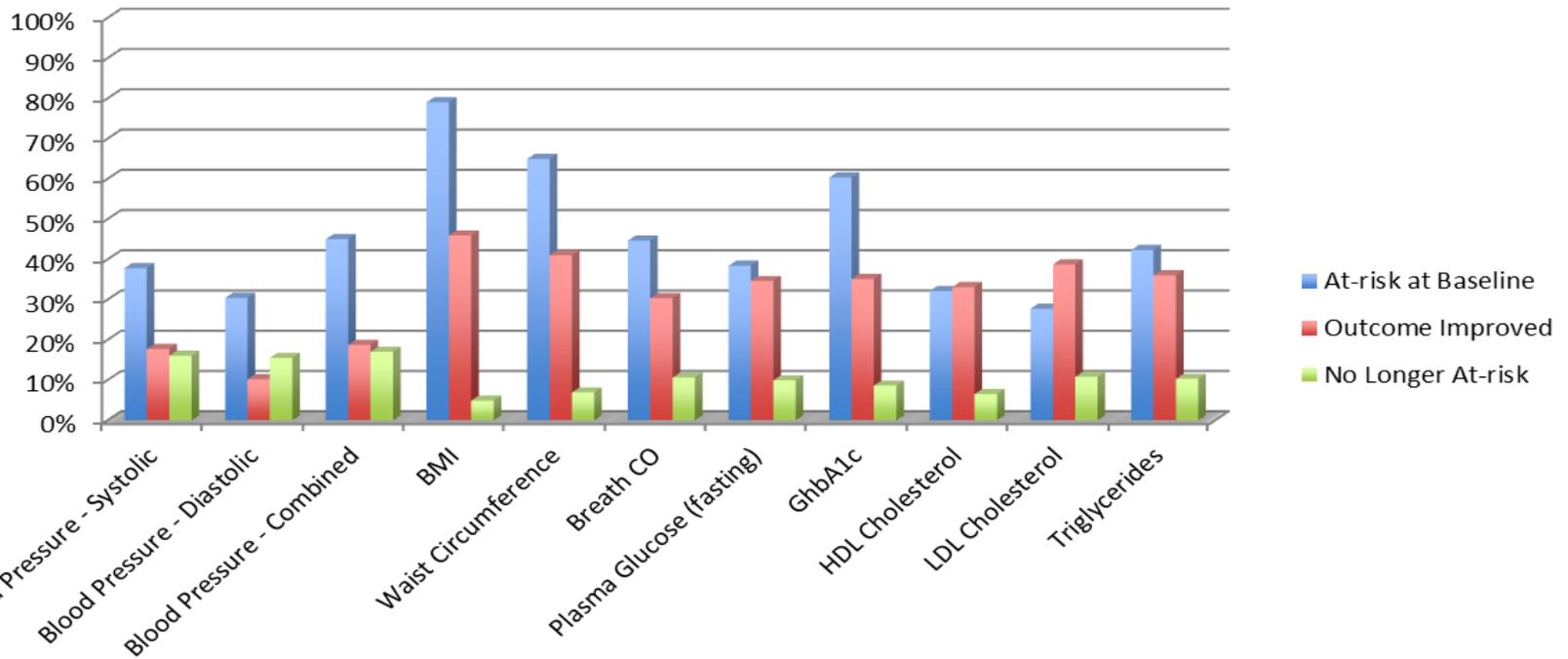
Essential Elements for Success in Health Homes for Persons with Serious and Persistent Mental Illness



- **The Care Coordination Standard: When I need to see a specialist or get a test, including help for mental health or substance use problems, help me get what I need at your clinic whenever possible and stay involved when I get care in other places.**
- **Services are supported by electronic health records, registries, and access to lab, x-ray, medical/surgical specialties and hospital care.**

Consumer Success

Change in Section H Indicators from Baseline to Most Recent Recording - Oct 11, 2012



- **Independent Living increased by 33%**
- **Vocational Activity increased by 44%**
- **Legal Involvement decreased by 68%**
- **Psychiatric Hospitalization decreased by 52%**
- **Illegal Substance use decreased by 52%**
- **IN ADDITION- Study shows CMHCs services substantially decrease overall medical cost**

Hello my name is Cassandra McCallister I am a Consumer with Washtenaw County Community Mental Health and also a patient with the University of Michigan Health Centers. I have been diagnosed with many disorders including Bipolar, Anxiety D/O, Clinical Depression, and Alcohol and Drug addiction. Medically I have Polycystic Kidney Disease, End Stage Renal Disease, and currently a Hemo-Dialysis patient waiting on a kidney transplant. Since I have been receiving for the last 6 years, through CSTS and the University of Michigan Health Centers, I have managed to stay "stable" with my mental health and overcome many obstacles with my physical health. I have learned the importance of ALL my healthcare to be linked together and for all those who are treating me to communicate with me so I can receive the best care available. My current case manager and my psychiatrist have discussed and helped make decisions with my PCP and any specialist that I currently see.

I have not been hospitalized for my Mental Health in over 7 years at which I was suicidal and could not manage to take care of myself or at the time my 14 year old son. I was unable to hold down a job, I was isolated and did not socialize with the community in any aspect. I have now remained sober for 14 years. Today I am very active in the Ann Arbor/ Ypsilanti AA community and I support and give guidance to many woman in recovery. Those suffering both from alcoholism and Mental Disorder.

I have dedicated my life to volunteering in any way possible to carry the message of hope to those with co-occurring disorders. I currently serve on the Board of Directors for Washtenaw Community Health Organization as a Consumer Board Member but also as a advocate to those who do not yet have a voice or may never have that voice. I proudly speak for them. I also have been able to return to work part time in a doctors office and I love working with patients. I have finally found freedom from my mental challenges. Although they still are a challenge I choose to own My Mental Disease instead of it owning me. I have Hope today. What a great feeling to know I can face the day and not feel as though I am living in the grips of darkness. Thank you Integrated Healthcare for giving me back my Life. Today I refuse to put the DIS- in my ABILITY.

Sara – New Jersey

Donna – Ann Arbor

Others?

kathyr@thenationalcouncil.org

www.integration.samhsa.gov

734.476.9879

Small Group Discussion

- What did you hear from Kathy?
- What is your reaction?
- What might that look like in Kansas? What creative ideas do you have?

Save the Dates!

Regional In-person Meetings (part 1)

- Apr 2 – Hays – FHSU, Robbins Center
 - One Tiger Place, Hays KS 67601
- Apr 3 – Dodge City – Dodge House Hotel
 - 2408 W Wyatt Earp Blvd, Dodge City KS 67801
- Apr 4 – Wichita – Hughes Metropolitan Complex
 - 5015 E. 29th Street N, Wichita KS 67220



Save the Dates! *(Continued)*

Regional In-person Meetings (part 2)

- Apr 7 – Chanute – Memorial Building, Alliance Room
 - 101 S. Lincoln Chanute, KS 66720
- Apr 8 – Kansas City KS - George Meyn Hall
 - 126th and State Ave, Bonner Springs KS 66112
- Apr 9 – Topeka – Ramada Inn
 - 420 Southeast 6th Ave, Topeka KS 66607



**Thank you for
participating!**

