OneCare Kansas

a program of KanCare, Kansas Medicaid

Changing Lives through Coordinated Health Services

January 2019

What is a “Health Home”?

- An expansion of the “patient centered medical home” model to include links to community and social supports for eligible Medicaid Members
- It is NOT a place, but a way to provide coordination of physical and behavioral health care with long term supports and services for people with certain chronic conditions
- Health Homes focus on the whole person and their needs to help that person be as healthy as possible.

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What is a “Health Home”?

OneCare Kansas (Health Home) members are eligible to receive six core services:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual & Family Supports
- Referral to Community & Social Support Services

These services are <u>in addition</u> to the services that members currently receive from their physical and behavioral health providers under Medicaid.

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Stories of Success

...from the members

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Meet “Katrece”:

Katrece had been hospitalized for one month due to Crohn’s Disease when she met her Health Home Care Coordinator in 2015. At the time of her discharge, she weighed 88 pounds and was experiencing significant consistent pain. She moved in with a family member because she was unable to care for herself or her two children. She was frequently tearful and reported feelings of hopelessness.

Over time, Katrece’s case manager was able to connect her to behavioral health support, boost her coping strategies and coordinate follow-up medical care. The case manager provided ongoing support and encouragement to assure that Katrece attended her appointments and that she had skills she needed to manage her family relationships.

After four months with support from her Health Home provider, Katrece was back in her own home with her children. She reported that her pain was under control, she was maintaining her behavioral health services and had managed to re-gain 30 pounds. Katrece appeared more optimistic about her future and had a stronger outlook on life.

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"Ramona" is 77 years old and lives alone in her own home in Kansas City. In 2015, her Health Home Care Coordinator discovered that Ramona did not have reliable transportation for medical appointments. She also reported that she had fallen in the past due to blackouts related to poor diabetes management. That fall had resulted in a broken pelvis and Ramona was still experiencing limited mobility. Ramona was also experiencing ongoing stress and worry related to very strained relationships with her adult children.

Ramona's Care Coordinator was able to help her develop a reminder system for her diabetic medication and connect her with transportation and in-home support services that she was previously unaware of for physical and behavioral health care.

When asked how the Health Home program has benefited her, Ramona stated, "It's more hands on, one-on-one. Maybe you don't even know what's out there to help and they can help find it. There are a lot of options that I know are there for me if I need to use them. Without this program I would have lost my Medicaid. I am very thankful about that."

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"Kenny" is diagnosed with Mild Intellectual Disability, Intermittent Explosive Disorder and Adjustment Disorder with Disturbance of Conduct. He was found naked in his front yard, unresponsive due to inability to manage his diabetes in November 2012. There were continued concerns about lack of diabetic monitoring, not keeping appointments and ongoing exploitation by family and others. When he entered Health Home services in 2014, the team discovered Kenny was only able to read and write numbers which impacted his ability to make healthy choices.

The team was able to provide grocery shopping assistance and develop strategies that allow Kenny to do this more independently. Kenny learned to monitor his glucose levels more consistently and learn more about a newly discovered citrus allergy – reducing his visits to the ER for allergic reactions. Staff were also able to provide reminders and transportation to appointments, allowing Kenny to receive more consistent physical and behavioral health care. The continuum of services provided helped reduce Kenny's risk for poor health outcomes, homelessness, and continued exploitation.

What HHPs had to say prior to the program closure in 2016

26 Health Home Partner Surveys received:

- 46% CMHCs
- 31% CSP-IDD Providers

When asked if HHs were beneficial to their clients (Scale = 1-10):

- 88.5% rated the program at an "8" or higher
- 46.2% rated the program at a "10"
- Only one respondent rated the program below a "5"

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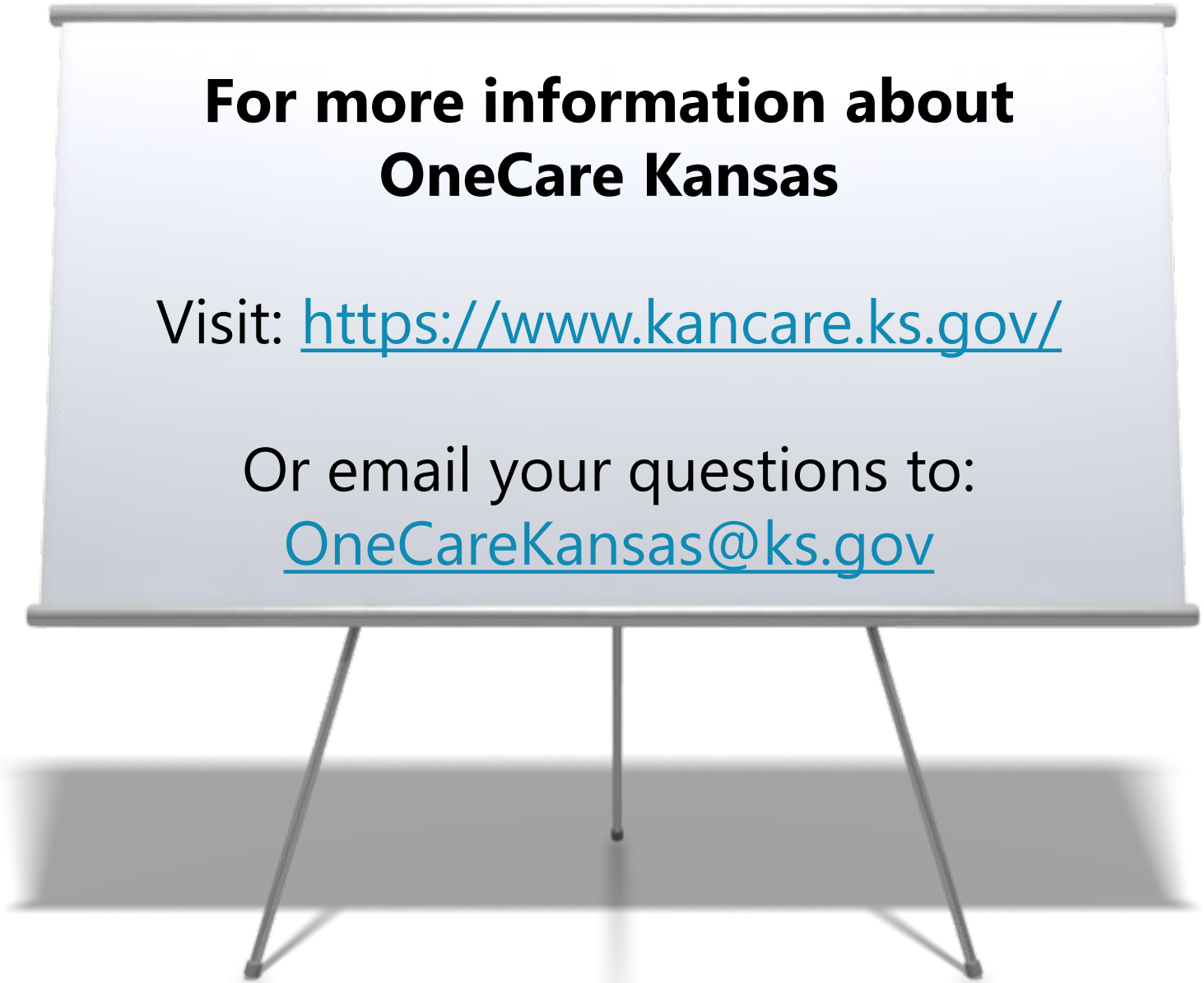
When asked if they would be willing to serve as an HHP should this population ever be reinstated into HHs:

84.6% of respondents reported they would serve as a HHP again.

When asked if they would be willing to serve as an HHP for other populations focused on primary care conditions such as diabetes:

88.5% of respondents reported that they would be willing to serve as a HHP.



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