# OneCare Kansas Partner Application

Revised 09/15/2020

| | | | |
|---|---|---|---|
| **Provider Legal Name** | | | |
| **Address of Main Office** | | | |
| **City, State, Zip Code** | | | |
| **Telephone for Main Office** | | | |
| **Name of Satellite Office(s)** | **Address of Satellite Office(s)** | **City, State, Zip Code** | **Phone # for Satellite Office** |
| | | | |
| | | | |
| | | | |
| | | | |
| **Email** | | | |
| **Website URL** | | | |
| **Areas served (counties/locations)** | | | |
| **National Provider Indicator (NPI)** | | | |
| **KMAP/Medicaid number** | | | |
| **Contact for Application Processing Name, Title** | | | |
| **Contact email** | | | |
| **Contact Phone Number** | | | |
| **Application Submission Date** | | | |

| | |
|---|---|
| **Target Start Date**<br>Though you can apply to become an OCK Provider at any time, we recommend that you submit this Application early to ensure that your organization receives members at the program launch date. Applications received after the launch date will still be evaluated but participation cannot be guaranteed. | Enter Target Start Date Here: |

| **The State encourages all potential OCK Providers to work with all three MCOs. However, you have a choice regarding who you would like to contract with. Please indicate those MCOs with which you are interested in contracting.** | | |
|---|---|---|
| **Aetna Better Health of Kansas** | **Sunflower State Health Plan** | **United HealthCare** |
| ☐ Yes | ☐ Yes | ☐ Yes |
| ☐ No | ☐ No | ☐ No |

# Purpose and Instructions

Purpose of this Application and Understanding the Application Process

The purpose of this Application is to aid the State in evaluating the readiness of interested providers to deliver OCK services. Submission of this Application to the State is the first step of a two-step process to become an OCK Provider. Your Application will be evaluated and if approved by the State, it will be forwarded on to the MCOs you designate for consideration and potential contracting. State evaluation and approval of an Application does not guarantee that any or all MCOs will award your organization a contract or that your organization will receive OCK members.

How to Complete the Application

This Application is designed to allow you to answer questions based upon an honest analysis of the current practices and processes within your organization. For your convenience, the State has identified two questions that must be satisfactorily answered if you are to be considered beyond this first step of the process. If your organization cannot satisfy these requirements, please do not continue the application. These are Questions 1 and 2 and are clearly marked.

**Pre-work:**

Prior to beginning the Application, it will be helpful to work with staff in your organization to collect:

- Data on demographics, service utilization and other characteristics of your current population (who you serve, how often you serve them and what processes you have in place).
- Information on current clinical, operational, and cultural practices and processes (the infrastructure of what makes your organization unique).
- Staff resumes, job descriptions and qualifications (including trainings completed and certifications held by your team members).
- Information on your organization's adoption of and adherence to the Kansas Tobacco Guidelines for Behavioral Health Care (https://namikansas.org/resources/smoking-cessation-information/)

# Process for Completing the Application:

- We recommend that you select a group of leaders and staff that have expertise on all levels of the organization (e.g., finances, operations, clinical processes, leadership practices, staff practices) to complete the Application. The time needed to complete it will vary depending on the availability of data/information within your organization. You may ask specific individuals to complete specific sections of the Application or you may ask a few individuals to complete as much of the application as possible.
- When finished, we recommend that you come together as a team to discuss the results and come to a consensus on final responses.
- Remember that Questions 1 and 2 of the Application may render your organization ineligible to serve as an OCK Provider. You should not continue the Application if you are disqualified by either Question 1 or Question 2.
- For those questions that ask for description, please be brief but thorough. The State may choose to reach out to your organization for additional information if we find your descriptions unclear.
- To aid in completion of this application, please reference Appendix A for service definitions and Appendix B for professional requirements.

# Process for Submission of the Application:

- The Application and all attachments should be completed electronically and sent directly to Samantha Ferencik at the Kansas Department of Health and Environment: samantha.ferencik@ks.gov
- Once received, the Applications will be evaluated by the State Evaluation Team. Incomplete applications will not be considered
- Unsuccessful applicants may reapply at any time.
- The applicant will receive a formal letter and response to their submission from the State.

MCO Response to Application:

Within 21 calendar days of receiving State-approved Application, the MCOs must schedule a follow-up call with each interested OCK Provider and provide a written evaluation of their Application. Not all applicants who submit the Application will be in a position to immediately become an OCK Provider. The written evaluation will indicate the MCO's assessment of the Application. After the follow-up call, the MCOs will have 10 days to provide potential OCK Providers with a contract amendment.

The potential OCK Providers will then have another 10 days to sign and return the contract amendment to the MCO. If at any point in this process the MCO or the applicant fails to meet a prescribed deadline as outlined above a 15-day grace period will take effect. If a final contract is not made within those 15 days, the provider will need to reapply.

# OCK Provider Application

1) Do you have an Electronic Health Record*? If you select "No" on this question this disqualifies you from consideration – please do not continue the application.

☐Yes
☐No

What Electronic Health Record (EHR) do you use? _____

a) Is your EHR capable of sending information to a specified data system, with the ability to produce reports from that system?

☐Yes
☐No

b) Is your EHR system accessible to an interdisciplinary team of providers?

☐ Yes
☐ No

c) Does your EHR include a community referral tracking component?

☐Yes
☐No

* An Electronic Health Record (EHR) is an electronic version of a patient's medical history, that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports The EHR automates access to information and has the potential to streamline the clinician's workflow. The EHR also has the ability to support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management, and outcomes reporting.

2) Please indicate by checking the appropriate boxes below how you intend to meet the following staff requirement:

| | Title | Have on Staff | Will Hire before launch* | Intend to Contract*** |
|---|---|---|---|---|
| A. | Physician/Psychiatrist** | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| B. | Mid-level Practitioner: APRN or PA | ☐ Yes ☐ No | ☐ Yes ☐ No | This disqualifies you from consideration-please do not continue the application. |
| C. | Nurse Care Coordinator | ☐ Yes ☐ No | ☐ Yes ☐ No | |
| D. | Social Worker/Care Coordinator | ☐ Yes ☐ No | ☐ Yes ☐ No | |
| E. | Peer Support Specialist | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| F. | Peer Mentor | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

Please attach the job descriptions of your staff to this application.
*Required prior to MCO contract.
**If you have a physician or psychiatrist on staff, this meets the requirement to have a Nurse Practitioner or PA on staff.
***If you have a physician or psychiatrist on contract and they are physically on-site at least part-time, please check "Have on Staff".

3) Did you participate as a provider in the previous Health Homes Program?
   ☐ Yes
   ☐ No

4) Do you have prior experience with similar program concepts such as:
   a) Care Management ☐ Yes ☐ No
   b) Patient Centered Medical Home (certified) ☐ Yes ☐ No
   c) Accountable Care Organization ☐ Yes ☐ No

| If you selected yes to any of the above, please briefly describe: |
|---|
| |

5) Do you have experience with and a process for coordinating and providing access to individual and family supports including the following:
   a) referral to community services; ☐ Yes ☐ No
   b) social support; ☐ Yes ☐ No
   c) mental health; ☐ Yes ☐ No
   d) substance abuse; ☐ Yes ☐ No
   e) recovery services; ☐ Yes ☐ No
   f) long-term services and supports; ☐ Yes ☐ No
   g) outreach efforts to the homeless population; ☐ Yes ☐ No

| If you selected yes to any of the above, please briefly describe: |
|---|
| |

6) Do you have experience with coordinating and providing access to
   h) comprehensive care management, ☐ Yes ☐ No
   i) care coordination, ☐ Yes ☐ No
   and
   j) transitional care across settings. (Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning.) ☐ Yes ☐ No

| If you selected yes to any of the above, please briefly describe: |
|---|
| |

7) Check all of the trainings that are required for your staff. Please explain how many staff members are trained and what positions the trainings are required for each training indicated. If you have an internal training plan for your staff, please attach.

☐ Diabetes Disease Management training (including Certified Diabetes Educator and Diabetes Self-management training)
☐ Tobacco Cessation (including Tobacco Treatment Specialist)
☐ Adherence to Medication
☐ Cultural Competency
☐ Screening, Brief Intervention, and Referral to Treatment (SBIRT)
☐ Mental Health First Aid
☐ Motivational interviewing
☐ Trauma informed care
☐ Others, please list: _____

| Explanation: |
| --- |
| |

8) Has your facility endorsed the Kansas Tobacco Guidelines for Behavioral Health Care?

☐ Yes
☐ No

9) If your facility has adopted the Kansas Tobacco Guidelines for Behavioral Health Care, check all the elements that your facility meets:

☐ Assess tobacco use regularly and provide tobacco treatment until quit attempts are successful
☐ Provide psychosocial treatment within whole person primary care and behavioral health care systems
☐ Provide cessation medications and ensure access without barriers through state Medicaid and other third-party payers
☐ Integrate tobacco treatment into assessment, treatment planning, and implementation
☐ Incorporate tobacco treatment into other ongoing efforts toward wellness and recovery
☐ Conduct quality improvement to define outcomes, monitor progress and improve tobacco treatment services
☐ Train staff how to treat and/or prevent tobacco dependence
☐ Bill for reimbursement and utilize other resources to pay for tobacco treatment
☐ Help staff who use tobacco to access evidence-based treatment for tobacco dependence adopting a tobacco-free environment
☐ Enact a comprehensive tobacco-free policy that includes buildings, vehicles, grounds and expectations for staff, visitors and clients
☐ Provide and/or support tobacco treatment for youth and young adults, especially high-risk youth and/or those in treatment for other conditions.
☐ Conduct and/or support tobacco prevention efforts and policies such as Tobacco “21”, school programs, community-based programs, disseminating messages to promote prevention, and other efforts.

10) Describe your facility's established partnerships with other health care providers and agencies in their area (local health departments, hospitals, physician practices, and others). Please attach agreements/contracts or letters of support with these providers/agencies

| Provider/Agency | How long | Describe the collaboration |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# Appendix A: Service Definitions

| Service |
|---|
| **Comprehensive care management** involves Identifying members with high risk environmental and/or medical factors, and complex health care needs who may benefit from OneCare Kansas (OCK), and coordinating and collaborating with all team members to promote continuity and consistency of care and minimize duplication. Comprehensive care management includes a comprehensive health-based needs assessment to determine the member's physical, behavioral health, and social needs, and the development of a health action plan (HAP) with input from the member, family members or other persons who provide support, guardians, and service providers. The HAP clarifies roles and responsibilities of the Lead Entity (LE), OCK Partner, member, family/support persons/guardian, and health services and social service staff. Critical components of comprehensive care management include:<br>• Knowledge of the medical and non-medical service delivery system within and outside of the member's area<br>• Effective cultural, linguistic, and disability appropriate communication with the member, family members/support persons, guardians, and service providers<br>• Ability to address other barriers to success, such as low income, housing, transportation, academic and functional achievement, social supports, understanding of health conditions, etc.<br>• Monitoring and follow-up to ensure that needed care and services are offered and accessed<br>• Routine and periodic reassessment and revision of the HAP to reflect current needs, service effectiveness in improving or maintaining health status, and other circumstances |
| **Care coordination** is the implementation of a single, integrated HAP through appropriate linkages, referrals, coordination, collaboration, and follow-up for needed services and supports. A dedicated Care Coordinator is responsible for overall management of the member's HAP, including referring, scheduling appointments, following-up, sharing information with all involved parties including the member, monitoring Emergency Department (ED) and in-patient admissions to ensure coordinated care transitions, communicating with all parties during transitions of care/hospital discharge, referring for LTSS, locating non-Medicaid resources including natural and other supports, monitoring a member's progress towards achievement of goals, and revising the HAP as necessary to reflect the member's needs. Care coordination:<br>• Is timely, addresses needs, improves chronic conditions, and assists in the attainment of the member's goals<br>• Supports adherence to treatment recommendations, engages members in chronic condition self-care, and encourages continued participation in OCK care<br>• Involves coordination and collaboration with other providers to monitor the member's conditions, health status, and medications and side effects<br>• Engages members and family/support persons/guardians in decisions, including decisions related to pain management, palliative care, and end-of life decisions and supports<br>• Implements and manages the HAP through quality metrics, assessment survey results and service utilization to monitor and evaluate intervention impact<br>• Creates and promotes linkages to other agencies, services, and supports |
| **Health promotion involves engaging members in OCK by phone, letter, HIT, and community "in reach" and outreach. Assessing members understanding of health condition/health literacy and motivation to engage in self-management, (e.g., how important is the person's health status to the member, how confident the member feels to change health behaviors, etc.). Assisting members in the development of recovery plans including self-management and/or relapse prevention plans including linking members to resources for: smoking cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on member needs and preferences. Assisting members to develop the skills and confidence that will enable them to independently identify, seek out, and access resources that will assist in managing and mitigating their conditions and in preventing the development of secondary or other chronic conditions. Health promotion:**<br>• Encourages and supports healthy ideas and behavior, with the goal of motivating members to successfully monitor and manage their health<br>• 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<br>• Ensures all health action goals are included in person centered care plans<br>• 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<br>• Offers prevention education to members, family members/support persons, guardians about proper nutrition, health screening, and immunizations. |
| **Comprehensive transitional care** is specialized care coordination designed to facilitate transition of treatment plans from hospitals, ED, and in-member units, to home, LTSS providers, rehab facilities, and other health services systems, thereby streamlining POCs, interrupting patterns of frequent ED use, and reducing avoidable hospital stays. It may also involve identifying |

| Service |
| --- |
| members not participating who could benefit from OCK. Comprehensive transitional care involves developing a transition plan with the member, family/support persons or guardians, and other providers, and transmitting the comprehensive transition/discharge plan to all involved. For each OCK member transferred from one caregiver or site of care to another, OCK coordinates transitions, ensures proper and timely follow-up care, and provides medication information and reconciliation. Comprehensive transitional care involves collaboration, communication and coordination with members, families/support persons/guardians, hospital ED, LTSS, physicians, nurses, social workers, discharge planners, and service providers. It is designed to ease transition by addressing the members understanding of rehab activities, LTSS, self-management, and medications. It includes scheduling appointments and scheduling and reaching out if appointments are missed. It may also include evaluating the need to revise the HAP. The transition/discharge plan includes, but is not limited to, the following elements:<br>• timeframes related to appointments and discharge paperwork<br>• follow-up appointment information<br>• medication information to allow providers to reconcile medications and make informed decisions about care<br>• medication education<br>• therapy needs, e.g., occupational, physical, speech, etc.<br>• transportation needs<br>• community supports needed post-discharge<br>• determination of environmental (home, community, workplace) safety |
| **Member and family support** involves identifying supports needed for members, family/support persons/guardians need to manage member's conditions and assisting them to access these supports. It includes assessing strengths and needs of members, family/support persons/guardians, identifying barriers to member's highest level of health and success, locating resources to eliminate these barriers, and advocating on behalf of members, family/support persons/ guardians, to ensure that they have supports necessary for improved health. Included in this service is assistance to complete paperwork, provision of information and assistance to access self-help and peer support services, and consideration of the family/support persons/guardians need for services such as respite care. To promote inclusion, consideration is given to accommodating work schedules of families, providing flexibility in terms of hours of service, and teleconferencing. The goal of providing member and family support is to Increase member's, family/support persons and guardians understanding of effect(s) of the condition on the member's life, and improve adherence to an agreed upon treatment plan, with the ultimate goal of improved overall health and quality of life. Member and family support:<br>• Is contingent on effective communication with member, family, guardian, other support persons, or caregivers<br>• Involves accommodations related to culture, disability, language, race, socio-economic background, and non-traditional family relationships<br>• Promotes engagement of members, family/support persons and guardians<br>• Promotes self-management capabilities of members<br>• 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<br>• Involves an awareness of complexities of family dynamics, and an ability to respond to member needs when complex relationships come into play |
| **Referral to community supports and services** includes determining the services needed for the member to achieve the most successful outcome(s), identifying available resources in the community, assisting the member in advocating for access to care, assisting in the completion of paper work, identifying natural supports if services providers are unavailable in the member's community, following through until the member has access to needed services, and considering the family/support persons/guardian preferences when possible. Community supports and services include long-term care, mental health and substance use services, housing, transportation, and other community and social services needed by the member. Referral to community and social support services involves:<br>• A thorough knowledge of the medical and non-medical service delivery system within and outside of the member's area<br>• Engagement with community and social supports<br>• 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.<br>• Fostering communication and collaborating with social supports<br>• Knowledge of the eligibility criteria for services<br>• Identifying sources for comprehensive resource guides, or development of a comprehensive resource guide if necessary |

# Appendix B: Professional Requirements

| Professional(s) | Professional Qualifications |
|---|---|
| Physician | Licensed to practice medicine in Kansas and can either be employed directly or contracted with the OneCare Kansas (OCK) Partner. If contracted, see notes on page 4 of the application regarding staffing requirements |
| Psychiatrist | Licensed to practice psychiatry in Kansas and can either be employed directly or contracted with the OneCare Kansas (OCK) Partner. If contracted, see notes on page 4 of the application regarding staffing requirements |
| Nurse Care Coordinator | RN, APRN or LPN actively licensed to practice in Kansas to support OCK in meeting the Provider Standards and needs to be employed directly with the OCK Partner. |
| Social Worker/Care Coordinator | The Care Coordinator must be a BSW actively licensed in Kansas or a BS/BA in a related field or a MH (Mental Health) Targeted Case Manager (TCM) or an I/DD (Intellectual/Developmentally Disabled) Targeted Case Manager (TCM) or a substance use disorder person centered case manager to support the health home in meeting the provider standards and deliver OCK services to enrollees. Case Managers must meet the requirements specified in Kansas Medicaid State Plan and Provider Manuals and must be employed directly by the OCK Partner. |
| Physician Assistant (PA) | PA must be actively licensed to practice in Kansas and must be employed directly by the OCK Partner. |
| Advanced Practice Registered Nurse (APRN) | APRN must be actively licensed to practice in Kansas and must be employed directly by the OCK Partner. |
| Peer Support Specialist/Peer Mentor | The Peer Support (PS) Specialist must meet the defined KDADS Behavioral Health requirements for Mental Illness or Substance Use Disorder (SUD). For Mental Illness, the PS Specialist requirements include being employed by a licensed Mental Health provider, meeting age requirements, as well as, passed state-approved training through a State contractor and background checks. Additionally, the PS Specialist must self-identify as a present or former primary recipient of Mental Health Services. For SUD, the PS Mentor must be employed by a licensed or certified SUD provider; meet age, training, and supervision requirements; as well as, self-identify as active in recovery from alcohol and/or illicit substances for at least one year. If employed in the agency in which the PS Specialist services is received, the PS Specialist must meet discharge requirements where the PS Specialist must have been discharged by that agency for a minimum of six months. |