OneCare Kansas Planning Council Meeting Summary

July 1, 2019

Members of the OneCare Kansas (OCK) Planning Council and the OCK State Project Team gathered at the Kansas Health Institute in Topeka on 06/20/19. The group was welcomed by Kansas Medicaid Initiatives Coordinator, Becky Ross, and the meeting was facilitated by staff from the Wichita State University Community Engagement Institute. A copy of all presentation slides are available on the OneCare Kansas website.

WSU staff provided a brief overview of the history of the OneCare Kansas Planning Council and their accomplishments to date.

Project Update

Becky Ross (KDHE DHCF) provided a brief update on progress since the May meeting including:

- Still on track for implementation on January 1, 2020.
- Meeting with MCOs and other contract partners monthly
- Developing training materials for providers
- Planning another forum later this summer to provide updated information to potential providers

Provider Outcomes Discussion

In an effort to further develop indicators of OCK program provider success, Amy Swanson, Quality Program Manager from the KDHE Division of Healthcare Finance, initiated a conversation with the group to identify potential elements and goals used by previous Health Home service providers to document member and program success. Members of the Planning Council were provided with questions in advance under four major topic areas and given the opportunity for discussion in a rotating, roundtable format. These four areas included: *Provider Programs, Data Sources, Provider Outcomes,* and *Provider Successes*. Information collected as part of these discussions are included as an appendix to this report.

Target Population Identification Update and Discussion

Dr. Tami Gurley-Calvez provided the group with preliminary information regarding the process being used to gather and analyze Medicaid data that will assist in identifying the population to be targeted by the OneCare Kansas program. This information is included in a PowerPoint presentation from this meeting and is posted for public viewing on the OneCare Kansas website.

Communication Updates

Samantha Ferencik, Program Analyst for the KDHE Division of Healthcare Finance, provided the group with a brief update on the types of information currently available on the OCK website for potential providers. These include the OCK newsletter, meeting information for the Planning Council, and a few of the forms that may be used by potential providers. Because the site is being continually updated, Planning Council members are encouraged to become familiar with how to locate information on the website and consult it regularly so they may assist their respective constituencies in answering program related questions.

Forum Planning

KDHE will be hosting a second Provider Forum in Newton, KS on August 15. Members of the Planning Council were asked to provide suggestions to assist in planning the agenda. The group suggested that it will be important to be clear about the types of information we intend to share to assure that participants can plan accordingly. If final information is not yet available, it may be difficult for potential providers to participate fully. The group suggested that it would be helpful to review the data from the Forum in March 2019 to identify areas that could be improved. Potential topics for presentations could include: Target Population, Payment Methodologies, and content from the Provider Webinar Series. There was a suggestion that it might be helpful to have a panel that represents organizations who previously provided Health Home services to discuss how their programs were set up as well as challenges/successes.

Next Steps

Potential next steps to accomplish prior to the next Planning Council meeting include:

- Send a save the date for the Provider Forum
- Continue to update the Planning Council on progress related to identification of the Target Population, development of payment methodologies, and development of the draft Program Manual.

Mark your calendars!

OneCare Kansas Planning Council
Meeting Dates:

July 18, 2019 – at KHI in Topeka, KS
10:00 a.m. – 4:00 p.m.

August 15, 2019 – Provider Forum in Newton, KS
September 19, 2019
October 17, 2019
November 21, 2019
December 19, 2019

(All meetings will be held at the Kansas Health Institute in Topeka from 10:00 a.m. – 4:00 p.m. unless otherwise noted.)

Report prepared by:

Planning Council Quality Provider Outcomes Discussion

Prior to the meeting, Planning Council members were asked to think about a health home partner they may have worked with, including:

- Their program structure (how they organize themselves, where did the program sit in the agency, staff reporting structure, staff roles, supervisory roles)
- The things they were excited to share with you (advancements, member outcomes, relationship development with other providers)
- How they assessed themselves (internal goals, program development benchmarks, staff performance criteria)
- How they overcame challenges (locating members, bringing up a new program, working across

The group then was then asked to answer a series of questions as part of a rotating roundtable process. The results of these discussions follow.

Provider Programs

What were key elements providers used to build their original program? (Ex: advertising, staffing, program management?)

Community Mental Health Center (CMHC) Example #1
Based on number predictions, started program with 7 Care Coordinators (Bachelor level), 2 Clinical Care Managers (QMHPs), 2 Nurse Care Managers, and a Health Home Manager. Created member cards that patients could provide to caregivers in the community and hospitals to identify that they belonged to a Health Home and provided contact information for our Health Home. Continued attempts to educate internal staff around the organizations as to what Health Homes were.

Community Mental Health Center (CMHC) Example #2

- Attended local Physician Alliance Meeting to share PowerPoint presentation
- Brought brochures to Primary Care Physician (PCP) offices and answered questions they had
- Invited pharmaceutical staff to CMHC Health Home staff meeting to discuss various program options, etc.
- Attended community health fairs and events
- Developed a separate department aimed to focus on health integration
- Posted positions on commonly used websites, new sources, local colleges, and with other health focused organizations
- Hosted a health fair
- In regard to program management, we monitored the following on a regular basis and the data was shared among the team:
  - Client engagement:
    - # of in person sessions post initial appointment

        - Completed Health Action Plans
        - No show and cancelled appointments
        - # of refusal/discharges
        - Group development and attendance
    - Outcome improvements based on assessments
        - PHQ-9
        - FACT-GP
        - CBCL
        - DLA
        - CAGE
        - CRAFFT
        - Closure reasons
        - PAM
        - # of hospitalizations and re-admits
        - Timeliness of follow-up post hospitalization
        - PCP visit every 90 days
        - Behavioral Health visit every 90 days
        - LCL, HBa1c, and Substance Abuse screens
        - Referral counts
        - Client satisfaction surveys
        - In-house and community education

Additional Discussion

- Constant education of staff
- Some hired and either found new or re-arranged building space
- Educated community when advertising for positions, emphasizing program innovation and impact on members
- Created posters to explain the program
- Did a needs assessment including all elements of care
- Focus on engaging consumers and locating members to inform them of choice to join
- Relationship building with hospital and other providers. Having staff know who to call at other providers
- Good referral processes
- Created program manuals to assure expectations were clear
- Specific cell phones so that staff could text members.
- Vehicles to visit members in the community

How did they determine whether an element was successful?

Community Mental Health Center (CMHC) Example #1
There was a lot of trial and course correction. Relied on staff feedback as well as data from MCOs to see what was successful, as well as tracking outreach attempts.

Community Mental Health Center (CMHC) Example #2
- Number of partnerships and correspondence from other providers
- Consumer and community partners survey results
- Demonstrated marked improvement in assessment scores
- # of consumers closing after having successfully met goals and acquired resources
- Improvements in measures sent directly from MCOs regarding hospitalizations, follow up, and other client information
- Used our own spreadsheets and software to measure some components

Additional Discussion
- Gathered anecdotal evidence
- Based assessment of success on members accessing services
- Tracked those eligible vs. those actually participating
- IDEA: Keeping track of social engagement
- Monthly reviews on an individual member level
- Ease of communication and growth as staff members across disciplines

What would the provider have done differently?

Community Mental Health Center (CMHC) Example #1
Consider having a couple of staff whose primary role was to work on outreach allowing other staff to focus on patients who were engaging. Plan more staff to carry weight of the administrative burden. The administrative burden was massive with large amounts of time spend pulling information for MCO reports and attempting to keep attributed member lists updated according to monthly lists received from the MCOs.

Community Mental Health Center (CMHC) Example #2
- Integrated the department within existing CMHC programming to ensure there was more resources, communication, and knowledge sharing
- Less duplication of paperwork (HAP & Plan of Care, Assessments with similar measurements, etc…)
- Reduced caseload to provide more follow through (mostly impacted by the amount of referrals given as a result of an opt-out program and taking on more counties than we should have.)

Additional Discussion

- Identify problems early. So much learning has already happened
- MCOs standardize whenever possible
- Sometimes member needs where overwhelming – this was eye opening
- More ability to respond to needs in real time
- Adjusting expectations for member/staff relationships
- Members are often in survival mode and cannot plan, only can react
- Sometimes smaller goals are better
- Having a smaller population will help

What elements would they replicate as they build a new program?

Community Mental Health Center (CMHC) Example #1
Continue educating internal staff about Health Homes. Similar structure on a smaller scale regarding staffing, but utilize QMHP and Nursing staff that are already in the organization more. Providing something to patients to identify them to community providers as Health Home providers.

Community Mental Health Center (CMHC) Example #2

- Partnerships with PCPs, Physician Alliance, community resources and partners (Butler Homeless Initiative, Resources for Community and Independent Living, Rainbows, Child Start, Law Enforcement, Safehouse, Children's Advocacy Center, Sunshine Children's Home, Butler Early Childhood Taskforce, DCF, etc.) and other agencies participating in the program
- Perhaps monitor some of the same health measures such as hospitalizations, attendance to PCP appointments and behavioral health appointments, and aftercare
- Access to health information via MCO portals

Additional Discussion

- Continue ongoing education of internal staff
- Hire less new staff, try to leverage existing staff as much as possible
- Team approach is huge. Sometimes 2 (or more) disciplines need to work together (at the same time even) to accomplish success for members.
- Bridges out of poverty education
- Health home cards

Data Sources

Excluding data required by the State/MCOs, what additional data did the provider collect?

Community Mental Health Center (CMHC) Example #1
Mostly data around outreach attempts.

Community Mental Health Center (CMHC) Example #2

- Referral counts and engagement in programming or supports to meet their physical or behavioral health needs
- Reasons for closure
- Face to face encounters with members
- Completion of documentation such as HAP, progress notes, releases, etc.

Additional Discussion

- Short survey to assess isolation/quality of life – ask about friendships, quality of life
- Gaps in care
- Reasons for missed visits
- Health outcomes – did they improve
- Integrate the HAP into electronic system to monitor 6 core services, referrals
- Health – smoking cessation, diabetes, nutrition
- Mileage
- Emergency funds

For what purpose did they collect the data?

Community Mental Health Center (CMHC) Example #1
Tracking staff time put into outreach efforts and attempting to gain more information about what methods worked best in finding and reaching members.

Community Mental Health Center (CMHC) Example #2

- Evaluation of performance
- Program management and evaluation
- Time and fiscal management

Additional Discussion

- Used HAP as a treatment plan
- Program length was too short
- Time and fiscal management
- Resource management – other types (beyond staffing) to expand access, like food bank, utilities – connected to social determinants of health

- Private money for emergency fund – used to get ID, gas, bus tokens

How was the data used to support program development/changes?

Community Mental Health Center (CMHC) Example #1
Program was constantly developing and changing based on data and information. Staff would share what worked and didn't work with each other. New approaches were discussed and plans put into place.

Community Mental Health Center (CMHC) Example #2
- Caseload management changes
- Program structure and supervision changes
- Personnel changes
- Training enhancement
- Sharing of success stories with state agencies and partners

Additional Discussion
- Changes were used to help with social determinants
- Quality improvement – what is working and what isn't
- Strategies that work to help develop patient programs
- Saw trend of connection to Substance Use Disorder with a number a providers
- Engagement – identifying crisis situations

Were reports or findings developed to share these findings?

Community Mental Health Center (CMHC) Example #1
Reports regarding staff activity were developed and share with staff. Reports from MCOs were also shared with staff.

Community Mental Health Center (CMHC) Example #2
- Personnel evaluations
- Meeting minutes and reports
- Managerial and program reports
- Company newsletter

Additional Discussion
- Individual consumer data – preview claims activity – sharing between MCO and partners

Provider Outcomes

What goals did providers set for their programs?

Community Mental Health Center (CMHC) Example #1
After the first 6-9 months, heavier emphasis on contacting patients within a month of their being added to our attributed member lists. Improving on 7 day follow up post-inpatient stay.

Community Mental Health Center (CMHC) Example #2
- Increase in service array and availability
- Increased compliance and improvement in MCO measures
- Stability and understanding

Additional Discussion
- Truly understanding the depths of the program
- Understanding all of the pieces and how to assess how we were doing (i.e. HEDIS)
- Most partners had their own provider manuals that listed their goals. May think to look into those (talk with United & Sunflower)
- It might be helpful that at the beginning of the program, the OCK partners meet with the MCOs to know about the expectations
- Engage with members to really connect and achieve the holistic health goals to integrate care. Used soft handoff.
- Meeting EHR requirements
- Attending regular meetings
- Health goals for the community as a whole
- Reduction in gaps in care
- Inclusion of intake of members that could benefit

For their members?

Community Mental Health Center (CMHC) Example #1
Getting established with a Primary Care Provider. (It was remarkable how many patients did not have a PCP.) Setting health goals and making forward progress on those goals.

Community Mental Health Center (CMHC) Example #2
- Reductions in hospital admits
- Improvements in overall health measures as indicated above
- Increased knowledge regarding health conditions and self-advocacy

Additional Discussion
- Physical/wellness checks (make sure up to date)

- Immunizations
- Up to date on appropriate labs and exams (pap smear, glucose, etc.)
- Smoking/tobacco cessation
- Weight loss & exercise
- Better eating habits (i.e. decrease sugar intake)
- Engagement of members in the program so they actively participate. This will be very important for the opt-in program
- Decrease isolation and feelings of loneliness. Ask "who are your friends" and track this
- Goals that the members sets or deems important
- Dental home – comprehensive health and access to care
- Filling of gaps outside of "health" – connected social determinants of health such as clothing, transportation, etc.
- Education of appropriate level of care surrounding health problems (ER vs. urgent care vs. doctor visit

For their staff?

Community Mental Health Center (CMHC) Example #1
Having a "can do" approach. Increasing patient engagement.

Community Mental Health Center (CMHC) Example #2
- Many had goals regarding knowledge advancement on health related conditions
- Personal targets for HAP completion, client referrals, and client engagement

Additional Discussion
- Internal guidelines for how many phone calls, touch points, etc. for the patient/member
- How often to contact the member
- Training certification goals (including learning collaborative and trainings provided by the state)
- How to determine level of case management and staff assignment
- Look for case management skills and higher skilled with technology
- Date of last contact
- How to use data that the MCO provided – hopefully will be more uniform among all MCOs
- Decreasing provider burnout to reduce turnover and keep people engaged
- Education of staff for specific disease processes and whole understanding of person (cultural competence)
- Education on ACEs – what it is, why it's important and how to apply
- Patient engagement
- Training on components of the program

For their organization?

Community Mental Health Center (CMHC) Example #1
Increasing patient engagement across the board.

Community Mental Health Center (CMHC) Example #2

- Improvements in embedding the program within the organization and integrating into the community
- Becoming the "go to" for overall health care and resources

Additional Discussion

- There may be association goals
- Informal surrounding reimbursements and sustainability goals
- Networking and how to partner with other organizations in the community
- Take the culture of the organization and expand that to the community
- Networking with safety net or existing PCPs of the members
- Build relationships with other social service agencies in community to address social determinants of health
- Financial goals were critical with a lot of budget cuts the first time
- How to graduate members from programs
- Assignment of members was messy and had issues the 1st time around inappropriate assignments/diagnoses for the members. Watch for competition in communities that have multiple OCK partners. Learning Collaborative could help decrease this.

Program Success

How did providers assess goal achievement?

Community Mental Health Center (CMHC) Example #1
Staff report was relied on quite a bit. Also patients provided feedback when they were on site. Utilized reports from MCOs to assist in identifying what areas we were excelling at and where we still needed improvement.

Community Mental Health Center (CMHC) Example #2

- Peer-to-peer kudos
- Success stories
- Employee evaluations
- Provider incentives.

Additional Discussion

- With each individual worked with they looked at the goals. Seeing someone consistently for diabetes, connecting them to a doctor, pulling them out of bad situations. Dependent on notes took (Individual notes when they heard successes).
- Organized data scorecards from MCOs (Not all providers had time for it because they started late in the game, but it could have been useful and been an indicator of success).
- Person being served able to set and move toward their target goals (HAP).
- Integrate and expand access to care when applicable to the member. Look at the whole person, whether they came to appointments or having to seek them out. (engagement, working with other systems)
- Contact point in morning huddles- identify needs when they are there. Getting people to a point where they could engage.
- Finding members
- Tracking isolation loneliness factor- asking for the names of friends when at an appt., if they don't have any that's an indicator of loneliness. If they can name some 6 months down the road, that's an indicator of success.
- Increase in peer support with CMHCs- new members get new services, current members get more services.
- Member starting to open up more
- Internal staff supports- looked at outreach efforts, reviewed regularly what worked vs. what didn't
- Patient feedback
- How many patients got PCPs after becoming a HH member
- Case managers and nurses working together
- Data received from MCOs
- Self-regulate when things went wrong
- Meetings with MCOs
- Getting HAP completed vs. how many didn't get done. More of them done was a success
- New people coming to the program because their friend had success with it

How did providers self-regulate when things went wrong?

Community Mental Health Center (CMHC) Example #1

There was a lot of course corrections throughout the program. There also continued to be changes in expectations through the two years and the staff had to remain open to change and willing to try to new things. Held weekly meetings throughout the two years to discuss methods, successes, brainstorm, etc.

Community Mental Health Center (CMHC) Example #2

- Supervision/consultation with their immediate supervisor or Clinical Coordinator
- Team building events – they went to lunch monthly as a group
- Self-care activities such as exercise, yoga, music, etc.

Additional Discussion

- Crisis response, look for trends when something is going wrong
- Staff to monitor situations
- Held weekly meetings to discuss methods, successes, brainstorm solutions to problems they were seeing.
- Stayed open to course correction, open to change
- Discussion at board meetings
- Providers had individual program manuals. (Are they reaching their own ideals or targets?)
- Reach out to MCOs to see if they could collaborate to improve something.
- Monthly joint operating committee meetings with MCOs

How did provider conduct internal auditing?

Community Mental Health Center (CMHC) Example #1

Utilizing staff activity reports and conducting chart reviews.

Community Mental Health Center (CMHC) Example #2

- Program coordinator and QA staff conducted chart reviews

Additional Discussion

- Review records, supervisors review what's going on
- Members to audibly come forward with problems, this was a more formalized process after HHs started
- Promote education to remind people what the program was about
- Monitoring EHRs, chart reviews
- Staff activity reports
- Nurse Case managers or program managers oversaw the general documentation and staff performance (HAP completion, timeliness, matters being handled)
- Overall quality monitoring and utilization review

How did the provider share their successes? (format, venue, audience)

Community Mental Health Center (CMHC) Example #1

Weekly meetings, emails to leadership, sharing with MCO contacts, sharing at state visit December of 2015.

Community Mental Health Center (CMHC) Example #2

- Team meetings
- Email
- Company newsletter

Additional Discussion

- Staff meetings (internally) shared with boards
- Very internal process
- Sharing success stories with state team and MCOs for newsletters
- Staff meetings to share successes/barriers
- Legislative testimony
- Shared information with grant funders- Example, HH consumers were able to get dentures through grants. Shared that information back to the funder.