OneCare Kansas Planning Council Meeting Summary

July 19, 2019

Members of the OneCare Kansas (OCK) Planning Council and the OCK State Project Team gathered at the Kansas Health Institute in Topeka on July 18, 2019. 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 for each OCK Planning Council meeting are available on the OneCare Kansas website.

Project Update

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

- A draft of the OneCare Kansas Program Manual has been developed and posted to the website. (See details below)
- KU continues to work on evaluating the data that will help identify the Target Population.
- There are a number of items on the timeline that will be completed once the Target Population and Payment Rates are determined. These include elements required by CMS such as submission of the State Plan Amendment for final approval.

DRAFT OCK Program Manual Review and Discussion

Samantha Ferencik, Program Analyst from the KDHE Division of Healthcare Finance provided the group with information on how to access the draft OCK Program Manual that is now available online. The group was encouraged to check the website often as the most recent version of the Manual will be posted monthly as new information becomes available. This manual will remain in draft form for quite some time. Notice of updates will be made available via the monthly OCK Newsletter.

Samantha walked through the highlights of each section of the draft (see PowerPoint slides from the meeting on the OCK website). Following the presentation, meeting participants were given the opportunity to ask questions and discuss issues related to the Program Manual and its dissemination:

Questions of clarification:

Q: Section 5 (slide 17) – Is the HAP Bonus tied to the 90 day deadline? Does this start with the day of assignment?
*A: There will be a **one-time only** bonus payment for completion of the member's first Health Action Plan within the first 90 days of the start of service delivery (which will be on the 1st of the month following assignment.)*

Comment: On page 18 of the manual the Clubhouse model is not listed as a possible partner.
A: This was an oversight on the part of the team and it will be corrected immediately. If other omissions are identified, please send these to OneCareKansas@ks.gov.

Discussion:

How do we best get this information to potential OneCare Kansas Providers (OCKP)?

- Associations that are represented on the Planning Council will send information to their membership along with the summary and other materials from today's meeting. Community Care Network of Kansas intends to send the information with a request that the network send them a list of potential training or support needs. All association networks are encouraged to do the same.

What other provider types might we need to provide information or training to?

- Because this is now an opt-in program, there will be providers out there that can push better awareness (MCOs, case managers, mental health centers) through more of a personal touch.
- We should be talking to hospitals, safety net clinics, health departments, emergency rooms to train up those providers to help people opt-in.
- The Kansas Hospital Association agrees that training for Emergency Department staff is important, however, the program is currently not at the top of their list given it has not yet launched. It was felt that timing is everything – if we train too far in advance, the information may be more easily forgotten. Once the target population is identified, then training for hospitals around the referral requirements and benefits of the program may be more effective.
- Crisis intervention points in primary care, physical healthcare, and behavioral health care will be important partners to educate as they may have direct access to members who are eligible and can make referrals for the program.
- KDHE staff reported that prior to the launch of the previous Health Homes initiative, the KDHE Secretary provided information to physician practices. This

could be an example of an avenue to explore for future education of hospital and primary care providers.

- KDADS staff mentioned that there are now a number of "crisis intervention centers" in Kansas that are seeing good outcomes and would be a good partner to reach out to since their patients/clients are often in care for up to 23 hours.
- Aetna staff suggested that the KDHE Population Health calls may be an opportunity to provide a wide variety of providers with a high level overview of the program and ways that different provider types can get involved.
- KALHD staff reported that they have a listserv ready to go but are unsure of what the "ask" is for Health Departments. Samantha explained that this will depend on the size of the Health Department. For the vast majority, they are very small and would not meet the provider staffing requirements to become a contracted OCKP. However, those smaller departments may want to collaborate with other OCKPs in their area to provide one or two services and can likely be a referral source for members. Larger health departments who do meet the staffing requirements may want to review the manual to better understand program expectations and begin preparing their systems to apply to become a contracted OCKP.

OCK Enrollment Process Review and Discussion

Samantha Ferencik then provided Planning Council members with an overview of the OCK Enrollment and Disenrollment processes. Flow diagrams for each process were shared as well as critical dates to remember. The diagrams that were made available do not include all of the "behind-the-scenes" processes – such as how files are transferred from the state's Medicaid partner, DXC, to MCOs, etc. – but outline the process that are important for providers to be aware of in order to keep the information as simple and clear as possible.

Critical dates to remember for all processes:

- The 9th of each month will be the last day for enrollment/dis-enrollment each month.
- MCOs will notify OCKPs of their enrollment rosters by the 18th of each month.
- Services will begin on the 1st of the next month for newly enrolled/assigned members.
- Services will end on the last day of the calendar month for those members who are dis-enrolled. (Information presented today indicated that this would the 1st of the month – this correction will be made on all upcoming materials).

<u>Discussion:</u>

Would it be better to provide these simplified flow charts or include the diagrams that have more of the "behind-the-scenes" information in the manual?

- It was felt that the simplified version would be best.
- Another possibility would be to provide this in timeline form or with a member scenario.

From the group:

- There will likely be members who will not read the letters of invitation or won't respond to the letter for a variety of reasons. Where do they fall in the process? Samantha shared that the team is working on a "re-invitation" process and will determine how often the invitation letters will be sent (these letters are required by CMS). However, we need to consider a balance between re-inviting members and "harassing" them to join the program. This is where providers and partner relationships will likely be very important.
    - It was noted that there are a number of representative payee programs across the state who receive mail on behalf of the member. Education of these groups could be very helpful in reaching some of the more vulnerable and high need members that might be eligible.
    - Encouraging providers such as FQHCs and CMHCs to include a prompt in their visit processes to ask member they think might be eligible about whether they have received the letter or are interested in opting-in could be helpful in identifying members. It was discussed that once the target population is identified, providers may be able to add a flag to their EHR systems that would signal the prompt.
- When education providers about the referral process, it might be helpful to provide guidance on what to do if a member has opted-out and wants to be referred.
    - Kansas Hospital Association indicated that Hospitals have access to claims data that might indicate a member's eligibility but may not have access to the data to see if they are currently enrolled. They are willing to work with KDHE to identify processes that would help Emergency Departments better identify potential members for referral.
    - It will be important to connect hospital staff with the OCKPs in each area to increase comfort level in making referrals.
- Need to identify communities where there are already strong medical partnerships and ways to capitalize on those collaborations.
- Is there an intention to have a "living" list of OCPs? Samantha indicated that this was available in the past both as a data file and as an online map so that people could identify the partners in their area. This will be made available in this initiative as well.

Payment Methodology

Adam Proffitt, Kansas Medicaid Director, presented the group with information on the methodology that will be used to determine rates for the OCK Program as well as the process that was used in the previous Health Home initiative. This information is available in the presentation slides for this meeting on the OCK website.

Questions of Clarification:

Q: When will there be real data related to payment?
A: Once the target population data is identified, that member data will be used to inform the process.

Q: Is there a limit to the number of services that a member can receive in a month?
A: No. However, they must receive at least one service in the month to trigger the Per Member Per Month (PMPM) payment to the MCO.

Q: What about the HAP Bonus Payment?
A: This was not included in the presentation, but will be part of the process.

Q: With the PMPM system, what would be the incentive for providers to document every service/contact they provide in a month? It will be important to keep this documentation process as simple as possible for providers.
A: Complete data allows the State to analyze the combination of services that are most effective and provide data for future sustainability and expansion of the project. There are also "indicators for underperformance" listed in the program manual that the MCOs will be using to audit provider performance.

Q: Will members be able to evaluate the OCK services that they receive?
A: In the previous initiative, this was discussed and ideas were considered as part of discussions during the Learning Collaborative (i.e. postage paid postcards sent following a visit.) Incorporating questions into the provider's existing feedback loops may also be an option. The team will continue to incorporate member voice into discussions about evaluating quality and effectiveness of the program.

Q: Does the rate impact the number of people that can be served within the allowed budget?
A: No. CMS does not allow exclusion of eligible members. The number of people to be served will be determined by how eligibility is defined and the number of people who choose to opt-in.

Target Population Identification Process Update

Dr. Tami Gurley-Calvez, Associate Professor from the University of Kansas Medical Center presented the group with an update on the process of identifying the target population to be served by the OCK initiative. Data that was shared are available in the presentation slides for this meeting on the OCK website.

Discussion:

What could account for the significant increase in depression diagnoses?

- Increased efforts to complete depression screenings
- Increased prescriptions for anti-depressants
- Increased awareness around depression

From the group:

- The launch of the Health Homes initiative could be attributing to the increase in the number of visits per year. The launch of KanCare and the subsequent inclusion of HCBS waivers could also be a factor.

OCK Provider Forum and In-Person Training Tour Discussion

Provider Forum

WSU staff reported that the vast majority of the people who are currently registered for the OCK Forum in August are from Community Mental Health Centers. All were asked to please send a reminder to their member networks of the upcoming forum. It was suggested that a list of topics that will be covered would be helpful to encourage people to attend. This list was discussed and an agenda will be available soon. Council members were asked to remind partners that the content is not a repeat of the March session, though some of the topics are similar. We encourage participation from a variety of provider types to assure that we get feedback from several perspectives.

The Forum may be a good opportunity to begin discussion about how to gather member input for evaluation of the program.

In-Person Provider Education Tour

KDHE is planning to host a provider education event in a number of locations across the state. This will not occur until the target population and payment rates are determined so that this information may be included. In the past, topics also included the member enrollment and referral processes as well as presentations from each of the MCOs related to their processes and expectations. Aetna staff noted that the MCOs are working on a standardized audit process and that it might be helpful to present this information at that time.

Next Steps

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

- Member associations will send a reminder of the August Forum to their networks
- WSU staff will distribute an agenda for the provider forum when it is finalized
- Member associations will continue to communicate updates with their networks and gather information on needs and questions to be discussed at these meetings
- The State team will work with provider groups on potential communication tools for member recruitment and provider education

Mark your calendars!

OneCare Kansas Planning Council
Meeting Dates:

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.