

Integrated Care & State Policy in Kansas:

Case Study of Community Health Center of Southeast Kansas



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Introduction

Community Health Center of Southeast Kansas began as an organization committed to meeting the health care needs of children, and found itself responding to numerous opportunities to meet patients' needs. Over the years, its primary strategy has focused on quality, innovation and growth. Their story is one of making a difference regardless of the challenges they face – including state policy upheavals and managed care implementation in Medicaid. Strong, experienced leadership and staff working hand in glove with a dedicated patient-governed Board of Directors lies at the heart of the organization's success.

Life in Kansas

The common perception that Kansas consists exclusively of vast plains of rolling wheat is not entirely accurate. The Great Central Plains of Kansas do sweep across its western expanse, but the plains give way to an area of southeast Kansas with rocky, rolling hills and lush deciduous forests peppered with oak, elm, and hickory trees along with the Eastern Cottonwood, the Kansas' state tree. To a large extent, southeast Kansas resembles its Ozark neighbors to the east rather than the "traditional" Kansas to its west. This terrain, and the minerals beneath it, shapes the history of Kansans.

Southeast Kansas has a long history of mining. A silent testament to this industry from the past is "Big Brutus," a giant 16-story, 11-million pound power shovel that can scoop up to 150 tons of earth in one bite. The machine's current function is to stand guard at the entrance of a coal mining museum in West Mineral. For a half century, southeast Kansas led the world in zinc production. The zinc was used to prevent corrosion on iron; win two World Wars; and make brass, paint, and soap. In 1877, rich veins of lead were discovered and miners and rail cars flocked to the area by the thousands. Hard-working yet poor immigrants from southern Europe settled in the area. They worked in the mines, in the brickyards and smelters, and on the farms. At one point, someone counted 34 different languages among the residents.

Over the years, the mines closed and the industries disappeared, leaving abandoned factories, generational poverty, and chronic illnesses behind in the region's nine square-shaped and tightly arranged counties: Woodson, Allen, Bourbon, Wilson, Neosho, Crawford, Montgomery, Labette, and Cherokee. Missouri flanks the eastern border of these counties and Oklahoma is to the south. Crawford County is the most populous of the nine, and is dubbed "The Fried Chicken Capital of Kansas." It also includes the city of Pittsburg, home to the Community Health Center of Southeast Kansas.

Community Health Center of Southeast Kansas

Started in 1997 as an outreach service of Mt. Carmel Regional Medical Center in Pittsburg, the clinic was housed in the 5th grade classroom of a 90-year-old former elementary school. The clinic's vision was to ensure that children

were “ready to learn,” and the staff achieved this vision by providing school physicals and immunizations five days a week. Every child was eligible for these services, regardless of a family’s ability to pay.

The clinic initially relied on support from the Medical Center and small grants, but was always struggling. With its sustainability in jeopardy, the clinic applied for and received a new access point award in 2002, becoming the first and only Federally Qualified Health Center (FQHC) in southeast Kansas. On May 3, 2003, the Community Health Center of Southeast Kansas (CHC/SEK) opened its doors—or rather door—in a 1,500 square-foot double-wide trailer and never looked back. CHC/SEK has expanded its services through the years to include medical, dental, and behavioral health, in addition to mobile medical and 340B pharmacy services. The health center has grown to include 11 clinical locations that serve 42,000 patients who have approximately 165,000 visits annually. The health center accomplished this growth by deftly maneuvering a maze of federal, state and local funding opportunities. CHC/SEK’s nearly 150 providers and staff see patients who have traveled from Oklahoma, Arkansas, Missouri and other parts of Kansas.

Journey to Integrated Care

The culture at CHC/SEK provided the foundation for a successful model of integrated care. Leadership principles include putting patients first, maintaining a sense of urgency, saying “yes” to opportunities and working out the details later, and being good stewards of resources. With these principles in mind, the management team of Chief Executive Officer Krista Postai; Chief Financial Officer Douglas Stuckey; Chief Medical Officer Linda Bean; and Executive Vice President Jason Wesco decided to look for opportunities to initially include behavioral health services within their primary care offices, which later transitioned and expanded to an integrated care facility. Prioritizing behavioral health integration was due in large part to a presentation many years earlier at a Health Resources and Services Administration (HRSA) conference for grantees. Cherokee Health Systems in Knoxville, TN, presented on what was then the revolutionary concept of embedding mental health professionals within a medical clinic. Subsequently, CHC/SEK piloted a program through an innovation grant funded by a Kansas Foundation. It immediately reduced unnecessary referrals to traditional therapy (for which there was a six week waiting list) and resulted in increased provider and patient satisfaction. This success motivated the health center to keep moving in this direction. When foundation support became available to send a local team comprised of CHC/SEK staff and the staff of the community mental health center to a training in Knoxville to learn more, they jumped right in and have never looked back.

At the time, the entire region was critically underserved with only a very small percentage of those with mental health benefits able to access services. The community mental health centers were divided into catchment areas and focused on the severe and persistent mentally ill. Traditional therapy was not readily available, which was a gap filled by CHC/SEK. Additionally, changes in the state contracts with the community mental health centers eliminated their requirement to serve the uninsured resulting in another gap. Another important factor was that CHC/SEK employed the region’s only full-time psychiatrist.

Getting the right behavioral health providers on board was the first step in this transition. The management team strategically looked for smart, committed, and mission-driven individuals. In 2005, a psychologist and a clinical social worker (coincidentally, a husband and wife team) joined the pediatric clinic. Thus began a co-location model that would be used until the complete integration of primary and behavioral health care became possible some years later.

Through a collaboration with a local foster care organization, another psychologist was hired in 2006 to work with the children in foster care. This joint effort exemplifies how CHC/SEK astutely and effectively uses collaborations to pursue and achieve its mission. Still adhering to a co-location model for integrating behavioral health, a fourth psychologist joined the clinic in 2007 to see patients referred from both primary and behavioral health care

practitioners. CHC/SEK also had an opportunity to hire a psychiatrist in 2007, whose patients were also referred by primary care practitioners and other behaviorists. Ideally, patients would be stabilized by the psychiatrist and then referred back to the primary care provider for ongoing care. However, this strategy was challenging to maintain because of the high demand for primary care services.

Of the numerous strong, visionary, and generous foundations located in Kansas, the Sunflower Foundation: Health Care for Kansans took a particular interest in efforts to integrate behavioral health and primary care. The foundation was created in 2000 as part of a \$75 million settlement between Blue Cross and Blue Shield of Kansas and the State. It was charged with serving the health needs of Kansas with emphasis on serving the poor, the uninsured and underserved. It strives to be a catalyst for change and recognized that integration was a promising model of care, especially in a state with limited access to behavioral health care and with the understanding that the majority of mental health concerns are first identified in the medical home. The Foundation provided both planning and implementation grants to help CHC/SEK (and other Kansas health centers) transition to a fully integrated care model using the definition recommended by the Agency for Healthcare Research and Quality (AHRQ):

“The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress related physical symptoms, and ineffective patterns of healthcare utilization (Peek, 2013).”

With support from the Sunflower Foundation, CHC/SEK was able to hire and train two additional behavioral health consultants (BHCs) and a Director of Integrated Care.

The leadership team at CHC/SEK also established a strong collaboration with a local community mental health center (CMHC) to expand behavioral health care resources. In this collaboration with Four County Mental Health Center, the leadership from both organizations worked closely together to increase school-based therapy services. They trained staff in motivational interviewing and implemented Mental Health First Aid. CHC/SEK also opened a clinic on site at the CMHC’s invitation and the organizations jointly employed a physician’s assistant who was formerly a mental health counselor. Integration looks different in every locale and the secret is that “one size doesn’t fit all”; it must be customized to meet the needs of the population served. This collaboration worked because the leadership of both organizations knew and trusted one another, and they maintained close communications through monthly meetings and shared strategies. In addition, CHC/SEK recently became licensed as an outpatient substance abuse facility and received a federal substance abuse grant (MAT Grant). The health center plans to hire another counselor, a nurse, and a peer support specialist.

Lessons Learned

Some of the lessons the CHC/SEK team has learned on their integrated care journey include:

1. The integrated care infrastructure and workflows should be in place and working smoothly to enhance (rather than deter) the efficiency and effectiveness of primary care practitioners. Integrated electronic records, quality control, scheduling, coding, and billing all need to flow properly.
2. Train your primary care providers on the integrated care model and how to use BHCs more effectively. Staff often had different ideas as to what “integrated care” meant and looked like. Most thought it only “had something to do with behavioral health crises.”

3. BHCs can and should do more than “crisis work.” They offer a significantly broader range of practices that can help patients with most behavioral changes needed to improve overall health and well-being.
4. Although referrals to specialty and traditional behavioral health clinicians should be available, try to keep as much behavioral health as possible in the primary care setting.
5. Schedule specialty behavioral health visits more efficiently. CHC/SEK began experimenting with “block scheduling” (30 minutes/30 minutes/30 minutes/open for a two-hour block in the morning and a similar two-hour block in the afternoon). Standard one-hour appointments are scheduled in the other two-hours (both morning and afternoon). This strategy has worked well and is helping the health center to achieve its goal of providing immediate (or near-immediate) access to care.
6. Listen to patients, community members and staff “in the trenches.” Many excellent ideas come from the people who are receiving or delivering care.
7. Culture matters – a lot. CHC/SEK’s culture is built on the following principles: putting the patient first, maintaining a sense of urgency, not overthinking solutions, and always doing the right thing.
8. Change does not just happen by itself. It takes leadership, encouragement, time, patience, communication, will and *verifiable* benefits.
9. “If it’s everyone’s job, it’s nobody’s job.” Everyone was delivering integrated care at CHC/SEK, but no single individual was charged with the accountability and responsibility for making integrated care happen. There was a clear and present diffusion of duties. To remedy the situation, CHC/SEK plans to hire a Director of Integrated Care funded by the Sunflower Foundation, whose duties will entail transforming practices and integrating all of the disciplines—dental, medical, and behavioral health and pharmacy.
10. Lack of experience should not deter an organization from moving forward with ideas. CHC/SEK “figured things out” as they went along.

Kansas State Policy and Integrated Care

Two seminal state government policies that significantly impacted integrated care in Kansas are (1) funding decisions made by Kansas Medicaid around 2005, and (2) the shift to managed care through KanCare.

Medicaid Funding Decisions

Around 2005, the Kansas State Medicaid Department made several bold policy decisions that serendipitously supported the development of integrated care a decade later. The Kansas Association for the Medically Underserved, the state primary care association, CHC/SEK and other Kansas FQHCs and health leaders worked with Medicaid to allow two or more visits on the same day (medical, dental, behavioral, etc.). This policy change supported far easier integration of primary care and behavioral health, and provided a solid base for the eventual sustainability of the integrated care model.

In addition, Kansas Medicaid and the FQHCs agreed to an alternative payment methodology (APM) that provided the “better of” the prospective payment system (PPS) or cost. Implementation of this APM helped to increase the

health center's capacity to deliver care to the underserved and to sustain innovations in care, including integrated care.

However, FQHCs encountered a barrier regarding payments for master's level psychologists, clinical marriage and family therapists and clinical professional counselors. These disciplines were paid fee-for-service. Only PhDs, PsyDs, and clinical social workers were able to receive PPS/APM payments. Like many states, Kansas used the provider classifications determined by the Centers for Medicare and Medicaid Services (CMS)¹ to determine the disciplines eligible for PPS/APM payments. However, the state has not acted on its latitude to expand that list to include other behavioral health providers

KanCare

In January 2011, Governor Sam Brownback and his staff decided to fundamentally reform Medicaid. The state was facing major Medicaid cost challenges, with few visible benefits in care and outcomes to justify the expenditures. The governor was determined to improve health outcomes while ensuring the financial stability of the new program. Consumers, providers, and advocates were invited to participate in public forums held across the state in Wichita, Topeka, Dodge City, and Overland Park. The purpose of the forums was to craft a new Medicaid program. Kansas submitted a Section 1115 Waiver to CMS for permission to transform Medicaid. As expected, parts of the 1115 Waiver were approved while other parts required more negotiations with CMS. The agency finally gave its full approval to the waiver, and the state privatized Medicaid in 2013 and created a new program called KanCare.

The vision statement for KanCare is *"To serve Kansans in need with a transformed, fiscally sustainable Medicaid program that provides high quality, holistic care and promotes personal responsibility."* Another phrase frequently used to describe the program is, *"The right care, in the right amount, in the right setting, at the right time."* In January 2013, KanCare had an enrollment of more than 415,000 across the State. The state contracted with three managed care organizations (MCOs) to coordinate healthcare for Medicaid enrollees. These MCOs (Amerigroup of Kansas, Inc. [Amerigroup]; Sunflower Health Plan [Sunflower]; and United Healthcare Community Plan of Kansas [United]) were required to coordinate all of the care for each Medicaid consumer. The goals were to improve overall health outcomes of the population and reduce the *rate* of growth in future costs. In addition, the MCOs were required to provide a stronger focus on prevention and screening in the management of ongoing chronic conditions among the enrollees.

The impact of KanCare on CHC/SEK was immediate and dramatic. No longer was the State the only payer. There were now three very different payers with different and sometimes conflicting organizational frameworks and processes. CHC/SEK's leadership had to develop new skills and procedures for contracting, credentialing, coding, and billing; and new revenue cycles in order to survive the transition.

Credentialing was especially challenging because the MCOs did not offer "provisional credentialing" (an expedited credentialing process pending final credentialing), which the State had previously accommodated. The ensuing credentialing delays generated additional challenges for the quick (provisional) approval of providers, which then delayed payments and hampered the use of locum providers. Delayed credentialing also wreaked havoc with providers' schedules, because not all CHC/SEK providers could be paid for seeing MCO patients. In short, the administrative challenges increased exponentially as CHC/SEK began dealing with three very different MCOs.

As part of Medicaid's plan to control costs, the MCOs adopted new value-based contracts. Building on the fee-for-service model, the MCOs offered bonus dollars for meeting certain quality and medical expenditure goals. As a high-quality, low-cost provider, CHC/SEK is ideally positioned to take advantage of these new revenue

¹https://www.ssa.gov/OP_Home/ssact/title18/1861.htm#act-1861-aa-1

opportunities. In addition, the practice transformation skills developed by implementing patient-centered medical homes and integrated care were likely to also return dividends in this new managed care environment.

In addition to offering more preventive care services, Kansas Medicaid had decided early on that benefits previously provided under the State plan would also be covered by KanCare. Telemedicine thus remained a covered component in this managed care environment, and CHC/SEK was considering its use in the integrated care efforts.

CHC/SEK also continued its 340B pharmacy and contract pharmacy arrangements with Walgreen's, Walmart and numerous other smaller pharmacies under managed care. These played a major role in their ability to meet prescription needs of patients while providing financial security for the health center. Lastly, the state's PPS/APM remained relatively untouched during the transition to KanCare, which again helped sustain integrated care.

Conclusion

The Kansas State motto, "Ad Astra per Aspera," is translated to mean "To the stars through difficulty"; or sometimes, "Through hardships to the stars." The motto was originally intended to describe the hard work and resilience of the early Kansan pioneers. The motto can just as easily describe the hard work and resilience of the Board, leadership, and staff of CHC/SEK today. They continue to navigate new ways to benefit their patients, and their commitment and hard work leave a blueprint for, and a legacy of, making a difference regardless of the challenges.

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Prepared By:
Joel Hornberger



National Association of Community Health Centers®

1400 I Street, NW, Suite 910

Washington, DC 20005

www.nachc.org/states

For more information about this publication, please contact:

Dawn McKinney

Director, State Affairs

dmckinney@nachc.org

202.296.3800

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