OHIO MEDICAID HEALTH HOMES FOR THOSE WITH SERIOUS AND PERSISTENT MENTAL ILLNESS

Health IT/Health Record & Treatment Plan Integration Committee

November 16, 2011

12:30 – 3:30 p.m.

Rhodes, Rm. 806

Purpose: *develop comprehensive recommendations for integrated personal health record that is inclusive of key health information data, providers and services such as assessment/screenings, diagnoses, medical tests, medications, clinical & non-clinical services, and treatment plan; align treatment plan requirements; identify barriers at the practice level and clinician level that hinder the development and use of a single, integrated treatment plan and recommend solutions.*

- **Welcome & Introductions**
- **Review of Purpose**
- **Review of State Plan Examples**
- **Review of Service Definitions**
- **Review of CMS Meaningful Use Requirements**
- **Health Record Integration**
- **Treatment Plan Integration**
- **Use of HIT to Support Health Home Services**
- **Next Steps**
- **Next Meeting: November 30, 2011 12:30 – 3:30 p.m., Rhodes Rm. 806**

Health IT/Health Record & Treatment Plan Integration Committee
Meeting Minutes
November 16, 2011

Attendees: Jon Barley, Angie Bergefurd, Kueiting Betts, Anita Bowman, Rafiat Eshett, Beth Ferguson, Janice Franke, Mary Haller, Cynthia Holstein, Deb Hrouda,Kythryn Carr Hurd, Terry Jones, Afet Kilinc, Teresa Lampl, Lynne Lyon, Jody Lynch, JP McInnes, Mary Norman, Michaela Peterson, Susan Rice, Cheri Rodman, Alicia Smith, Peggy Smith, Jean Solomon, James Vernon, Lisa Wiltshire, Hugh Wirtz

WELCOME AND INTRODUCTION & REVIEW OF PURPOSE:
The meeting opened and the attendees introduced themselves. The kick-off meeting PowerPoint presentation was shared with the group. Ms. Bergefurd provided an overview of the Ohio Medicaid Health Home Program:

- A Health Home is a whole person care coordination/care management for consumers with complex conditions. Person-centered planning approach to identify needed services and supports.
- For Medicaid consumers with one serious and persistent mental health condition or two or more chronic and complex conditions, or one chronic condition and at risk for a second are eligible for the services. , including SPMI, SMI and SED populations. Cannot exclude dual eligible and cannot target specific ages.
- Built on the patient centered Medical Home model.
- Health Homes services include comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support, referral to community and social support, and use of HIT to link services.
- Providers need to meet the core qualifying elements. Please read the provided draft Medicaid Health Home Provider Site Recognition/Accreditation/Integration document for detailed information.
- Funding is a federal-state match. States contribute 10% and Feds contribute 90% of cost for first 8 quarters; then regular match after that.
- We are taking regional approach.
- Payment methodology is flexible, per member per month (PMPM) approach and reimburse on the monthly basis.
- We want the Health Home program to be able to accommodate various models of integration that we have set up already throughout the state.

The conversation today should focus on: How are we going to address the use of HIT across different services? What information and data elements need to be exchanged between primary care setting and behavioral care setting or other settings? Identify the barriers of having an integrated treatment plan at the agency level – how are people accommodating that and how can HIT to support that.

The approved State Plan Amendment (SPA) from Missouri and submitted SPA from Rhode Island were reviewed by the group. Ms. Smith provided the HIT requirements/information from these States:

- Both States are pursuing Health Homes for SPMI populations (Missouri also includes SED, substance abuse and DD populations).
- As people are at various stages of implementing electronic information usage, it is not required to have electronic information exchange among behavioral health providers,

primary care providers, hospitals, etc. State can set some standard requirements that all CMHO health homes have to meet.

Rhode Island:

- Some of the Community Mental Health Organizations (CMHOs) in Rhode Island (total 7 CMHOs) have electronic medical records (EMR). Two CMHOs are SAMHSA grantees have co-located physical health.
- Rhode Island does not mandate to use a specific type of EMR. There is no standardized way of using EMR among the few CMHOs that have EMR system. They are in the learning mode to transition from focusing solely on the behavioral health system to paying attention to the whole person and interacting with primary care.
- Provider standards are on page 7 of the SPA. The two health plans that are in the State are required to share information with CMHOs on a routine basis.
- Because of varying use of HIT, some of the CMHOs will be able to receive information electronically from the plan and use electronically internally. Others will have to take the paper version. Ideally and eventually the State would like to make it easier to utilize information electronically in the entire system.

Missouri:

- Missouri has full use of health information exchange (HIE) electronically throughout the State.
- Cyber Access is a claim based software system, which is fully described on page 7 of the SPA.
- All Medicaid providers in Missouri have the ability to login Cyber Access to understand an individual Medicaid utilization history.
- When hospital pre-certification vendors notify Medicaid to get authorization, Health Home will also be informed when a consumer is hospitalized so care coordination can be connected.
- Detailed provider standards are on the page 5-6 of the SPA. All CMHOs health home providers have to use the electronic comprehensive health record (Cyber Access). Have to utilize a registry, if they have one. Routinely use a behavioral pharmacy management system to determine problematic prescribing patterns. Need to submit reports, not really electronic, but at least on Excel. Eventually need to meet NCQA level 1 PCMH requirements as determined by State.
- Detailed HIT information is listed on page 7-8 of the SPA.

Discussion Ensued and main highlights are below:

- We will have to submit a Medicaid State Plan Amendment (SPA) to CMS in February 2012 with the effective date of June 1, 2012. What we need to do at this point is to have a solid design and approach for the Health Home, not every question needs to be answered today.
- Managed Care Plan will be performing an administrative function for the program. One of the functions would be to use medical infomatics to view a client's claims and produce detailed patient's summary, and then provide this information to the team that is working on an individual's case.

- For people who are not enrolled in the Managed Care Plan, they will still be able to get data from ODJFS and use the same tool to produce summaries.
- Community Mental Health Providers do not have to be in the Managed Care Plan network to receive administrative functions.

Ms. Smith described the CMS requirements in the state plan about the use of health information technology (HIT). How does your state envision using HIT to support delivery of health home services and to report/evaluate on the quality measures to CMS? How will HIT be used in the delivery of each service?

- Per SPA from Rhode Island, the state will phase-in the use of HIT to support health home services. Initially, provides will be supported in their delivery of health home services through data profiles supplied by Medicaid Managed Care Organizations (MCOs). The state is currently working with the MCOs to develop health utilization profilers. Not everybody who is SPMI in the CMHC is an MCO. In those cases, the state will use the Medicaid data warehouse to mimic those profiles develop by the plans and provide the same information to the CMHOs. CMHOs will get two sets of reports: one from two of the health plans from the State, and the second one comes directly from the data warehouse. The example of captured data is listed on the page 3 of the SPA. The state will query providers about the use of HIT in the delivery of care coordination services. Has to report on 7 quality measures and CMS is hoping that the state can find the majority of those measurement data sources through claims.
- ODJFS just started a contract with Thompson Reuters to pull Medicare data information from CMI. Have not talked about linking the information to health home at this point. They are encountering data transferring problems. The data might possibly link with health homes in the future.
- It is required in Rhode Island to get Medicare data to health homes as dual eligible individuals cannot be excluded from the services. The plan is underway to get the data to the Executive Office of Health and Human Services and figure out a way to provide the information to health homes.
- As dual eligible individuals cannot be excluded from the health home services, we will figure out a plan to incorporate Medicare data into the plan.

Ms. Smith asked the providers at the table if they can share how they use health information to deliver care or track care/outcomes. Below is the summary:

<u>Shawnee Mental Health Center</u>:

- Has health data for consumers when consumers seeing PCPs outside the clinic. If the data indicates a consumer is at risk, the system will generate a letter to the consumer's PCP. The clinic also use this information to contact the consumer about his/her health condition and inform the consumer if he/she needs to see a PCP immediately and make an appointment for the consumer, then do a manual follow-up.
- Built their own patients' registry and use AVATAR system.
- Has a relationship with a local hospital and can use the hospital portal to view consumers' lab test result, x-ray electronically that the clinic has ordered.
- Sometimes phone providers to facilitate and management care transitions.

- Sometimes clinics will get calls from hospitals to verify medication requests from consumers. Hospitals get clinics information from consumers, if they are capable of providing the information.

Connections Cleveland:

- Historically had hard time finding out their patients in the hospitals, especially medically related. In the past 6-9 month, they started to have hospital liaison coordinate with local hospitals to keep an eye on their patients in the hospital.
- CPST monitors their cases and has electronic record submit to their system when their consumers have been hospitalized. Find out when patients tell them or through social workers.
- Pulls report for consumers who have been hospitalized more than once in the past 6 months, then develop a better treatment plan and perform clinical review. Also go through other needs of building claims to find other individuals.
- Currently using a purchased electronic medical record system but it is cumbersome. They are in the process to custom design a new system. Patient registry will be built into the new system.

Eastway:

- Spot information from psychiatric admissions, mostly as a request for aftercare appointment vs initial discharge.

Discussion ensued and highlights are as below:

- The vendors of anyone who has electronic medical record are mental health and potentially behavioral health but has no capacity pre-bill for anything at primary care universe. We need to think about the support and methods to help using HIT to support this in health homes. System issue having relationship with local providers should also be addressed at later stage.
- There are separate computer systems. MACSIS system processes the claims for mental health and substance abuse. ODMH and county boards have direct access to the MACSIS system. Direct care providers do not have direct access to MACSIS and need to get information from local boards.
- For Medicaid primary care health, different providers developed relationship with managed care organizations for data sharing and information exchange.
- The plan can provide the consolidated information from MACSIS and MITS. We will need to take a look at the services funded by boards in order to configure a standardized way to get information.
- Things to think about: Will MACSIS claims data be available in MITS for health home providers to use provider portal in MITS to access? In Managed Care Plan, a lot of it depends on varying level of interoperability and being able to accept information electronically. There are places getting reports but they are aggregate reports or patient specific paper reports. Don't know if the plans regularly communicate data exchange. This would vary depending on providers' IT systems and capabilities. Varying products do not do well on both BH/PH sides. Even NextGen system is having difficulty on the behavioral health side because of the way the Ohio system is structured.

- When vendors want to develop a product that is integrated but they are not familiar with the field, they still need to meet all the legacy requirements when going through the transition period because this is where providers get revenue flow and billing process.
- Systems have been built to meet financial needs, not clinical care needs.
- Most of organizations use EHR for claim process, not for clinical propose. A number of organizations use funds to upgrade their systems in order to be able to use EHR for both claim and clinical process.
- The National Council Center for Integrated Health Services is aiming to facilitate integrating primary health and mental health. It is a significant undertaken to be able to map from one system to the other before they can even start connecting.
- There should be some baseline requirements to start health home, and additional requirements over a period of time.
- We will start with the regional approach. It was recommended that it should be replicated at the statewide basis within a certain time frame.
- Email is considered an electronic exchange and use Excel spreadsheet to update consumers' health records. The question was raised about source of record and how to reconcile records to get a current snap shot of a consumer's up to date history. The data source is coming from Managed Care Plan (MCP). Once a provider finishes updating information, send it back the MCP. It is not passing the Excel spreadsheet from one provider to another.
- The concern of high level of human resources was raised because of the volume of the data. It would be good if there is way we can have portal for repository purpose.
- Some of the MCPs use dashboard. It would be helpful to have one centralized data bank so providers do not need to log into multiple data portal to get information. It would also be helpful if the health home can receive health information for their patients from the data bank. Even though there are some profile/report systems developed, it would be challenging to get all different kinds of reports/profiles from different plans when providers are dealing with a lot consumers. In addition, the data might not be completed as it might not capture behavioral health data and state hospitalization data.
- It was suggested to look into VA system as they are able to track members from state to state all across the world from one computer system. One great advantage for VA system as they are the payer and provider.

OHIO MEDICAID HEALTH HOMES - SERVICE DEFINITIONS:

Discussion ensued and highlights are as below:

- The received patients' summary data is going to be based on the claim data. This does not replace the fact that the health home still need to collaborate with PCPs.
- It was suggested that the day-365 requirements should not be set at this point as there are still a lot of unknown pieces.
- Need to consider up-front investment on HIT.

The standard requirements on day 1:

Comprehensive Care Management:

- Have the capacity to receive electronic high level patients' summary data,specifically to the care management piece.
- Need to be able to describe/demonstrate the operational process on health information exchange flow.
- Build the capacity to exchange information through the statewide HIE.
- State hospital information should be included in the data exchange.

Care Coordination:

- The health home will utilize the information received to develop (for new patients) or update/modify treatment plan.
- Establish relationship with new providers.
- Sharing information with other treating providers to facilitate their ability to treat.
- Health home should coordinate with the PCPs and speciality providers to have open communication and exchange health information, whether or not the health home is a co-located entity (BH/PH).
- Using web portal or have a form created in the electronic medical record to inform other providers about health information to close the loop.
- Use paper tracking system to close the loop on referral.
- Update treatment plan quarterly.

Transition of Care:

- Psych Admission to State Hospitals:
  - The gate keeper to state hospitals is through boards.
  - State could also generate a notification to the health home from behavioral health centers.
  - One provider at the table has been receiving faxes (census of everyone from their board area in the hospital) from their designated state hospital on the daily basis.
- Psych Admission to General Hospitals:
  - State (Health Care Excel) does pre-certification. When they generate a pre-certification to the hospital they could also generate a notification to the health home.
- General Medical Admission of a MCO Enrollee with a CBHC Health Home:
  - All enrollees will always have a prior authorization requirement. On the one hand, each CBHC has to establish relationships with all hospitals. Also, the State could ask the MCO to notify the CBHC of a pre-certification.
- General Admission of an non-MCO Enrollee with a CBHC Health Home:
  - There is no pre-certification requirement.
  - If a consumer goes to a hospital that has an established relationship with the health home, this could help to narrow the gap. However, this does not address the issue if the consumer goes to a hospital that has no established relationship with the health home.
  - Once an individual has an identified health home, State can share the information with hospitals.
  - It would be helpful if a health home enrollee's information can be displayed in the web portal or identified on the membership card. Can consider a flag in the portal

and card.

- Hospital Emergency Department Visit:
  - Same recommendations as to the "general admission of an non-MCO enrollee with a CBHC health home"

<u>Referrals to Community and Social Supports</u>:

- Currently use phone or fax to do referral s.
- Can monitor the results of referrals through the registry or the push down data.

<u>Health Promotion</u>:

- Currently using progress note and EMR progress note to document referral follow-up, but they are not structural data in a lot of cases.
- Should consider using check boxes for documentation reduction.

<u>Individual and Family Supports</u>:

- Some providers are planning to have a patient portal in about 5 years. To consider a long-term plan, need to follow-up with MITS.
- Possibly use website, YouTube, FaceBook, secure email or voice mail as patient education tools.
- Auto-generated letters/information and mail letters to patients and family members.

NEXT STEP:

- The received recommendations and feedback will be used to fill in the State Plan.
- The information about HIT will be put in the user friendly format and will be share with the group.
- Health home case scenarios will be distributed to the group for feedback.
- Provide updates from other committees.
- Next meeting is scheduled for 11/30/2011 from 12:30 pm – 3:30 pm.