

## **Behavioral Health Health Home Operational Logistics Framework**

**Documentation, Billing & Other Regulatory Requirements:** develop recommendations related to aligning documentation, billing and other regulatory requirements to support integration; review certification, licensure and national accreditation standards to assure a bi-directional approach to integration that is balanced, including expansion of accreditation and development of new standards to formally recognize the emerging service delivery model of Behavioral Health Homes.

**Reimbursement:** align fee for service reimbursement and PMPM reimbursement to avoid duplication of services and payment; explore overall payment methodology and HH service reimbursement rates, including tiered PMPM reimbursement models, shared savings and bonus payments; assure that the reimbursement is adequate to accomplish the goals of the HH initiative; identify variables that should be taken into account for determining level and type of reimbursement such as volume, acuity and severity of patients, cost, provider capacity/qualifications for meeting the health home criteria.

**Health Record Integration/Treatment Plan Integration:** 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.

**Health Information Technology:** develop recommendations related to: the use of EHRs & achieving meaningful use; the ability to store and maintain historical utilization data including hospitalizations, pharmacy, lab, etc.; the ability to report outcome measures and other requirements to oversight and regulatory bodies and health home administrators; determining the linkage of HIT to each of the required health home services; and the ability to use analytics to determine who may be eligible for health home services.

**Staffing Arrangements & Team Composition:** review functions and credentials of the care manager, the supervisory structure and team requirements.

**Technical Assistance & Learning Collaboratives:** develop recommendations for communication strategies, provider education & outreach; develop approaches for sharing models and best practices in integration; identify other initiatives that are aligned with BH/PH integration and the health home initiative and opportunities to combine or leverage efforts and resources

**Consumer/Family Engagement and Buy-in:** develop recommendations for: approaches to consumer/family education and engagement; use of peers; practice guidelines for client/family-centered care; assessing consumer experience of care; and consumer enrollment including opt-in versus opt-out.

**Quality Improvement: Performance Measures & Outcomes:** develop recommendations for approaches and tools to assure fidelity and robustness of integrated care and health homes; review and align all mandatory outcome measures and data requirements under the health home, the ODMH TEOS and the discretionary SAMHSA grant for integrated care; consider burden and feasibility.