

**HIT/HEALTH RECORD/TREATMENT PLAN INTEGRATION COMMITTEE
RECOMMENDATIONS FOR USE OF HIT TO SUPPORT COMPONENTS OF HEALTH HOMES
November 2011**

Health Home Component: Comprehensive Care Management

Day 1 Requirement:

- CBHC health home must receive electronically the health utilization profile from an MCP or the Office of Ohio Health Plans. These should be updated on a quarterly basis.
- Develop internal processes to be able to act on and disseminate the data.
- Consider the implications of charting (the level of human handling that is required to make it real).
- What the MCPs have and what is in MITS will not facilitate care management (i.e., lab values) in its entirety.
- All parties should be able to accept data/information in an electronic format.
- We need to determine capacity to exchange non-Medicaid and ODMH Regional Psychiatric Hospital data.
- CBHCs must demonstrate how data will be utilized. They need to demonstrate how they re-deploy teams to act on the data. Could be individualized based on the provider's practices.

Future Requirement:

- The state will continue to build capacity to exchange data through the HIE.

Health Home Component: Care Coordination

Day 1 Requirement:

- Utilize MCP and/or Office of Ohio Health Plan profile information to develop /update the integrated care plan. Propose that profile information be received quarterly.
- If available, develop a unified care plan electronically.; however, If the client chooses not to receive primary care services at the CBHC health home site, then to demonstrate how primary care is integrated at the CBHC site?
 - Joint treatment planning may be an area where it is sufficient that the CBHC at least "knows" what primary care is doing but it may not be feasible to have the PCP info in the CBHC client record initially.
- Update the treatment plan.
- Establish relationship with treatment providers (e.g., hospital, LTC, Rx).
- Share information with other providers to facilitate their treatment of clients.
- Medication management and reconciliation.
- Connect clients with necessary social supports.
- Open communication at periodic intervals.
- Lab portals (retrieve).
- Auto-generated letters that notify PCPs of lab values
- Closing the loop: Paper tracking system (e.g., mammogram) to identify patient movements→
Loops back to Care Management and ability for providers to take patient summary info and putting into whatever format is useful for the client.

Future Requirement:

- The state will continue to build capacity to exchange data through the HIE.

Health Home Component: Comprehensive Transitional Care

Day 1 Requirement:

- *Inpatient Admissions – goal is to inform CBHC health home as soon as a hospital admission occurs*
 - ODMH Regional Psychiatric Hospital Admission: ODMH may be able to generate a notification to the health home; Board or their designated front door agency could generate a notification to the health home (One CBHC already sends a daily fax to the CBHC with daily census of all inpatient admissions in that geographic area).
 - Psych General Hospital Admission: For both health plan enrollees and fee-for-service beneficiaries, the MCPs or State could generate a notification.
 - General Medical Admission of an MCP 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. On the other hand, the State could ask the MCP to notify the CBHC of a pre-cert
 - General Admission of a NON-MCP Enrollee with a CBHC Health Home: There is no precertification requirement. A partial narrowing of the gap could be where the person went to the hospital with whom the CBHC has a relationship. Doesn't address where a person accesses care in another part of the state. MCPs providing information even two months later is a good thing. Loop back to hospital relationships.
 - The state could also institute the requirement of information going from the state directly to the hospitals. The State should provide health home enrollee list to hospitals.
- Hospital ED Visits
 - Partial relationship driven. Could also be facilitated by the State updating the eligibility portal/card.
- Could consider a flag on the Medicaid eligibility card and in the Medicaid portal that member is enrolled in a health home.

Future Requirement:

- The state will continue to build capacity to exchange data through the HIE.

Health Home Component: Referral to Community and Social Supports

Day 1 Requirement:

- Connect clients with necessary social supports via call or fax.

Future Requirement:

- The state will continue to build capacity to exchange data through the HIE.

Health Home Component: Health Promotion

Day 1 Requirement:

- Auto-generated letters that notify PCPs of lab values
- New med, went to doctor. Would we require that folks utilize their EMR to document in the progress note? What about down the line?

Future Requirement: ?

Health Home Component: Individual and Family Support Services

Day 1 Requirement:

- ODJFS will follow-up to determine MITS capacity.
- Use of website, YouTube, FaceBook, Secure Email and Voice Mail.
- Auto-generated letters that gets sent to patients and family members of next appointment.

Future Requirement:

- Some CBHCs (five years from now) are planning to have a patient portal.