

Health Home HIT Provider Qualification Standard Completed by: _____, _____	Qualification Criteria	Guidelines	Findings
<p>6a: Health home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.</p>	<p>Procedure follows policy _____</p> <p>Demonstration of procedure is adequate _____</p> <p>Patient care plan review follows HIT Standard _____</p> <p>Outside providers are able to access system _____</p>	<p>Health Home should have policies and procedures that describe:</p> <ol style="list-style-type: none"> 1. HIT and electronic health record capabilities for: <ol style="list-style-type: none"> a. Making data regarding past use of general medical and behavioral health services available to care managers to support care planning and coordination; and b. Ensuring that care plans and service use information can be readily exchanged and accessible to other providers serving the client; 2. How the Health Home will use data for predictive modeling and risk stratification to identify members in need of enhanced monitoring and outreach; 3. How the Health Home will identify high-need members with notification flags in its electronic health record; 4. How the Health Home will ensure that all relevant privacy standards for data exchange are met. 	
<p>6b. Health home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care.</p>	<p>Care plan process for follow-up on:</p> <p>Tests _____</p> <p>Treatments _____</p> <p>Referrals _____</p>		

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<p>6c. Health home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.</p>	<p>Health Information and care plan accessible by interdisciplinary team ____</p> <p>Population management exists ____</p> <p>Review of access log for patients successful ____</p>	<p>2. QA and Performance Improvement.</p> <p>Does the Health Home monitor and report periodically on timeliness and success of outreach and engagement efforts?</p> <p>The Health Home should report how outreach and engagement vary by client demographic and clinical characteristics, including housing stability/homelessness.</p>	
<p>6d: Health home provider makes use of available HIT and accesses data through the regional health information organization/qualified entity to conduct these processes, as feasible.</p>	<p>HIT used to access care plan and member information ____</p> <p>HIT used to link services ____</p> <p>RHIO participation (indicate which RHIO in comment section) ____</p> <p>Health Home can describe how the DOH-5055 supports RHIO access ____</p>	<p>RHIO participation agreement indicates contract with RHIO is current</p>	
<p>6e: Health home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.</p> <p>The health home provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers, and local supports.</p>	<p>Visual demonstration of care plan tool ____</p> <p>Tool used according to the policies and procedures established by Health Home ____</p> <p>Downstream provider(s) understands HIT system ____</p> <p>Downstream provider is able</p>	<p>Live care plan can be demonstrated.</p> <p>Policies and procedures are followed by lead Health Home as well as any downstream care management agency</p>	

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	to use HIT tool in an effective way to connect with lead Health Home _____ View of access log for care plan _____	Health Home shows documentation of care team members accessing the electronic care plan	
6f: Health home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.	Electronic Health System meets Meaningful Use provision of the HITECH ACT _____ Select downstream provider(s) are able to access electronic Health systems certified for MU (where applicable (<i>If not a plan is provided on how this will be implemented</i>)) _____ Random sampling of random sampling downstream provider contracts with EHR vendor _____	Select Health Home Providers have Electronic Health Records certified for Meaningful Use. <u>Select providers include:</u> * Primary Care Providers (MD, DO, NP, PA) * Clinical Behavioral Providers (Psychiatrist, Psychiatrist)	
6g: Health home provider will be required to comply with the current and future version of the Statewide Policy Guidance which includes common information policies, standards and technical approaches governing health information exchange. http://www.nyehealth.org/shin-ny-policy-governance/public-comments/	Demonstrate consent and information sharing procedures are in place according to Statewide Policy Guidance _____	<u>SPG issues include:</u> * Consent * Sharing of Personal Health Information	

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7a.	To facilitate Health Home use of Health Information Technology (HIT) to improve service delivery and coordination across the care continuum, initial and final HIT standards were included in the NYS Health Home Provider Qualification Standards for Chronic Medicaid and Behavioral Health Patient Population.	Health Home meets initial and final HIT standards and meets requirements for use of HIT (refer to Health Home HIT Survey Checklist).	
7b.	The Health Home Care Management Assessment Reporting Tool (HH-CMART) is a case management reporting utility for Health Homes. The submission file will include information for all Medicaid members involved in Health Home care management programs during the reporting period.	Health Home collects and tracks CMART submissions from network care management partners and submits files to the Department as required_____.	