DRAFT January 10, 2013

Initial Standards	Questions	Answers
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.	A) Who signs and updates the Health Home Member's care plan? B) Does the Lead Health Home need to have submitted written Policies and Procedures? C) Who is the Health Home Provider?	A) The Care Manager is typically tasked with signing and updating the care plan for the Health Home Member. This will depend on the policies and procedures surrounding workflow set forth by the Health Home. B) Yes. They should be submitted to OHITT. C) In reference to this standard, the provider is the Lead Health Home.
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.	A) Does the Lead Health Home need to have submitted written Policies and Procedures? B) Who is the Health Home provider?	A) Yes. They should be submitted to OHITT. B) In reference to this standard, the provider is the Lead Health Home.
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	A) Can faxes and mail be used to satisfy this requirement? B) Who is the Health Home Provider?	A) Yes. Faxes and mail can satisfy this initial standard. B) In reference to this standard, the provider is the Lead Health Home.

including preventive services.		
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.	A) Are Care Managers responsible for getting patients to sign the Health Home Consent Form (5055)? B) Who is the Health Home Provider? C) Are Care Managers responsible to "ensure" Health Home Clinical Partners get patients to sign a RHIO consent form? D) What documentation do I need to satisfy this requirement? E) If the Care Manager is not a part of the Lead Health Home agency, will they have RHIO access for any Health Home member signing of the Health Home consent form?	A) Yes. B) In reference to this standard, the provider is the Lead Health Home. C) No. Care Managers and Health Home Partners should encourage Health Home Patients to sign the RHIO consent form for Health Home Partners that are members of the RHIO. Benefits of signing this form include enhanced information sharing through the SHIN-NY. D) Demonstrate a plan and timeline for how the Health Home will transition from paper sharing to electronic sharing. E) No. The Lead Health Home will have RHIO access for each patient signing the Health Home consent form. The Lead Health Home can access patient information via the RHIO and share any pertinent information with the Care Manager.

Final Standards	Questions	Answers
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.	A) Who is the Health Home Provider?	A) In reference to this standard, the provider is the Lead Health Home providing a structure whereby all Health Home Partners are able to share care management information.
	B) Can faxes and mail be used to satisfy this requirement?	B) NO. Although faxes can meet the initial standards, by the end of the 18 months, capabilities to share care plan and health information must to be accomplished via the RHIO (for those providers with an Electronic Health Record (EHR)) or via a web-based portal (for those Health Home partners without an EHR).
	C) What is the definition of an interoperable health information system?	C) An interoperable health information system facilitates exchange between disparate electronic record applications. This allows information technology systems and software applications to exchange and consume clinical and administrative data efficiently. This is the reason for prompting Certified meaningful use EHRs. It is the preference to have care management plans having the same interoperable capabilities. At this time, because of the lack of consistent standards for capturing and consuming this data, an interim solution could involve a web-based portal which could be updated in real time by the provider or via the Care Manager.

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.	A) Who is the Health Home provider? B) What defines a Health Home Clinical Partner/Provider Organization? C) Who is responsible for Certified Meaningful Use (MU) Electronic Health Record (EHR) adoption among Health Home "Required" Clinical Partners/Provider Organizations? D) If no Certified MU EHR exists for a particular provider specialty, is that Clinical Partner/Provider Organization required to adopt an EHR? E) Does a "Required" Clinical Partner/Provider Organization need to attest to Meaningful Use in order	A) In reference to this standard, the provider is the Health Home Clinical Partner/Provider Organization. B) A Health Home Clinical Partner/ Provider Organization is defined as any organization that has signed a subcontractor packet (including a Business Associates Agreement (BAA) with the Lead Health Home for the purpose of providing clinical services to Health Home Members. For those clinical providers/organizations not required to sign a sub-contractor packet but still have patients being referred to them by the Lead Health Home, OHITT is considering them a Health Home Clinical Partner/Provider Organization. C) The Lead Health Home is responsible for a plan for the adoption of Certified MU EHRs by Health Home "Required" Clinical Partners/Provider Organizations. Where Certified MU EHR systems do not yet exist, this requirement is waived. See 6F Graph 2 for a list of required Clinical Partners/Provider Organizations. D) No. However, the State still encourages adoption of EHRs but suggest these particular Clinical Partners/Provider Organizations discuss options with Regional Extension Centers (RECs) for guidance on acceptable EHR products in the marketplace. E) No. "Required" Clinical Partners/Provider Organizations must adopt a Certified MU EHR but attestation is not required.

	to meet requirement 6F?	
	F) Must the Lead Health Home support "Required" Clinical Partners/Provider Organizations in their adoption of Certified MU EHRs?	F) Yes. The Lead Health Home is responsible to ensure that "Required" Clinical Partners/Provider Organizations adopt a Certified MU EHR. This support could include but is not limited to financial, in-kind, or grant dollar support.
	G) Which "Required" Clinical Partners/Provider Organizations must the Lead Health Home support in EHR adoption?	G) Refer to HIT Standard 6F Graph 2.
	H) What support is available for adoption of Certified MU EHRs?	H) Potential opportunities to support adoption of Certified MU EHRs may include the 1115 waiver, ARRA funds, HEAL grants and the RECs.
	I) Does Standard 6F apply to both Physical and Behavioral Health providers?	I) Yes.
	J) Does Standard 6F apply to all "Required" Clinical Partners/ Providers Organizations who are treating Health Home Members or just those with who have signed subcontractor packets?	J) Standard 6F applies to all "required" Clinical Partners/Provider Organizations who have signed a subcontractor packet (including a BAA) with the Lead Health Home. For those clinical partners/provider organizations not required to sign a sub-contractor packet but still have patients being referred to them by the Lead Health Home, OHITT is considering them a Health Home Clinical Partner/Provider Organization. If the Health Home Member requests to receive care from a

		provider who has not signed a subcontractor packet, the member can see that provider without standard 6F applying to that provider. In contrast, if a Health Home Care Manager *refers* a member to a provider who has not signed a subcontractor packet, standard 6F will apply to that provider.
	K) What authority does the state have to enforce these standards?	K) This is a program requirement of the Health Home and is part of the State Plan Amendment that was approved by CMS.
	L) What if a Lead Health Home can't comply with standard 6F within the 18 months?	L) Because this is program requirement, Medicaid/OHITT will work with the Lead Health Home to outline challenges/barriers and submit a proposed solution. Barriers might include but are not limited to money, policies, resources, technical challenges, and timeframes.
	M) What options are currently available for Health Homes not able to get 100% of the "Required" Clinical Partners/Provider Organizations to use Certified MU EHRs?	M) At the end of the 18 months, at least 90% of the "Required" Clinical Partners/Provider Organizations must be using Certified MU EHRs. The Lead Health Home must submit a plan of corrective action with timeline for the remaining percentage.
	N) What if a Lead Health Home *refuses* to comply with standard 6F?	N) They must withdraw as a Lead Health Home.
	O) What if a "Required" Clinical Partner/Provider Organization either cannot afford or just refuses to adopt Certified MU EHRs?	O) It is in the interest of Health Homes for "Required" Clinical Partners/Provider Organizations to be using this technology. We encourage the Lead Health Home to promote adoption of Certified MU EHRs.

	P) Will the categories in the 6F Graph Series denoting required, encouraged, and not required (regarding adoption of Certified MU EHRs) be changing?	P) Although there are no immediate plans to do so, DOH maintains authority to change categorizations for those Clinical Partners/Provider Organizations required to adopt a Certified MU EHR. Changes may be based on future Federal or State benchmarks, HIT standards, or HIT dollars available.
	Q) What is DOH proposing for future standards in regards to HIT?	Q) Although there are no immediate plans to incorporate changes to the HIT standards, the bar will continue to rise in terms of Clinical Partners/Provider Organizations being required to use Certified MU EHRs. This could include the need to connect to the SHIN-NY. DOH maintains authority to change requirements/standards to align with Federal or State HIT benchmarks, standards, or dollars available.
	R) Is interoperability of a care plan the same thing as interoperability of an Electronic Health Record?	R) No. The term interoperability refers to a back-and-forth exchange of patient health data among different organizations and different health systems. Sharing a care plan and sharing information in an electronic health are both goals for health homes in New York. While many care management platforms are not yet capable of the full functionality of working with an EHR, this does not distract from the objective of 6F to promote the adoption of Certified MU EHRs. Just having interoperable care management applications will not meet the requirement for 6F.
6G: Health home provider will be	A) Does this requirement apply to	A) This applies to all HIEs used to share patient information

required to comply with the current and future version of the Statewide Policy Guidance http://nyehealth.org/wp-content/uploads/2012/07/Privacy-and-Security-Policies-for-RHIOS_v2.2.pdf) which includes common information policies, standards and technical approaches governing health information exchange.	internal Health Information Exchanges among Health Home Partners/Provider Organizations, or just to Health Information Exchanges via the RHIOs/SHIN-NY? B) This standard's link doesn't appear to work? C) What is the Statewide Policy Guidance (SPG)? D) What is the Statewide Collaboration Process (SCP)?	as part the management of Health Home Patients. B) A new link at the New York e-Health Collaborative (NYeC) is under construction. C) SPG refers to common policies and procedures, standards, technical requirements and service requirements developed through the Statewide Collaboration Process (SCP). This includes: - Privacy and security P/P for interoperable HIE, including but not limited to authorization, authentication, consent, access, audit, breach and patient education and outreach. - EHR interoperability standards for HIT vendors - HIE standards that allow data sharing across the SHIN-NY. D) SCP Refers to the open, transparent process to which multiple stakeholders contribute, administered by NYeC, to develop Statewide Policy Guidance, to be adopted and complied with by all RHIOs/Qualified Entities (QEs) and

		their participants.
6H: Health home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE (Qualified Entities) provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY)	A) Who is the Health Home Provider? B) Does the Lead Health Home need to join a RHIO? C) Why should a Lead Health Home become a member of a RHIO? D) Are there fees or dues associated with being a member of a RHIO? E) Who is considered a Health Home Clinical Partner/Provider Organization?	A) The **first** reference to a Health Home Provider in 6H refers to the Lead Health Home. The **second** reference to a Health Home Provider in 6H refers to the Clinical Partners/Provider Organizations. B) Yes. The Lead Health Home must become a member of a RHIO. C The Lead Health Home must be able to transmit and receive data electronically with its associated organizations and providers. Becoming a member of a RHIO ensures an understanding of the Statewide Policy Guidance. The preferred method of sharing health information is through a RHIO. D). RHIOs are independently governed, and have different membership requirements and fees. Please contact your local RHIO for more information. E) A Health Home Clinical Partner/Provider Organization is any organization for which a sub-contractor packet (including a BAA) has been signed with the Lead Health Home. For those providers/organizations not required to sign a sub-contractor packet but still have patients being referred to them by the Lead Health Home, OHITT is considering them

		a Health Home Clinical Partner/Provider Organization.
	F) Does the Health Home Program require Health Home Clinical Partners/Provider Organizations to become members of the RHIO?	F) No. Health Home Clinical Partners/Provider Organizations are not required to join a RHIO but RHIO membership will enhance the quality and quantity of EHR data shared. Ultimately, the goal is to have as many health care providers in NYS as possible connected to the SHIN-NY through a RHIO.
	G) If the Care Manager is not a part of the Lead Health Home, will they have RHIO access for Health Home members who have signed the Health Home Consent Form (5055)?	G) No. After signing the Health Home Consent Form (5055), only the Lead Health Home can access patient records through the RHIO. The Lead Health Home can then share pertinent information with the Care Manager and other stakeholders involved in the care of the Health Home Member.
	H) Can Health Homes use Health Information Exchanges other than a RHIO as my local Health Information Exchange or to engage directly to the SHIN-NY?	H) No. Health Homes must utilize a RHIO/QE as an exchange and ultimately to connect to the SHIN-NY. Currently only RHIOs are certified as qualified entities in NY. The State will be developing criteria and a certification process for qualified entities.
	I) What documentation do I need to satisfy this requirement?	I) The Lead Health Home will need to submit a signature page from the contract or agreement between the Lead Health Home and the RHIO.
	J) Is interoperable electronic sharing of information a requirement for all Health Home Partners?	J Yes – sharing of electronic information is a requirement for all Health Home Partners either through web-based portals or preferably via a RHIO exchange (where applicable).

	K) What technical services are offered by the RHIO?	K) Technical services include HIT interface support to connect to the RHIO (SHIN-NY). Please contact your RHIO for more details.
6I: Health home provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance. One example of such a tool is PSYCKES.	A) Is PSYCKES the only clinical decision making tool allowable to satisfy this requirement? A) Do my tools/ guidelines satisfy this requirement?	A) No, PSYCKES is only an example of a type of clinical decision support (CDS) tool. Other CDS examples include medication management and treatment protocols. You should discuss your options with OHITT. B) These tools/guidelines should electronically and automatically guide Providers/Care Managers with alerts or suggested next steps for a patient. Examples of these tools could include medicine reconciliation, risk factor alerts, practice guidelines, or electronic tools that clarify further action. A test/tool which only produces test results will not satisfy this standard.