Health Homes, Care Management and Primary Care/Behavioral Health Integration

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Health Homes and Medical Homes

- Health Home expands on the Medical Home model
  - Enhanced Care Management and Coordination
  - Integration of Medical and Behavioral health care
- The Health Home and PCMH retain the goal of the Triple Aim
  - Improve the population's health
  - Improve the quality of health care
  - Improve the patient's experience

What Has the Health Home Done?

- Create wholly new and unique positions
  - Team Leader
  - Care Manager
  - Embedded Clinician
  - Qualified Health Home Specialist
- Think about the mission of a CBHC in a new way
  - "Whole Person" Orientation
  - Accountability for a Population
- Transformation of the Mental Health system
  - establish the competency of staff to recognize and deal with new clinical issues
  - Redesign the model of care

Accountability, Planned Care and Risk

The Health Home is responsible for coordinating and provide access to :

- high-quality health care services for all conditions informed by evidence-based clinical practice guidelines;
  - preventive and health promotion services
  - mental health and substance abuse services;
  - comprehensive care management, care coordination, and transitional care across settings (transitional care)
- appropriate follow-up from inpatient to other settings
- chronic disease management, including self-management support to individuals and their families;
- individual and family supports, including referral to community, social support, and recovery services;
  - long-term care supports and services

Accountability, Planned Care and Risk

Health homes must:

- develop a care plan for each individual that coordinates and integrates all clinical and non-clinical services and supports required to address the person's health-related needs.
- use HIT to link services, facilitate communication between and among providers, the individual, and caregivers, and provide feedback to practices.
- establish a continuous quality improvement program, and collect and report data that support the evaluation of health homes.

Accountability, Planned Care and Risk

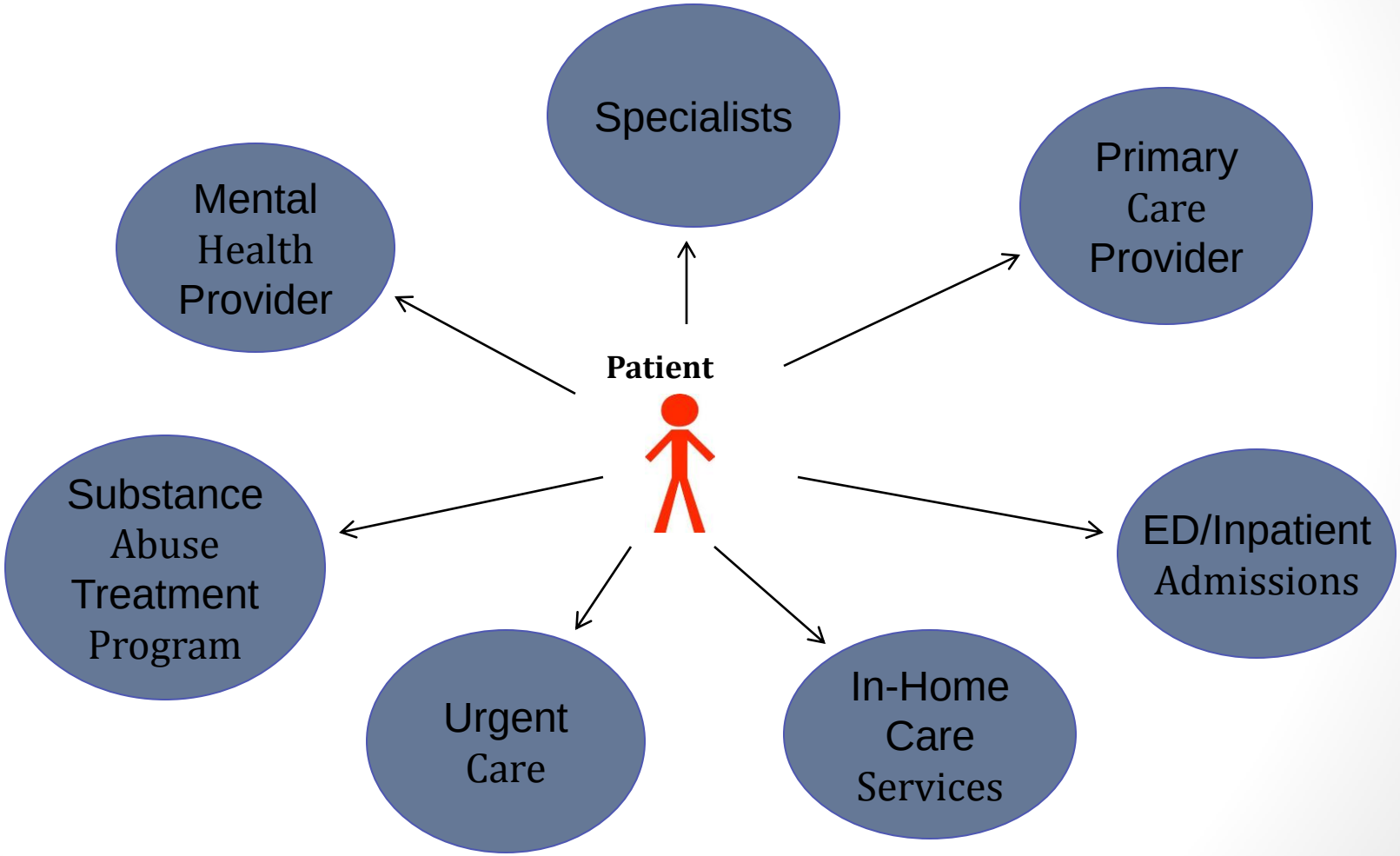
- The Health Home is accountable for all the health needs of its members
  - By assuring and coordinating that care is received even if the Health Home doesn't provide it
  - By assuring all of the HH population is addressed even those who rarely "show"
- Planned Care is the only effective manner to meet all the needs of members
- Certain members provide most of the decrease in health status and most of the costs

Panels and Health Homes

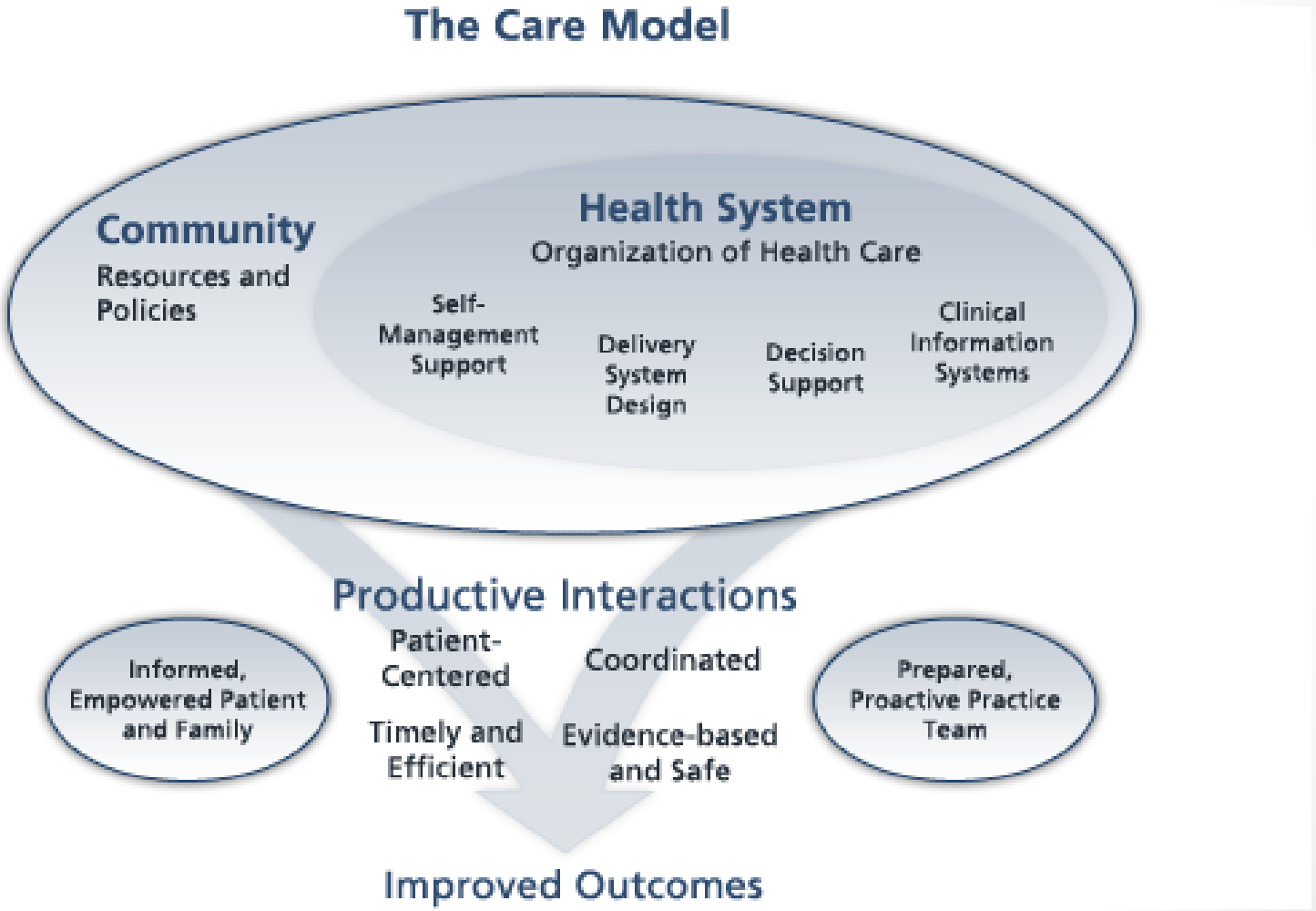
The Institute for Healthcare Improvement states, *"Empanelment (i.e., assigning each provider a set number of patients) is a proven method to create continuity for both patients and providers."*

- Each Health Home care team has a group of patients for whom they are responsible;
- Patients can identify to whom they can turn for their health care;
- There is regular reporting of how well each Health Home care team is doing in meeting goals for their patients;
- Each care team's mix of patients, in terms of age, gender and complexity/risk is known and a defined amount of

Clinical needs for individuals with SMI or SED



Planned Care Model
(Chronic Care Model or Care Model)



Essential Team Member Roles

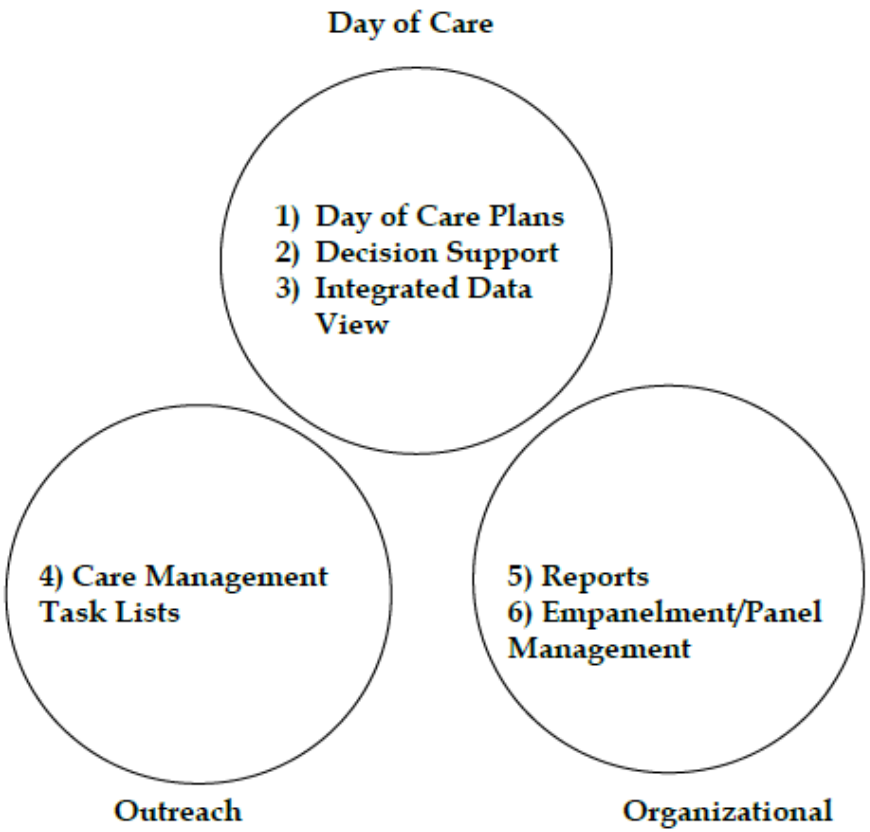
- Using a team-based care approach
- Continuous healing relationships
- Clinicians working at the top of their licensure
- Providing care outside of the “clinic visit”
- Establishing caseloads and ratios

Use of Health Information

- Patient registries
  - Contains patient information most relevant to chronic illness or preventive care, provides decision support
  - Is effective in avoiding patients "falling through the cracks"
- Electronic medical records
- Shared care plans
  - Contain all the care a patient needs and is dynamic
  - Rarely a paper document
- Care transitions
  - Where the "money is at" (Willie Sutton)
  - Real time notification of inpatient or ED admission and that an intervention has occurred by the Health Home
- Notifications from hospitals and other partners in care

Functions of Registries

During a Visit, Between Visits, Unrelated to a Specific Visit



Registry Functions (Divided into Sub-Categories)

Core Patient Registry Functions

A patient registry is a set of functions within an electronic tool that facilitates the delivery of deliver planned care. Registries are most effective when they:

- Aggregate data (from EMR, hospital admit/discharge, vaccine registry, shared info from other partner health organizations). Business rules are developed.
- Result in development of a care plan.
- Summarize tasks to be completed and alerts team members (e.g., telephone outreach).
- Stratify populations by risk (e.g., demographic, clinical) .
- Generate reports to show whether quality is improving over time.
- Facilitate provider empanelment is a key piece of the patient centered medical home. The registry is a key place where empanelment resides.
- Allow for customization (e.g., creation of disease management protocols).

Patient Visit Summary (Diabetic)

									Last Visit	This Visit
Patient ID:	2996	MR:		Age:	54 Yrs	DOB:	4/20/1957	Sex: F	Date:	9/7/2010	
Name:	Richardson, Anna			Race:	HISPANIC				Blood Pressure:	120/88	
Address 1:	822 East Valley			Language:	English				BMI:	43.49	
Address 2:				Phone:	707-385-2371				Pain Score:	1	
City:	Santa Rosa			PCP:	Robert Wright, MD				Weight (lbs):	245	
State:	CA	ZIP:	95403	Insurance:	None						

PROBLEMS: Depression (i2i); Diabetes (MU); Diabetes Type II; DVT History; Family History of Breast Cancer; Leg Ulcers; Vascular: HTN (i2i)

MEDICATIONS: Anti-Depressant, Unspecified (i2i) (100 mg once every day); ARB, Unspecified (i2i); Coumadin (i2i) (1 mg 3 times every week); Diuretic, Unspecified (i2i); Lipid Lowerer

Alerts:

Due: Procedure / Referral: Mammogram (i2i)	Due: Procedure / Referral: Pap (i2i)
Due: Procedure / Referral: Depression Screening (i2i)	Due: Procedure / Referral: Colonoscopy (i2i)
Due: Procedure / Referral: Mammogram	Abnormal EyePACS Case (8/27/2008)

Procedures / Referrals	C	Date	N
Due: Depression Screening (i2	Received	12/16/2009	
Ophthalmology Visit (i2i)	Received	11/25/2010	
Podiatry Visit (i2i)	Received	3/12/2010	
EKG (i2i)	Not Applicable		

Other Profile Items	C	Date	N
Smoker (i2i)	Present - No coun	12/4/2006	
Homeless Status	Transitional	9/8/2007	
Drug Asst Program	Approved	9/8/2007	

Educations	C	Date	N
Diabetes (i2i)	Received	6/2/2011	
Exercise (i2i)			
Med Management	Received	9/7/2010	

Immunizations	C	Date	N
Flu (i2i)	Received	9/7/2010	
Pneumovax (i2i)	Received	12/3/2009	
Tetanus (i2i)	Received	5/7/2009	

Goals	C	Date	N
Exercise (i2i)	3 or more times/w	2/22/2008	
HbA1c (i2i)	less than 8	9/8/2007	

Blood Pressure	
Date	Val
9/7/10	120/88
3/18/10	140/95
12/3/09	118/77
10/18/09	122/68
5/7/09	114/80

BMI	
Date	Val
9/7/10	43.49
3/18/10	34.61
12/3/09	42.96
10/18/09	42.6
5/7/09	41.36

HbA1c	
Date	Val
9/29/10	8.7
9/17/10	7.1
10/29/09	8.2
5/20/09	9
10/14/08	13

LDL	
Date	Val
10/29/09	114
5/20/09	142
2/20/09	150
10/14/08	185

INR	
Date	Val
9/17/10	3.3
8/15/09	1.7
5/20/09	1.7
8/15/08	3

Care Management

Identification for Care Management

- Risk Assessment performed
  - Uses diagnoses
  - Utilization visits
  - Staff assessments
- The Amount of Care Management Effort is Tiered Based on Level of Risk
  - Highest tier perhaps 5% of population and receives perhaps 6 hours of specific CM effort
- The Whole Health Home Team is Involved
  - Care Manager is the person responsible for the overall care management effort
  - Qualified Specialist performs tasks that do not require a license

Care Management

- Utilization:
  - Inpatient
  - ED
- Chronic Care Follow-up:
  - Home monitoring
- Self-Management Support:
  - Assist adherence
  - Goal setting
- Pharmacy
- Places that Care Management occurs
  - Group: Health Educator/CRM disease management staff
  - Telephonic: Nurse Care Manager or Health Coordinator (MA)
  - Day of Care: Nurse Care Manager or Health Coordinator (MA)

7- CARE COORDINATION/ COMPREHENSIVE CARE

- Link patients with community resources to facilitate referrals and respond to social service needs.
- Have referral protocols and agreements in place with an array of specialists to meet patients' needs.
- Proactively track and support patients as they go to and from specialty care, the hospitals and the emergency department.
- Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- Test results and care plans are communicated to patients.

Medicare

- Transitions
  - One out of every five Medicare patients discharged from the **hospital** is readmitted within 30 days
  - Nearly 75% of those **readmissions** are preventable.
  - Costs total more than $17 billion in additional Medicare spending each year

New England Journal of Medicine, (April 2, 2009)

Essential Elements of Transitional Care

Mathematica Study: Key Components of Effective Transitional Care

- Patients first engaged while hospitalized
- Followed intensively post-discharge
- Receive comprehensive post-discharge instructions on medications, self-care, and symptom recognition and management
- Patients reminded/encouraged to keep follow-up physician appointments

Collaboration and Transitions: Hospital

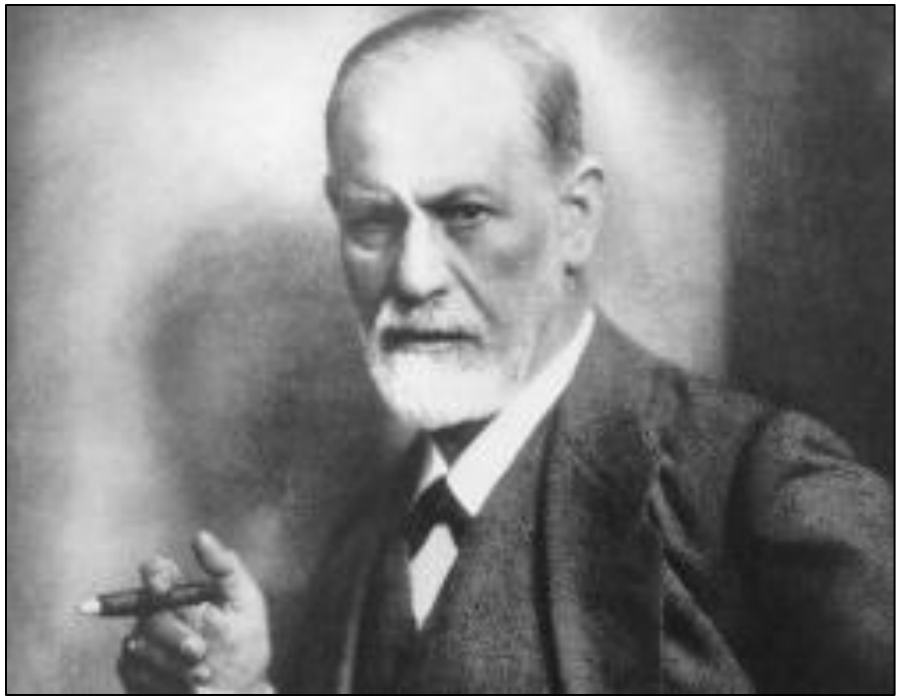
- Real time links
  - A transition occurred or is about to occur
- Plan
  - Who is the continuity agent?
  - Contact (hospital inpatient case mgr.), Care Plan , risk assessment for readmission, evidence based response
    - Standardized
    - Who does it, how?
- Understanding
  - Not just the Care Manager
  - Hospitalist
  - Hospital
- Assessment
  - Risk assessment of patients and patient populations
  - What happened here, why, what can be done
- Communication
  - Medication reconciliation
  - A care plan established by the primary care physician should be available to and updated by health care providers involved in emergency department visits and hospital admissions.
  - Unfinished business

Collaboration and partnerships

- CBHC Health Homes cannot do this alone
- Integrated physical and behavioral health care is a challenge that must be met
- Established relationships between the health home, primary care, specialists, hospitals, long-term care services
- Identifying and aligning incentives (i.e., "what's in it for me?")

Collaboration to Integration

Mental Health/Primary Care



This may take a while

Ohio Medicaid Health Home Program

IT INFORMATIONAL FORUM

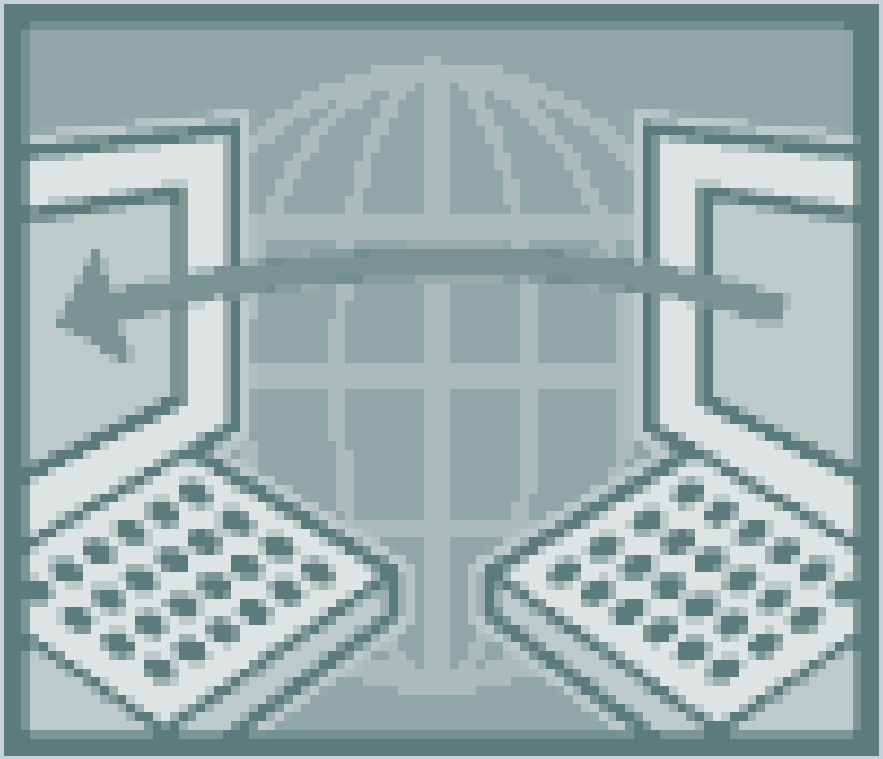
OCTOBER 30, 2012

Legal authority in place to transfer PHI

- Business Associate/Data Sharing Agreements signed
- ODJFS 7078 Code of Responsibility Form signed
- Returned signed copies to each HH
- These documents make Health Homes “Covered Entities” in HIPAA terms and allow ODJFS and ODMH to send PHI with Medicaid and state hospital claims history to Health Homes.

Data Exchange Between State & Health Homes

- Update on Secure File Transfer Protocol (SFTP)
- Client Enrollment
- Clarification re: submission of claims for Health Home services
- Medicaid and State Hospital Utilization Profile



Step 1: Health Home creates list of clients to be enrolled

Step 2: HH saves file in CSV format and sends to its Secure FTP Server which transmits to ODJFS FTP site

Step 3: ODJFS Office of Information Services picks up HH files and sends to HP and ODMH

Step 6: ODJFS OIS sends completed files from HP and ODMH back to HH

Step 5 A & B: ODMH runs data as CSV files. HP runs data as tilde delimited files. Both return files to ODJFS OIS.

Step 4 A &B: HP runs Medicaid claims history & ODMH runs Psych Hospital history for each HH client with a claims

Client Enrollment In Health Homes

From October 1 - November 2012

- HHs submit files listing clients who meet the HH eligibility criteria. This file will be used to enroll clients into HH and to generate service utilization history.
- Enrollment dates on these files may be backdated, current or future; but in any case enrollment dates should reflect the date the recipient met all requirements for Health Home participation.
- Backdating is only allowed via HH enrollment files - only during October and November.
- HHs will be able to send in client lists until MITS Health Home client enrollment is functional
- Enrollment by the Health Home is required before HH service will be paid.

Health Homes Identify Clients

- Create a list of clients including the following data elements on each:
  - Provider Medicaid ID (needed on each entry)
  - Recipient Medicaid ID
  - Recipient Last Name
  - Recipient First Name
  - HH Effective Date (current or future date)
  - HH End Date (can be defaulted)
  - Recipient Date of Birth
  - Recipient Social Security Number
  - Recipient Gender

Health Home output file: CSV file **without headers**

	Format	Length	Notes
Provider Medicaid ID	Character	7	
Delimiter		1	Value “,”
Recipient ID	Character	12	
Delimiter		1	Value “,”
Recipient Last Name	Character	15	
Delimiter		1	Value “,”
Recipient First Name	Character	15	
Delimiter		1	Value “,”
HH Effective Date	Number	8	CCYYMMDD
Delimiter		1	Value “,”
HH End Date	Number	8	CCYYMMDD Default to 22991231 when open-ended
Delimiter		1	Value “,”
Recipient Date of Birth	Number	8	CCYYMMDD
Delimiter		1	Value “,”
Recipient SSN	Number	9	
Delimiter		1	Value “,”
Recipient Gender	Character	1	F - Female M - Male U- Unknown
Delimiter		1	Value “,”

Note: Carriage return no longer needed; variable field lengths being tested for first and last names. “csv” file extension is case sensitive and should be lower case

HH file transfer to ODJFS Mailbox

- ODJFS has written programming logic to search each HH mailbox continuously from 10 am – 10 pm every day.
- Files submitted by HHs to their mailbox will be picked up and sent to HP and ODMH to run client utilization data
- Files submitted prior to 10 am or after 10 pm will stay in the mailbox until the next day's "sweep" cycle.
- Speed of file transfer will be "a matter of minutes"

Once HH File is Picked up…

1. ODJFS will transfer health home file to:
   - ODMH who will generate Regional Psychiatric Hospital data
   - HP (MITS Vendor) who will generate Medicaid recipient and utilization profile for each client
2. ODMH and HP will produce files and send to ODJFS for return to the HH within 5 business days of file receipt.
   - ODJFS will return a "Tilde" delimited file
   - ODMH will return a CSV file
3. ODJFS "pushes" data files back to each HH secure FTP server site.

Status Report: Secure FTP Server Access & File Transfer Testing - 1

- HHs have all obtained SFTP server sites
- HHs have shared SFTP address and password information with ODJFS
- Access problems on both sides have been reviewed and resolved
- ODJFS has created secure individualized mailboxes for each HH
- HHs have received credentials and access info to their ODJFS mailbox
- HHs have each placed a test file in their mailbox

Status Report: Secure FTP Server Access & File Transfer Testing - 2

- All test files submitted by HHs have been transferred successfully to ODMH and to HP
- HP and ODMH have both returned all test files to ODJFS
- ODJFS has returned all test files back to HHs
- Up to Tuesday, Oct 30, file transfer has been a manual process. Beginning today (10/30) we will test the automated file transfer process
- As soon as automated process tests successfully, we will be READY for HH's to submit REAL client lists

Outstanding issues

ODJFS IT staff, Matt Barlow (matthew.barlow@jfs.ohio.gov) will continue to be available to Health Home IT staff to assist in resolving File Transfer issues, concerns.

Between Now and November

- HHs will continue using this process until MITS functionality is in place in November.
- Initial enrollment will generate the 24 month client claims profile and monthly updates thereafter.
- Training will be provided to Health Homes later in November about how to use the MITS HH portal functionality including HH Enrollment, HH client search, Psych hospital PA search (see following screen shots).
- New HHs will still be offered mass enrollment of clients for the first month of their existence.

Submitting Health Home Claims

- Claims for HH service (S0281) are submitted exactly like other behavioral health services (portal or EDI)
- CPT Level 2 Codes are submitted as a behavioral health service claim with billed amount of "zero." Can be a line/detail on a HH S0281 claim or submitted separately.
- HH Claims may be submitted 365 days from the date of service. No need to submit before the end of the month to be paid for HH service during that month. Service only needs be rendered during that month.
- Rate for HH service is the individualized case rate as negotiated with ODMH and verified by ODJFS.

Health Home and other MH Services

- ONLY during the first month of HH start up, CPST claims may be billed up until the day a client is enrolled in the health home.
- CPST claims submitted on or after HH enrollment will be denied.
- Health Home comprehensive care coordination does not alleviate the need to render (and bill for) other MH services such as counseling, diagnostic assessment, pharm management, etc.

Client Specific Extract Files

Medicaid client data extract

Section 1: Demographics & Summary Extract File

1. Name, Medicaid ID, address, DOB
2. # ER Visits w/in past 24 months
3. # hospital admissions – psychiatric
4. # hospital admissions – non-psych
5. # Physician visits
6. # Behavioral Health visits
7. List of Prescription medications within last 6 months
8. List of Lab or diagnostic tests within last 6 months
9. List of “other” claims from specialists (non physician or lab)

Client Specific Extract Files

- ODJFS - Medicaid patient demographic and health summary for each client
- ODJFS - Medicaid FFS selected claims and MCP encounter utilization data
- ODMH - Regional Psychiatric Hospital inpatient utilization data

ODJFS Medicaid Client Extracts

Two Data Extracts

1. Patient Demographics and Summary
2. Selected claims and encounter data

Criteria for Inclusion

- Includes both FFS and Managed Care Encounter Data
- Initial request will contain 24 months of claims data for specified provider types and 6 months of pharmacy and lab data

Medicaid - Demographics and Summary, cont.

A 'Y' will be listed in the diagnosis field when any Medicaid claim or encounter data during the past 24 months lists a **primary or secondary** diagnoses of:

- Asthma diagnosis
- Diabetes diagnosis
- Coronary Artery disease diagnosis
- Bipolar
- COPD diagnosis
- Obesity Diagnosis
- Schizophrenia diagnosis
- Nicotine Dependence diagnosis

Select Medicaid claims / encounter data

Claims information will include date of service, provider name and contact info; provider type and specialty, procedure code and name; diagnosis for client served will be returned for the following categories:

1. ER visits
2. Hospital admissions – psychiatric
3. Hospital admissions – non-psych
4. Physician visits
5. Behavioral Health visits
6. Prescription medications within last 6 months
7. Lab or diagnostic tests within last 6 months
8. “Other” services by specialists (non physician or lab)

Medicaid Extract file updates – Thereafter

For each client identified by HH, MITS will automatically generate a monthly claims update following the same basic layout as for the 24 month summary. 2 parts as before:

1. Patient demographics and summary
2. Select Medicaid claims data

Files will automatically run at the end of the next calendar month after first file run.

A few additional fields will be added after MITS go live (e.g. medication possession ratio) More specifics to be provided in later training.

ODMH Regional Psychiatric Hospital Data

- Provider Medicaid ID
- Recipient ID
- Patient First & Last Name
- HH Effective Date
- HH End Date
- Recipient SSN
- Recipient Gender
- Date of Birth
- Hospital Name
- Patient Primary & Secondary Admission Diagnosis Code & Name
- Patient Primary & Secondary Discharge Diagnosis Code & Name
- Admission Date & time
- Discharge Date & Time
- Length of Stay

CSV with Headers file Layout for ODMH Psychiatric Hospital Inpatient Utilization

Column Name	Format	Length	Notes
PROVIDER_ID	Character	7	Provider Medicaid ID
RECIPIENT_ID	Character	12	
LASTNAME	Character	15	Recipient Last Name
FIRSTNAME	Character	15	Recipient First Name
HH Effective Date	Number	8	
HH End Date	Number	8	Default to 22991231 when open-ended
DOB	Character	8	Recipient Date of Birth CCYYMMDD
SSN	Number	9	Recipient SSN
GENDER	Character	1	Recipient Gender
HOSPITAL	Character	20	Hospital Name
ADMPRIICD9FMT	Character	6	Client Primary Admission Diagnosis ICD9 Code XXX.XX
ADMPRIDXNM	Character	50	Client Primary Admission Diagnosis Name
ADMSECICD9FMT	Character	6	Client Secondary Admission Diagnosis ICD9 Code XXX.XX
ADMSECDXNM	Character	50	Client Secondary Admission Diagnosis Name
DISPRIICD9FMT	Character	6	Client Primary Discharge Diagnosis ICD9 Code XXX.XX
DISPRIDXNM	Character	50	Client Primary Discharge Diagnosis Name
DISSECICD9FMT	Character	6	Client Secondary Discharge Diagnosis ICD9 Code XXX.XX
DISSECDXNM	Character	50	Client Secondary Discharge Diagnosis Name
DOA	Character	8	Admission Date CCYYMMDD
ADM_TIME	Character	4	Admission Time Military Format
DISDATE	Character	8	Discharge Date CCYYMMDD
DISTIME	Character	4	Discharge Time Military Format
LOS	Numeric	5	Length of Stay

Health Homes Enrollment Layout

Health Homes Enrollment Maintenance

Medicaid Billing Number	Effective Date	End Date
4117716794	10/11/2011	12/31/2299

delete add

*Medicaid Billing Number:

*Date of Birth:

*Effective Date:

*End Date:

First Name, MI:

Last Name:

*Health Home Type:

add new member submit cancel

Health Homes Enrollment Search Layout

Health Homes Enrollment Search: 852065877 MCD - REVCO 4702

Medicaid Billing Number 4117716794

Last Name

First Name, MI

search

clear

add

Search Results

Name	Date of Birth	Medicaid Billing Number	Effective Date	End Date
DOE, JOHN M	01/01/1962	4117716794	10/11/2011	12/31/2299

Provider Search for Health Home Enrollment

- Medicaid providers will be able to find a client's Health Home enrollment and Health Home contact information by performing a Medicaid client eligibility search.
- See samples of MITS Medicaid eligibility search panels on following pages

MITS Provider Portal – Medicaid Recipient Eligibility Look Up

Recipient Eligibility Verification-Request Layout

Eligibility Verification Request

Medicaid Billing Number		Birth Date	
SSN		DOS Date Format	MM/DD/YYYY
Procedure Code		From DOS	07/28/2009
		To DOS	07/28/2009

search

clear

Recipient Eligibility Verification-Recipient Information Layout

Recipient Information

Medicaid Billing Number	4805998220	SSN	
Last Name	SMITH	County of Residence	JACKSON
First Name	ALEIDA	County of Eligibility	JACKSON
Gender	MALE	County Office http://jfs.ohio.gov/county/cntydir.stm	
Date of Birth	03/28/1952	Number Bed Hold Days Used Paid CY	2008: 5
Date of Death		Number Bed Hold Days Used Paid CY	2009: 3

Recipient Eligibility Verification-Managed Care Layout

Managed Care			
Plan Name	Plan Description	Effective Date	End Date
Buckeye Community Health Plan - ABD	HMO, ABD	07/01/2008	07/31/2008
Unison Health Plan - CFC	HMO, CFC	07/01/2008	07/31/2008
Amerigroup Ohio, Inc. - ABD	HMO, ABD	06/01/2008	06/30/2008

Recipient Eligibility Verification-Benefit Plans Layout

Benefit / Assignment Plan					
Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
N : Limited to emergency services	03/01/2009	05/01/2009			
Hospice	03/01/2009	05/01/2009	NATIONAL MENTOR HEALTHCARE, LLC	$6.30	$5.35

Recipient Eligibility Verification-LockIn Layout

This is where Health Home enrollment will be listed

Lock-In					
Lock-In Plan	Lock-In Type	Effective Date	End Date	Provider Name	Provider Phone
Hospice	HOSPC	03/01/2009	05/01/2009	NATIONAL MENTOR HEALTHCARE, LLC	(429)546-0695

Pre-Admission certification for psych inpatient

- Client level information can be viewed by HH in the MITS provider portal for any client for whom a psych inpatient PA has been requested
- MITS will send e-mail alert to HH service location e-mail address each time there is a PA made for any client assigned to that HH.
- HH should review their MITS provider maintenance panel to verify service location, e-mail address (and all other agency information) is correct and up to date
  - "Mail to" e-mail address will be used to send psych PA alerts

PA - Search

- Providers are encouraged to check panel daily
- E-mail alerts are designed as a reminder
- Search criteria limited to six months retrospective
- Search criteria: Can use either Medicaid billing number <u>or</u> admission "From" and "To" date range. Must enter both dates where "To" date must be greater than or equal to "From" date.
- Business impact: Health Homes should train their care management team members to use these screens

E-Mail sample text

The Ohio Medicaid Program has received a psychiatric admission pre-certification request on (mm/dd/ccyy) for a consumer in the Health Home Program, for admission to an inpatient facility on (mm/dd/ccyy). Please log on to the Ohio MITS secure Portal to retrieve Psychiatric Admission information related to this pre-certification request.

Psychiatric Admission Search Layout

Psychiatric Admission Search: 852065877 MCD - REVCO 4702

Medicaid Billing Number:

Admission From Date: 05/31/2012

Admission To Date: 05/31/2012

search

clear

Search Results

Date Submitted	Medicaid Billing Number	Recipient Name	Facility Name	Contact Name	Contact #	Ext	Admission Date
05/31/2012	713123456101	SMITH, JOY	THE CHRIST HOSPITAL	HEALTH CARE EXCEL	800-580-1937		05/31/2012
05/31/2012	783012345601	FRANK, KIM	WARREN OHIO HOSPITAL COMPANY	HEALTH CARE EXCEL	800-580-1937		05/31/2012
05/31/2012	252344545001	CHARLES, CHARLES	SAINT RITAS MED CTR	HEALTH CARE EXCEL	800-580-1937		05/31/2012
05/31/2012	103843554099	KING, KING H	UNIVERSITY HOSPITAL	HEALTH CARE EXCEL	800-580-1937		05/31/2012

Resource List

1. Health Home client list – CSV file layout
2. Excel file demonstrating the Medicaid client demographic and health summary, plus file layout
3. Excel file demonstrating Medicaid fee for service and managed care encounter claims, plus file layout
4. ODMH - Regional Psychiatric Hospital inpatient utilization data File layout

Resources can be found on the ODMH Health Home website under the Provider tab

Questions?