PCP Health Home Flow Chart

Patient Background

- Tier 4
- 45 year old female
- 25 ER visits
- 10 IP admits including 6 readmit, $22,224 IP spend
- 24 physicians
- Hx of anxiety, asthma, epilepsy, hypertension, low back, Musculoskeletal, sleep disorder, substance abuse, smoker, chronic pain, depression
- $49,321 total spend
- $2359 Rx spend 7.3 Rx/mo., 12 chronic drug classes

Recipient qualifies for Health Home participation and using CDPS is placed in Tier 4

Based on her previous relationships of care she is assigned a Health Home.

HH reviews recipients EHR and DSS claims and contacts the recipient and schedules an appt.

Prior to recipient's appointment, EHR is printed/flagged to highlight alerts and reminders

Recipient arrives for the appointment, a routine depression screening is conducted, other tests are conducted as necessary and medication reviewed

Depression screening positive?

Yes

No

Designated Provider determines mental health professional evaluation is needed. Designated provider reviews remaining chronic conditions and determines if additional tests are needed.

Designated provider, recipient and care manager develop recipient plan of care for all conditions. Care Manager establishes regular contact with recipient. Plan of Care and goals are documented in the EHR

HH Pharmacy team member reviews HH recipient medications

Review shows issues?

Yes

No

Medications reconciled and education provided

Flag EHR to check medication annually.

Care Manager continues to work with patient to meet the goals of the established care plan. All actions are documented in EHR.

HH Mental Health Professional provides recipient follow-up information to care manager and requests one week follow-up contact

HH Care Manager contacts recipient one week later to assess compliance with mental health follow-up plan and address further questions

Care manager establishes appointments with mental health professional and pharmacist; recipient history and goals provided; and develops follow-up contact with recipient

Recipient agrees to see HH mental health professional team member
Referral Process for PCP

Health Homes

Referral is assigned to HH

Referral is chosen

Referral is not chosen

Referral is passed to next provider

Referral specialist or behavioral health specialist needed?

Referral specialist or behavioral health specialist needed?

Referral specialist or behavioral health specialist needed?

Physician spot

HH number submitted with claims

HH necessary

Referral written

Recipients visits

Recipients visits

Recipients visits

No

Yes

No

Yes

No

Yes
CMHC Health Home Flow Chart

**Patient Background**
- Tier 4
- 44 year old female
- $49,387 Total Spend
- 15 ER Visits
- 27 physicians
- 5 IP admit $13863 IP spend
- Hx of Bipolar, Chronic Pain, Low Back Pain, Musculoskeletal disorder, obesity, pre-diabetes, Schizophrenia, Sleep Disorder, Smoker and Substance Abuse
- $20,195 Rx spend 15.7 Rx/mo., 12 chronic drug classes

1. **Recipient qualifies for Health Home participation and using CDPS is placed in Tier 4**
2. **Care Coordinator works with recipient to establish appointments with primary care physician as well as other local support services as needed.**
3. **Based on her previous relationships of care she is assigned a Community Mental Health Center Health Home.**
4. **As a result of the initial appointment, Designated Provider determines that recipient needs to be seen by a primary care physician to better manage her Obesity and Pre-diabetes. Education about appropriate ER**
5. **Recipient meets with HH Care Team to integrate physical health conditions into the Plan of Care and goals are documented in the EHR.**
6. **Prior to recipient's appointment, EHR is printed/flagged to highlight alerts and reminders.**
7. **Review shows issues?**
   - **Yes**
     - **Care Coordinator communicates reconciliation to primary care physician so medications can be adjusted.**
     - **Medications reconciled and education provided.**
     - **Flag EHR to check medication annually.**
   - **No**
     - **Care Coordinator continues to work with recipient to meet the goals of the established care plan. HH Care team meets with recipient on a quarterly basis to update goals. All actions are documented in EHR.**
8. **Care Coordinator contacts recipient two weeks later to assess compliance with plan of care.**
9. **Care Coordinator and recipient meet with local support services as appropriate to support the Plan of Care Follow-up plan developed.**
10. **Local support service agencies update Care Coordinator and request follow-up in 2 weeks.**
11. **HH Pharmacy team member reviews HH recipient medications.**