Clinical Risk Group – 10.22.2013

<div align="center">Attendees</div>

Neil Pessin	CCMP
Michelle McElroy	Southern Tier AIDS Program
Karen Nelson	Maimonides
Shawna Craigmile	Onondaga Case Management Services
Lyn Hohmann	NYSDOH Health Homes
Deirde Astin	NYSDOH
Susan Essock	OMH
Sheila Donahue	OMH
Jessie Sullivan	Hudson Health Plan
Donald Bux	University Behavioral Associates
Brian Maxey	NYC HHC

Call began with a report from L. Hohmann on the factors submitted to 3M for consideration.

She spoke with Dr. Goldfield regarding recommendations. She hasn't distributed the notes to the whole group yet as she is still waiting for his approval of them, but she was willing to walk through the list of things they discussed. She did share with him the list of the five factors identified as the most important to the group, as well as the information submitted by J. Sullivan of numerous ICD-9 codes that could prove valuable. They discussed using the blank field on the claims form for other diagnoses codes that help to inform member need and circumstance. It was reported by L. Hohmann that the number of codes to be attached to a HH claim can be the same as a standard claim.

Homelessness codes – V60 series - L. Hohmann stated that if providers were willing to agree to use the HUD definition of homelessness that would be useable. However, while the V60.0 code can be used, it is not possible to add a fifth digit for Health Homes reporting to differentiate HUD categories 1(i) from 1(ii or iii). The VA has used the V60.0 coding with veterans and found it to be relevant in some regards. Additionally, V60.89 cannot be used for HUD level 3 and 4, as this is not the true meaning of this code. Several group members asked if this code could be used (despite not meaning the other specified criteria assigned to the coding) within the context of HH and L. Hohmann indicated that this was unlikely but could be brought to N. Goldfield during the next call with 3M.

Additional codes –

> **V60.81** Foster Care, **V61.05** Child in Welfare custody - These codes will be included in the next version of the CRG. A presentation on their inclusion may be possible.
> **V62.5** Legal Circumstances (imprisonment, litigation) – Too vague and encompassing
> **V15.81** Non-compliance with medical treatment - Not specific enough to be valuable
> **V62.4** Social maladjustment (acculturation problem, cultural deprivation) - too vague
> **V62.22** Personal Hx of Return from Military Service - Not useful without a diagnosis of PTSD or something to link it to
> **V15.41** & **V15.42** Hx of physical / emotional abuse – No comments
> **V62.0** Unemployed – Could be useful

Lyn will send out the notes from her meeting once she gets approval. She will let Dr. Goldfield know the group would like a presentation on the v Codes.

DISCUSSION: N. Pessin reiterated an earlier request to have more information about the premise and method behind the CRG, so as to know what types of information the group should be looking for and what types of specific data sources might prove most valuable. It would be useful to know what factors are used to determine the CRG score to see how well the status of our members correlates. The scores don't seem to represent functional status in regards to amount of time spent and cost, and the consensus on the part of the group is that the acuity scores are not serving as an accurate prediction of level of need in the majority of member cases. CRG's are being used to calculate pay and predict the kinds of services that will be needed for each patient. Is the goal of the group to modify them in order to be paid more accurately? Or to better serve clients? What data would need to be collected to have the CRG be more accurate? How do you quantify social issues not addressed by CRG's? The group feels like we need to look at our real life experience and identify issues that present and be able to quantify them.

L. Hohmann did indicate that some of these issues could be due to older data and also acknowledged that it is necessary to include some additional factors into the analysis, hence the group's work.

Concern was raised that many of the identified V-codes cannot be used, despite several of them being representative of the identified elements for inclusion. Additional questions about the possibility of using other (non V code) identifiers on claims were brought up, and whether or not there could be agreed upon alternate codes for the claims within the system.

A recent analysis in which OMH examined Medicaid claims from individuals who had had frequent psychiatric hospitalizations found that neither failure to fill a psychotropic prescription nor failure to attend an outpatient visit were good predictors of who would continue to have frequent hospitalizations. The analyses we did were prompted by an initiative in Brooklyn but were based on 10,000+ individuals state wide who had frequent hospitalizations for psych disorders.

Several group members also asked whether this is a one-time opportunity to make modifications to the analysis, or if there can be rolling input? If modifications could be made going forward based on additional observations or assessment tools, then it may be easier to create useful indicators and data. L. Hohmann will discuss with Norbert whether this will be an ongoing dialogue or a one-time opportunity. The group agreed to try to revisit the homelessness definition in the interim.

NEXT STEPS:

1. L. Hohmann will work on schedule for another conference call / presentation with Dr. Goldfield.

2. Group will revisit Homelessness definition in order to solidify concrete working definition that can be submitted as a suggestion for all Health Homes programs to adhere to.

3. Group will discuss the possibility of using alternate meanings for codes with Dr. Goldfield and L. Hohmann to explore the possibility of using alternate (non V codes) codes to capture relevant data and whether or not this is possible or allowable to be attached only to HH claims for reporting purposes. There is a field in the form not currently being used where this data could be collected but it is unclear if this can be coded within a HH claim and not cause difficulty with other data.