New York State DOH
Health Home Care Management Reporting Tool (HH-CMART)
Bi Weekly Support Calls – Session #18
October 30, 2013

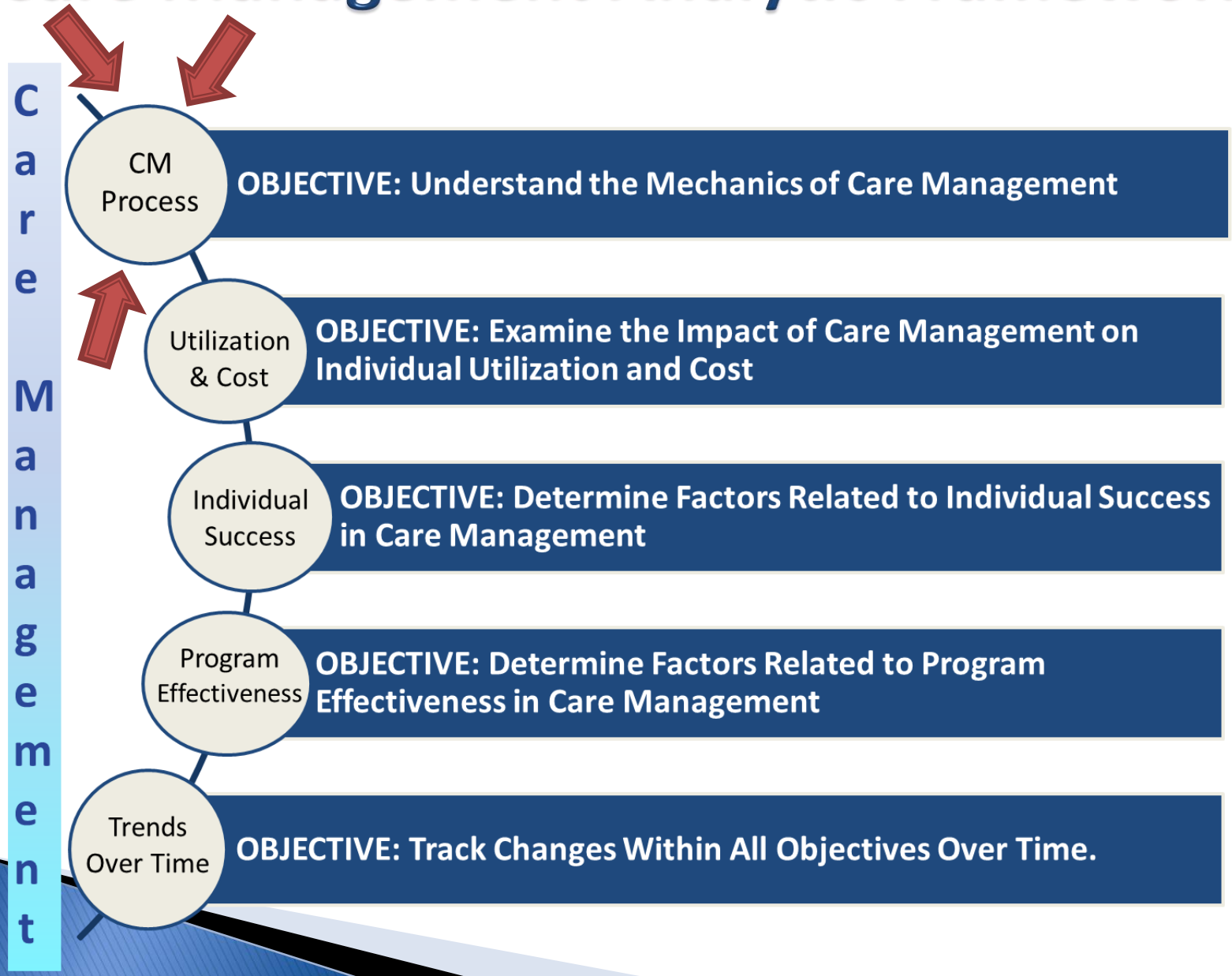
Questions?

- Please submit your questions in writing to the webinar
- If you would like to ask your questions, raise your hand (making sure you have entered your audio pin code) and we will unmute the call one at a time

Agenda

- Overview of Data Summary Reports
- Preliminary Process Measure Results
  - Initial process measures that do not require elements from PTS
- Overview of CMART Analysis Plan
  - Reports specific to each Health Home
  - Quarterly versus Cumulative results
- Quality Measurement Plan for Health Homes
  - Overview of Quality Measure Plan and Measures
  - Reporting time line
- Feedback, Help & Ongoing Support
- Q & A

Care Management Analytic Framework



Data Summary Reports - Structure

- Two Sections -
  - Health Home specific information
  - Statewide information (i.e., all reporting Health Homes combined)
- Two Tables:
  - Data Completeness Summary
    - Indicates the number of HH records submitted for each element by response category (where applicable).
  - Logic and Consistency Checks
    - Indicates the number of HH records that have logic and consistency issues between elements.

Data Summary Reports – Structure, cont.

- The Data Completeness Summary table consists of 5 columns:
  - **Item No.** – Element Number from the Technical Specifications;
  - **Item Description** – Import Field Name from the Technical Specifications;
  - **Population Definition** – Summarizes the group of members included in that element.
  - **Response Value** – Lists the response options submitted for that element:
    - "Valid" – Submitted values met the specification criteria for that item.
    - "Response Issue" – Submitted values did not meet the specification criteria for that item. This includes incorrect spellings and out of range values.
    - "Value-Missing" – Value of 'missing' submitted for a subset of members for that item.
    - "Blank-Missing" – No values were submitted for a subset of members for that item.
    - Other Values – Mean and Range are indicated for numeric elements that do not have specified Response Values.
  - **N** – Indicates the actual number of records submitted for the indicated Response Value.

Data Summary Reports – Structure, cont.

- The Logic and Consistency Checks table consists of 4 columns:
  - **Item No.** – Logic/consistency check number.
  - **Item Description** –
    - Dark grey – Brief description of the logic/consistency check;
    - Light grey - Import Field Name(s) from the Technical Specifications associated with the logic/consistency check.
  - **Definition** – Summarizes the logic/consistency issue examined
    - Dark grey – General description
    - Light grey – Specific description (if needed)
  - **Checks N** – Indicates the actual number of records found to contain the indicated logic/consistency issue.

Data Summary Reports – Example #1

Total Number of Records				71,178
Item No.	**Item Description**	**Population Definition**	**Data Completeness**	
			Response Value	**N**
1	OMC Plan ID	All members	Valid	60,333
			Invalid	9,852
			Blank-Missing	993
2	HH MMIS #	All members	Valid	71,178
			Invalid	0
			Blank-Missing	0
3	CIN	All members	Valid	71,178
			Invalid	0
			Blank-Missing	0
4	DOB	All members	Valid	68,960
			Invalid	440
			Blank-Missing	1,778
			Age range (years)^	0.003 to 113.5
			Mean age (years)^	49.3
5	Primary care Management Program Type	All members	Behavioral Health	18,101
			Chronic Adult	27,885
			Children	2
			Long Term Care	6
			Value-Missing	23,390
			Blank-Missing	1,551
			Response Issue	243
6	Able to Contact	All members	Yes	35,998
			No	22,630
			Blank-Missing	9,630
			Response Issue	2,920
7	Outreach Effort	All members	Valid	40,012
			Blank-Missing	31,166
			Range[1]	0 to 384
			Mean[1]	2.6

Data Summary Reports – Example #2

Item No.	Item Description	Definition	Checks
			N
1	**Duplicate CINs**	**CIN appears more than once**	
1a	In Data File	CIN appears in data set more than once	1,474
2	**EngagedCM**	**EngagedCM is Yes but required elements are blank**	
2a	CountMail		5,235
2b	CountPhone		4,103
2c	CountPerson		3,527
2d	CareManage		4,920
2e	HealthPromote		5,453
2f	TransitionCare		7,560
2g	MemberSupport		8,209
2h	CommSocial		7,217
3	**Not EngagedCM**	**EngagedCM is No and required elements are not blank**	
3a	Intensity		1,292
3b	CountMail		330
3c	CountPhone		333
3d	CountPerson		339
3e	CaseClosed		148
3f	CaseReopened		980
3g	PlanUpdate		35,229
3h	CareManage		375
3i	HealthPromote		371
3j	TransitionCare		371
3k	MemberSupport		370
3l	CommSocial		370
4	**Consistency**	**Responses are not consistent between 2 variables**	
4a	AbleContact & ContactDate 1	Able to Contact is No and Contact Date is there	22,630
4b	AbleContact & ContactDate 2	Able to Contact is Yes and Contact Date is NOT there	369
4c	AbleContact & AppropriateCM 1	Able to Contact is No and AppropriateCM is No or Yes	11,800
4d	AbleContact & AppropriateCM 2	Able to Contact is Yes and AppropriateCM is Not Able to Contact	888

Process Measures

- **Definition:** These are measures that describe the care management process during the reporting period. The two main areas of focus are:
  - The process of engaging members in care management;
  - The volume of services provided to members once engaged.
- **Examples:**
  - *Amount of outreach efforts* made to contact members,
  - *The percentage* of members who are *able to be engaged* in care management,
  - *The average length of time* between "trigger" and engagement for members,
  - *The amount of care management* services provided ('dose'),
  - The *status of the case* (ongoing or closed),
  - *Reasons for closure* ('met goals' versus 'incomplete')
- **Use:** The information will be incorporated with utilization and quality measures to evaluate the impact of care management on members who participate in the Health Home programs.

Preliminary 1Q-2Q 2013 Process Measure Results

Measure Domain	Care Management Measure	Description	Measure Population	Measurement Period: 2013 Q1/Q2	
				Statewide *	Rate Range Across Health Homes * (min – max)
Process Efficiency	CONTACT RATE	Number of members contacted / Number of members initiated for outreach/engagement by the HH	All members in the Health Home (excluding those already engaged ^)	**61.4%**	**21.4% - 100%**
Process Efficiency	OUTREACH EFFORT AVERAGE	Total Number of Outreach Activities/ Number of Members in Outreach	All members in the Health Home in Outreach (excluding those already engaged ^)	**1.8**	**0 – 4.9**
Process Efficiency	REFUSAL RATE	Number of members who opted out / Number of members deemed appropriate and contacted	All members who were deemed appropriate and contacted (excluding those already engaged ^)	**20.3%**	**0% - 66.9%**
Process Efficiency	ENGAGEMENT RATE	Number of members engaged in CM / Number of members initiated for outreach/engagement by the HH	All members in Health Home (excluding those already engaged ^)	**36.6%**	**0.2% - 100%**

^ An indication of 'Already Engaged in CM' for AbleContact was used as a proxy of converting members for these preliminary results.

* Rates and means based on valid, non-missing values for those defined in the measure population.

Preliminary 1Q-2Q 2013 Process Measure Results – cont.

Measure Domain	Care Management Measure	Description	Measure Population	Measurement Period: 2013 Q1/Q2		
				Statewide *		Rate Range Across Health Homes * (min – max)
Dose Measures	CARE PLAN UPDATE	Number of members with care plan updated / members engaged in HH	All members who engaged	**51.7%**		**0% - 100%**
Dose Measures	INTERVENTION MODES	Mean number of interventions.	All members who engaged	Total	**10.6**	**1 – 24.6**
				Mail	**0.4**	**0 – 2.7**
				Phone	**5.6**	**0 – 15.6**
				In-Person	**4.7**	**1 – 13.5**
Dose Measures	TYPES OF CM SERVICES	Mean number of CM services by service type	All members who engaged	Care Management	**4.9**	**1.2 – 10.4**
				Health Promotion	**4.2**	**0.4 – 15.4**
				Transition of Care	**1.3**	**0.01 – 10.0**
				Member Support	**1.3**	**0.9 – 10.0**
				Community/Social	**1.5**	**0.1 – 10.5**
Dose Measures	CLOSURE RATE	Number of members with a closed case / Number of members engaged.	All members who engaged	**9.2%**		**0% – 73.7%**

* Rates and means based on valid, non-missing values for those defined in the measure population.

Process Measure Results – Pending for 1Q-2Q 2013

Measure Domain	Care Management Measure	Description	Measure Population
Process Efficiency	PROCESS LENGTH (mean/median days) INITIATE-CONTACT	Time between triggering and initial contact (in days). For those contacted.	All members who were contacted
Process Efficiency	PROCESS LENGTH (mean/median days) INITIATE - ASSESSMENT	Time between triggering and initial assessment. For those assessed.	All members who were assessed
Process Efficiency	PROCESS LENGTH (mean/median days) INITIATE - ENGAGE	Time between triggering and CM engagement. For those engaged.	All members who engaged
Outcomes	MET GOALS	Number of members with Closure Reason of MET GOALS / Number with a closed case	All members who engaged and had their case closed

Next Steps for HH-CMART Measures

- Health Home specific process measure results
- Quarterly views and Cumulative views
  - Still developing framework but examples of how we might approach:
    - Intake measures based on ‘new’ or ‘renewing’ members for each reporting period.
    - Measures about the care management services both for a reporting period and cumulative for the ‘segment’.
      - Note, segment is defined as the period from initiation through closure. Members can close a segment and then start a new segment later.

Quality Measurement Plan for Health Homes

- Quality measures will be calculated by DOH using Medicaid transactional data (claims and encounters).
- Some of the CMS core set will require supplemental information from medical records for a few measures. We're awaiting CMS guidance. We'll let you know more when we do.
- The majority of measures are based on a calendar year time frame for reporting.
- Members who are engaged in Health Homes will be included in the results for the health homes. This is narrower than all Health Home members. Allows 'fairer' comparison.
- Population characteristics will be analyzed for influence on results of measures to identify potential differences in membership. Characteristics include things like region, age, gender, aid category, CRG, MH or SA indicators.

Quality Measures for Health Homes

Measure	Measure
1. Inpatient Utilization – General hospital/Acute Care	14. Cholesterol Testing for Patients with Cardiovascular Conditions
2. Ambulatory Care (ED Visits)	15. Comprehensive Care for People Living with HIV/AIDS
3. Mental Health Utilization	16. Chlamydia Screening in Women
4. Follow Up After Hospitalization for Mental Illness	17. Colorectal Cancer Screening
5. Follow up After Hospitalization for Alcohol and Chemical Dependency Detoxification	18. Adult BMI Assessment
6. Antidepressant Medication Management	19. Ambulatory Care-Sensitive Condition Admission
7. Follow Up Care for Children Prescribed ADHD Medication	20. Care Transition – Transition Record Transmitted to Health care Professional
8. Adherence to Antipsychotics for Individuals with Schizophrenia	21. Plan- All Cause Readmission
9. Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	22. Screening for Clinical Depression and Follow-up Plan
10. Use of Appropriate Medications for People with Asthma	23. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
11. Medication Management for People With Asthma	24. Controlling High Blood Pressure
12. Comprehensive Diabetes Care (HbA1c test and LDL-c test)	25. Potentially Preventable Readmissions
13. Persistence of Beta-Blocker Treatment after Heart Attack	26. Prevention Quality Indicators

Shaded Measures are from CMS' core set for Health Homes.

Initial Measures for 2013

Five measures have short or no continuous enrollment criteria and will be the basis for the first reporting period.

1. Inpatient Utilization – General hospital/Acute Care
2. Ambulatory Care (ED Visits)
3. Mental Health Utilization
4. Follow Up After Hospitalization for Mental Illness
5. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Anticipate first reports to be completed in the first quarter of 2014.

Ongoing support

- Weekly support calls are on a **TBD** basis, Wednesdays from 10 a.m. to 11 a.m. Announcements will be made directly to the HH CMART email list and also it will be posted on the HH Website.
- DOH expects to release FAQ's and Case Scenarios soon.
- Slides from all webinars can be accessed by visiting the Health Home website at:

  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/meetings_webinars.htm

Feedback and Help

- We encourage your feedback by either:
  - Emailing the Health Home Team with the subject of *Quality Metrics* via the Health Home website at:
    https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action
    or
  - Calling the Health Home provider line: 518.473.5569

- Additional HH-CMART resources are available at:
  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/process_measures.htm