Health Home Care Management Assessment Reporting Tool (HH-CMART) Introductory Webinar

February 13, 2013

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DOH, Office of Quality and Patient Safety

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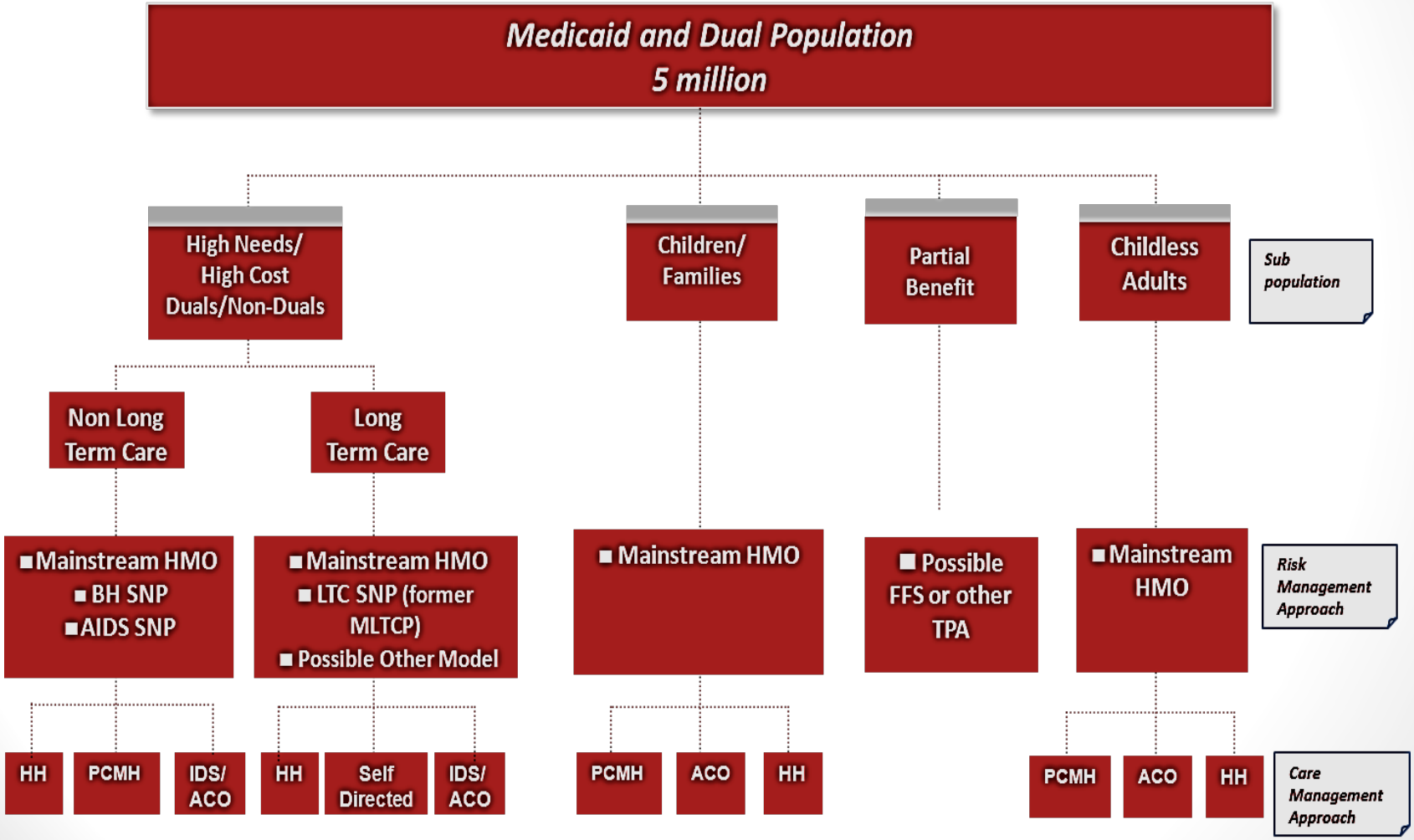
IPRO

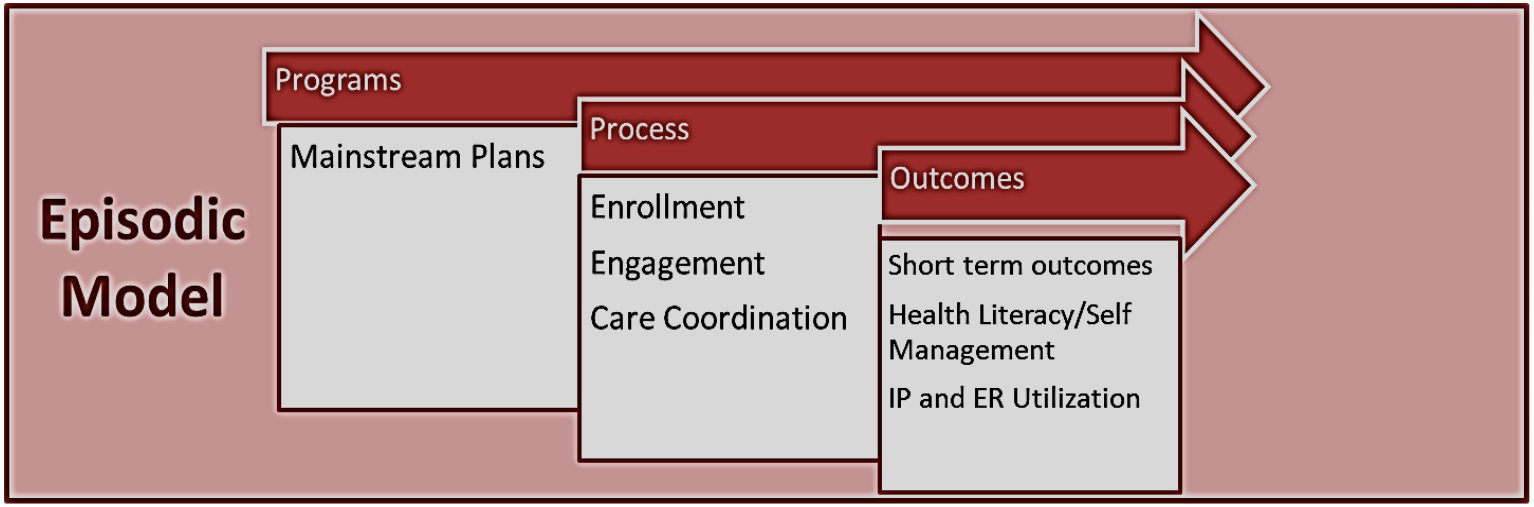
Objectives

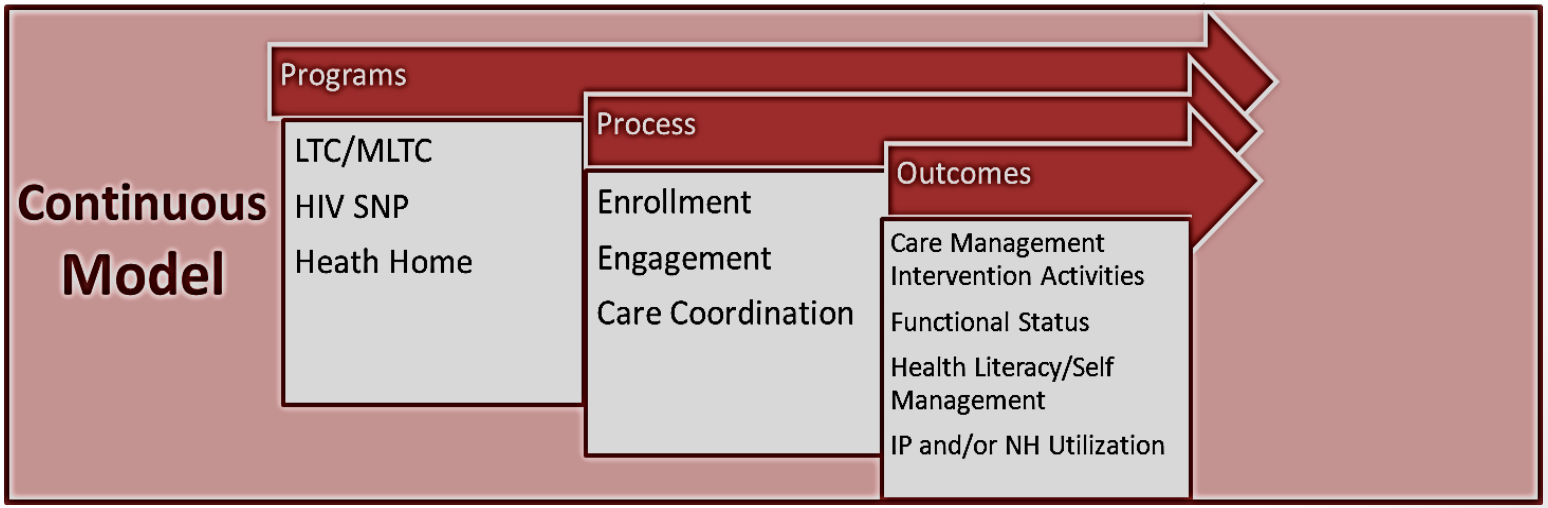
1. Provide overview of care management evaluation
2. Review HH-CMART data elements and response options
3. Demonstrate use of the tool
4. Review reporting periods and submission time frames
5. Provide brief overview of data uses, feedback reports, and how to get help with questions

The Vision: Care Management for All

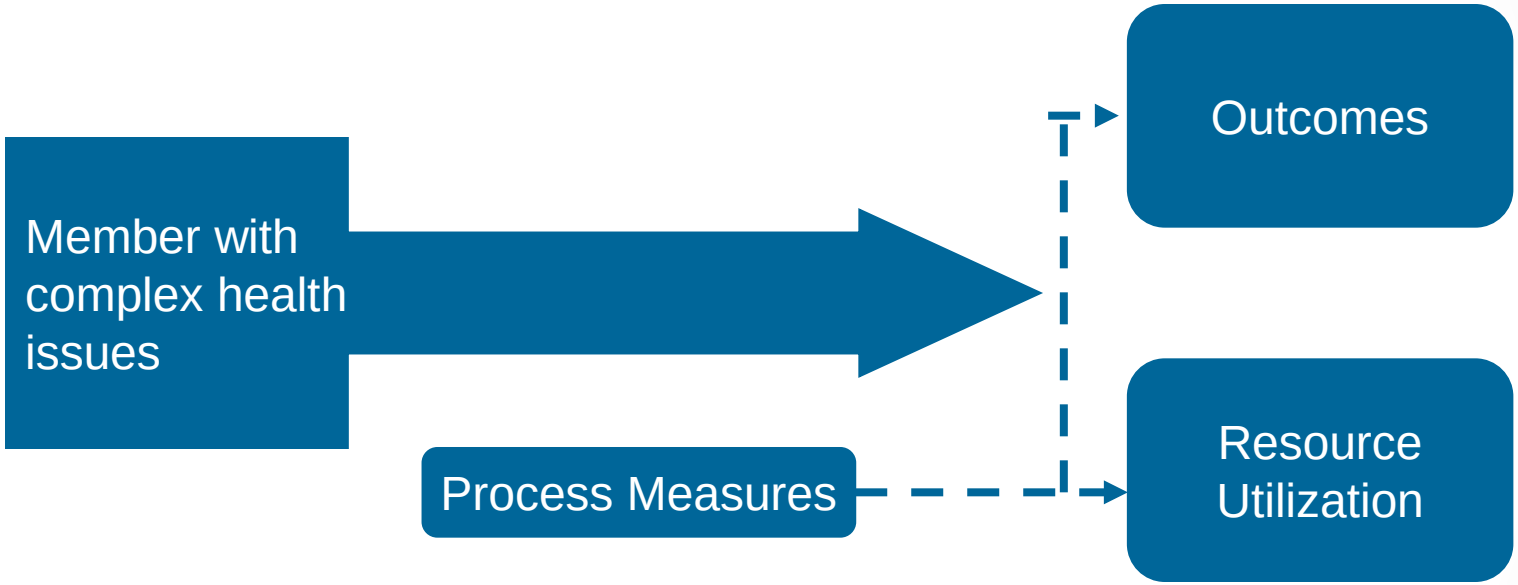


Evaluation of Care Management – Across the Medicaid Program





Care Management Logic Model*



*Adapted from AHRQ: Effective Health Care Program "*Comparative effectiveness of case management for adults with medical illness and complex care needs"* (published online January 11, 2011 www.effectivehealthcare.ahrq.gov)

HH- CMART Overview

- Population
- Reporting
- Elements

HH-CMART Data

- Population:
  - Medicaid Managed Care and Medicaid Fee-for service members participating in a Health Home. 'Participation' is defined as member accepted by the Health Home with initiation of either outreach or active care management services.
  - If a member's case is closed in the prior reporting period, the member is not in the file for the current reporting period.
- Specifications
  - Version 1.0 (dated December 14, 2012)
- File:
  - One Member-Level Care Management Data Submission File for each Health Home for the reporting period
- Submission Process:
  - Files submitted by Health Homes to DOH via secure system (HCS secure file transfer)

HH-CMART Data Elements

Grouped by related items

- Health Home and Reporting Period Information
- Member Information
- Initiation and Outreach
- Assessment, Care Planning and Stratification
- Interventions and Monitoring and Evaluation
- Care Management Services
- Functional Assessment Evaluation

Color Coded by data collection needs for each element by reporting period

- Green = changes each reporting period
- Red = Once in, remains the same always
- Orange = Needs to be reviewed for new information each report
- Blue = DOH will fill in

Data Elements

Health Home and Reporting Period Information

Element Name	Element Number	Format	Description
PlanID	#1	Text Field, 1111111	Managed Care Plan ID or '9999999' for FFS. Required for reporting
HHID	#2	Numeric	MMIS ID for the Health Home. Required for reporting
ReportDate	#3	Numeric Field Q/YYYY	Jan-March = 1/YYYY Apr-Jun = 2/YYYY July-Sep = 3/YYYY Oct-Dec = 4/YYYY

Data Elements

Member Information

Element Name	Element Number	Format	Description
Medicaid CIN	#4	Text Field, AA11111A	Required for reporting
Last Name	#5	Text Field	DOH will fill in the field using Medicaid data system.
First Name	#6	Text Field	DOH will fill in the field using Medicaid data system.
Date of Birth	#7	Numeric Field, MM/DD/YYYY	Member's date of birth

Data Elements (continued)

Initiation and Outreach

Element Name	Element Number	Format	Description
TriggerDate	#8	Numeric Field, MM/DD/YYYY	DOH will complete using 'Begin Date' of PTS
AbleContact	#10	Drop down Yes/No or Yes/No Hiatus Period	May change between reporting periods, but once completed, stays the same
ContactDate	#11	MM/DD/YYYY	Date of initial contact or interaction
OutreachEffort	#12	Numeric field	Count of contact attempts for the reporting period
OptOut	#16	Drop down Opted out/Did not opt out	Member's agreement or refusal to participate in Health Home

Data Elements (continued)

Assessment, Care Planning and Stratification

Element Name	Element Number	Format	Description
Program Type	#9	Drop down Program options	Primary focus of care management
Appropriate CM	#13	Drop down Yes/No	Member's appropriateness for care management
AssessedCM	#14	Drop down Yes/No	Member's needs assessed with care plan
AssessDate	#15	MM/DD/YYYY	Date the initial assessment and care plan are completed
Level of Intensity	#20	Drop down High/Medium/Low	Maximum level of intensity needed for the reporting period

Data Elements (continued)

Interventions and Monitoring and Evaluation

Element Name	Element Number	Format	Description
EngagedCM	#17	Drop down Yes/No	Member agrees to participate in care management
EngageCMDate	#18	Numeric Field, MM/DD/YYYY	DOH will complete with 'Begin Date' in PTS
ConsentDate	#19	Numeric Field, MM/DD/YYYY	DOH will complete with 'Consent Date' in PTS
Intervention Counts	#21, 22, 23	3 numeric fields Mail, phone, in-person	Counts of interventions for each mode for the reporting period

Data Elements (continued)

Interventions and Monitoring and Evaluation

Element Name	Element Number	Format	Description
CaseClosed	#24	Drop down Closed/Open	Care management segment ended
ClosureDate	#25	Numeric Field, MM/DD/YYYY	DOH will complete with 'End Date' in PTS
ReasonClosure	#26	Test Field	DOH will complete with 'Segment End Date Reason Code' in PTS
CaseReopened	#27	Drop down Reopened/ Not Reopened	Inactive segment is reactivated with member
DateReopened	#28	Numeric Field, MM/DD/YYYY	DOH will complete with 'Begin Date' following an 'End date' in PTS

Data Elements (continued)

Care Management Services

Element Name	Element Number	Format	Description
PlanUpdate	#29	Text Field	Indicates care plan was reviewed, updated or modified
CareManage	#30	Numeric Field	Assess needs, monitor progress , modify or update the care plan or goals
HealthPromote	#31	Numeric Field	Assist in scheduling and keeping appointments, advocate and arrange for needed services
TransitionCare	#32	Numeric Field	Evaluate care needs at transitions, arrange safe transition plan, update care team
MemberSupport	#33	Numeric Field	Self –management, family meetings, peer supports, educate member rights
CommSocial	#34	Numeric Field	Collaborate with CBO for services or needs.

Data Elements (continued)

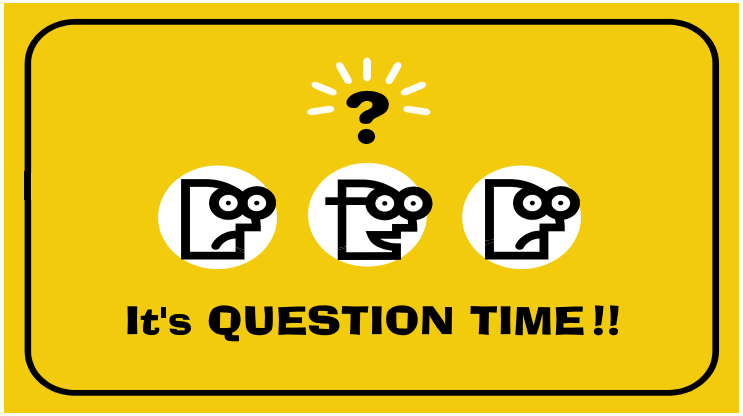
Functional Assessment Evaluation

Element Name	Element Number	Format	Description
DateFACTHH	#35	MM/DD/YYYY	Date the assessment was completed.
ReasonFACTHH	#36	INITIAL ANNUAL DISCHARGE	The reason this assessment was conducted.
PWB	#37	Numeric	Physical Well Being Subscale Score
SWB	#38	Numeric	Social/Family Well Being Subscale Score
EWB	#39	Numeric	Emotional Well Being Subscale Score
FWB	#40	Numeric	Functional Well Being Subscale Score
FACTGP	#41	Numeric	FACT-GP Total Score

Data Elements (continued)

Functional Assessment Evaluation - continued

Element Name	Element Number	Format	Description
HH1 – HH6	#42-#47	Numeric	Health home specific questions
HHSubscale	#48	Numeric	HH specific questions total score
HHFACTGP	#49	Numeric	FACT-GP Total + HH specific Total (#41 + #48 = #49)



Questions??

Reminder - Questions should be submitted using the questions section.

HH-CMART
Tool Demonstration

Lisa Balistreri

IPRO

HH-CMART Overview

- **Tool developed with Microsoft Access**
- **Choice of:**
  - Manual data entry directly into the tool or
  - Importing data from an external Excel file
- **Eight screens:**

  1) Main Menu Plan Registration Screen
  2) Manual Data Entry - Main Form
  3) Data Entry / Data Editing
  4) Import Data Menu
  5) Data Entry Errors - Report Generation
  6) Frequencies - Report Generation
  7) Member-Level Data - Report Generation
  8) Export Data

Screen 1: Main Menu Plan Registration Screen

Main Menu - HH Care Management 2012

Home Add-Ins

Main Menu v1.0

Health Homes Care Management Assessment Reporting Tool

Exit

Health Home 1

Enter the # for your Health Home and press ENTER: 1111111

Print Submission Cover Sheet

Enter Health Home's Registration Information:

Enter the name and address information of the contact person for your health home's submission.

First Name: Lisa
Last Name: Balistreri
Address1: 1979 Marcus Avenue
Address2: Grey Area
City: Lake Success
State: NY
Zip Code: 11042
Email Address: ebalistreri@ipro.org
Work Phone: (516) 555-1212 Ext. 357
GeneralFax: (516) 555-1234

Data Entry

Manual Data Entry

Import Data

Reports: Print / Preview

Data Entry Errors

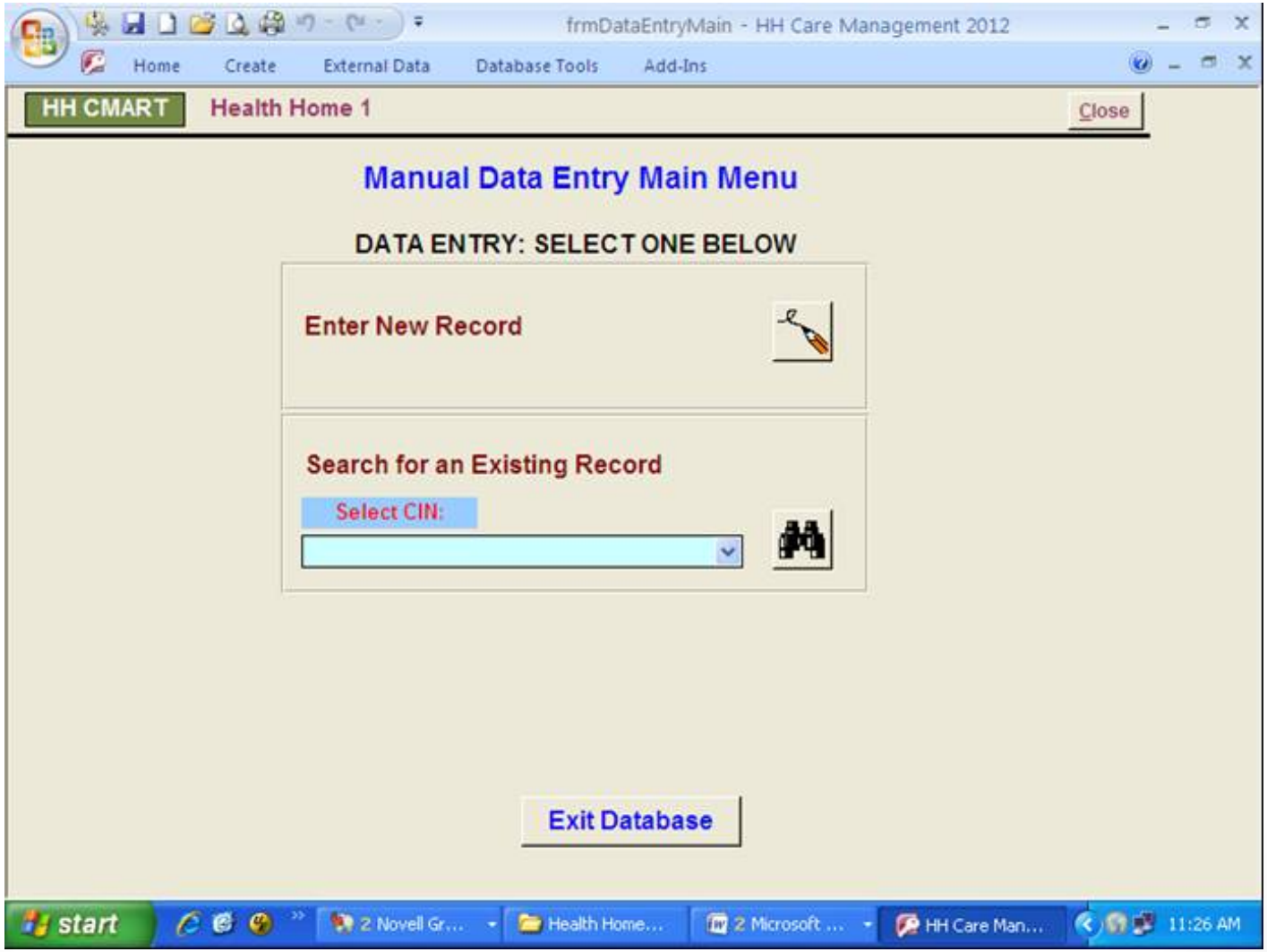
Frequencies

Member-Level Data

Export Data

start Novell Group... Health Home... HH CMART M... HH Care Man... 10:44 AM

Screen 2: Manual Data Entry - Main Form



Screen 3: Data Entry / Data Editing

frmDataEntry - HH Care Management 2012

Home | Create | External Data | Database Tools | Add-Ins

HH CMART | Health Home 1

1	Plan ID#	1050178
2	Health Home ID#	12345
3	Report Date Q/YYYY	4/2012
4	Medicaid Client Identification Number	AA99999A
5	Member Last Name	
6	Member First Name	
7	Member Date of Birth	5/15/1997
8	Trigger Date	
9	Program Type	HH Chronic Adult
10	Able to Contact Flag	Yes
11	Contact Date	2/2/2012
12	Outreach Effort Count	5
13	Determined to be Appropriate for HH	Yes
14	Assessed	Yes
15	Initial Assessment Completed Date	2/16/2012
16	OptOut Flag	Did Not Opt Out
17	Engaged CM	Yes
18	Engaged in CM Date	
19	Consent Date	
20	Level of Intensity	Medium
21	Mail Interventions Count	3
22	Phone Interventions Count	6
23	In-Person Interventions Count	1
24	CaseClosed	Closed
25	ClosureDate	
26	Reason for Closure	

Go to Main Menu

Go to Previous Screen

Add a New Record

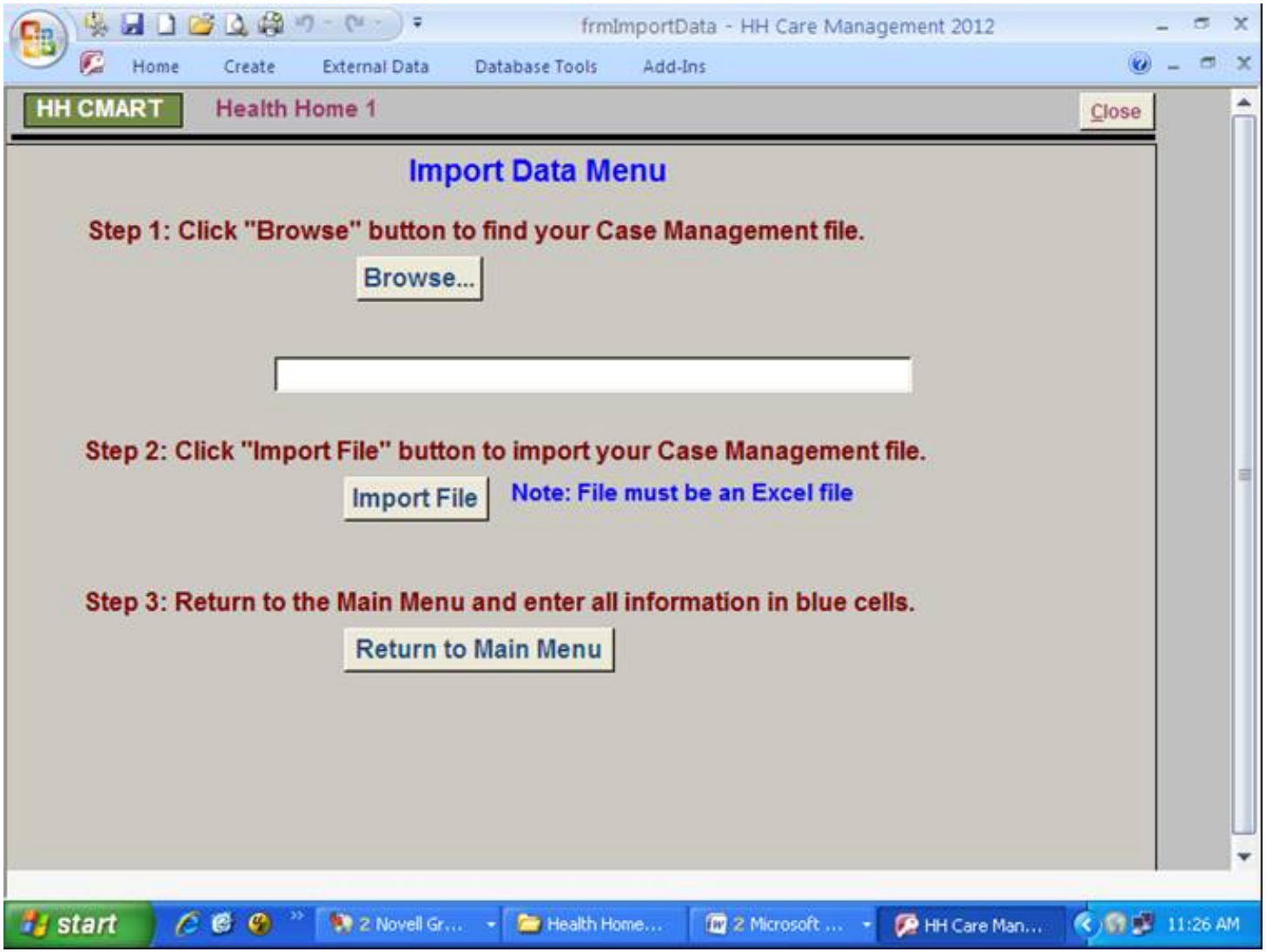
Print This Record

start | Novell GroupWise - M... | Health Homes CMART | HH CMART MANUAL ... | HH Care Managemen... | 10:36 AM

Screen 3: Data Entry / Data Editing Notes

- The Health Home ID number is always autopopulated.
- The CIN and Plan ID # are required data elements in order to save data entry for the record.
- The data entry form includes drop down menus with response options to select.
- All dates have prepopulated slashes to separate months, days, and years, and the user will enter MMDDYYYY.
- This screen contains edit checks to minimize data entry errors. If an invalid entry occurs, a warning message will alert the user.
- Some items are permanently grayed out because they will be filled in by the state and do not have to be entered by the user.
- To account for unknown data, use the missing flags specified in the manual.

Screen 4: Import Data Menu



Screen 4: Import Data Menu Notes

- The 1st step is to click on the "Browse" button to find your Care Management Excel file. This Excel file must adhere to the field names listed in the User's manual.
- Once you select the file, the file name will appear in the box between step 1 and step 2.
- The 2nd step is to click the "Import File" button to import your Excel file. If successful, a message will appear that notifies you that the import worked.
- The 3rd step is to click on the button "Return to the Main Menu" and make sure all information in blue cells has been entered.
- If you use the import feature more than once, any member-level data that had been imported previously will be deleted prior to importing.

Import Template

Import Template.xls [Compatibility Mode] - Microsoft Excel

ReportDate	CIN	DOB	ProgramType	AbleContact	ContactDate	OutreachEffort	AppropriateCM	AssessedCM	AssessDate	C
4/2012	AB12345C	1/18/1978	HH Behavioral Health	Yes	3/13/2012	11	Yes	Yes	3/22/2012	D
4/2012	XB78945W	6/3/1954	HH Chronic Adult	No Hiatus Period		12	Not Able to Contact	Not Able to Contact		

Screen 5: Data Entry Errors - Report Generation

Errors - HH Care Management 2012

Home | Create | External Data | Database Tools | Add-Ins

HH CMART | Health Home 1 | Close

To Preview or Print, Click on a Button: Preview Print

	Summary of Number of Errors per Edit Check	
	All Error Reports	
Duplicate CINs	Each member should appear only once in the file	
Missing Data	Required fields Items 1, 2, and 4: PlanID, HHID, CIN	
Inconsistent Responses	If AbleContact (#10) = Yes, ContactDate (#11) should be entered If AbleContact (#10) = No, ContactDate (#11) should be blank	
	If AssessedCM (#14) = Yes, AssessDate (#15) should be entered If AssessedCM (#14) = No, AssessDate (#15) should be blank	
	OptOut (#16) and EngagedCM (#17) have inconsistent responses	
	If EngagedCM (#17) = No, all remaining items should be blank	
Format	CIN numbers (#4) are not Valid	
Response Options: Values do not match response options of project	ProgramType (#9)	
	AbleContact (#10)	
	AppropriateCM (#13)	
	AssessedCM (#14)	
	OptOut (#16)	
	EngagedCM (#17)	
	Intensity (#20)	

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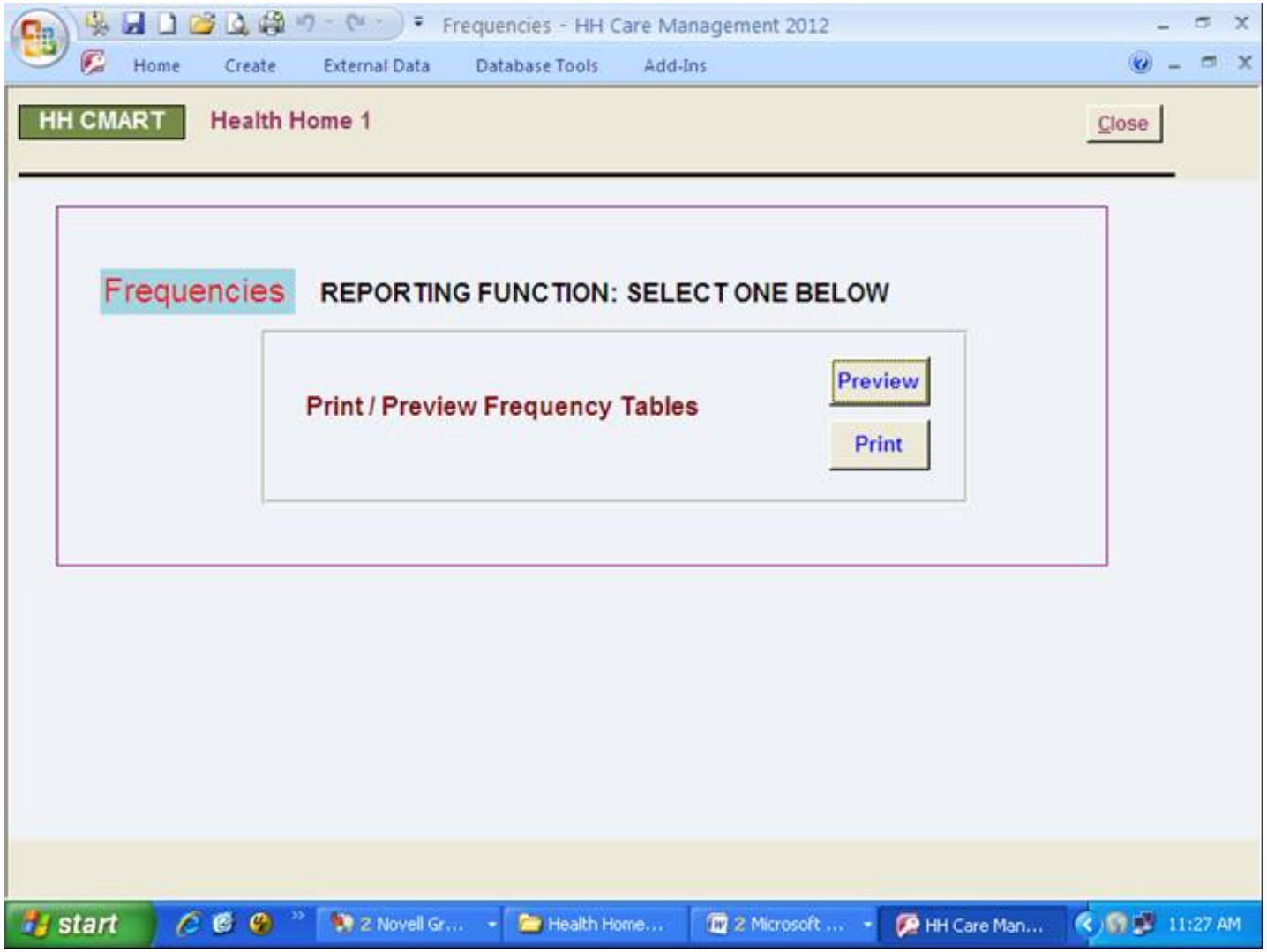
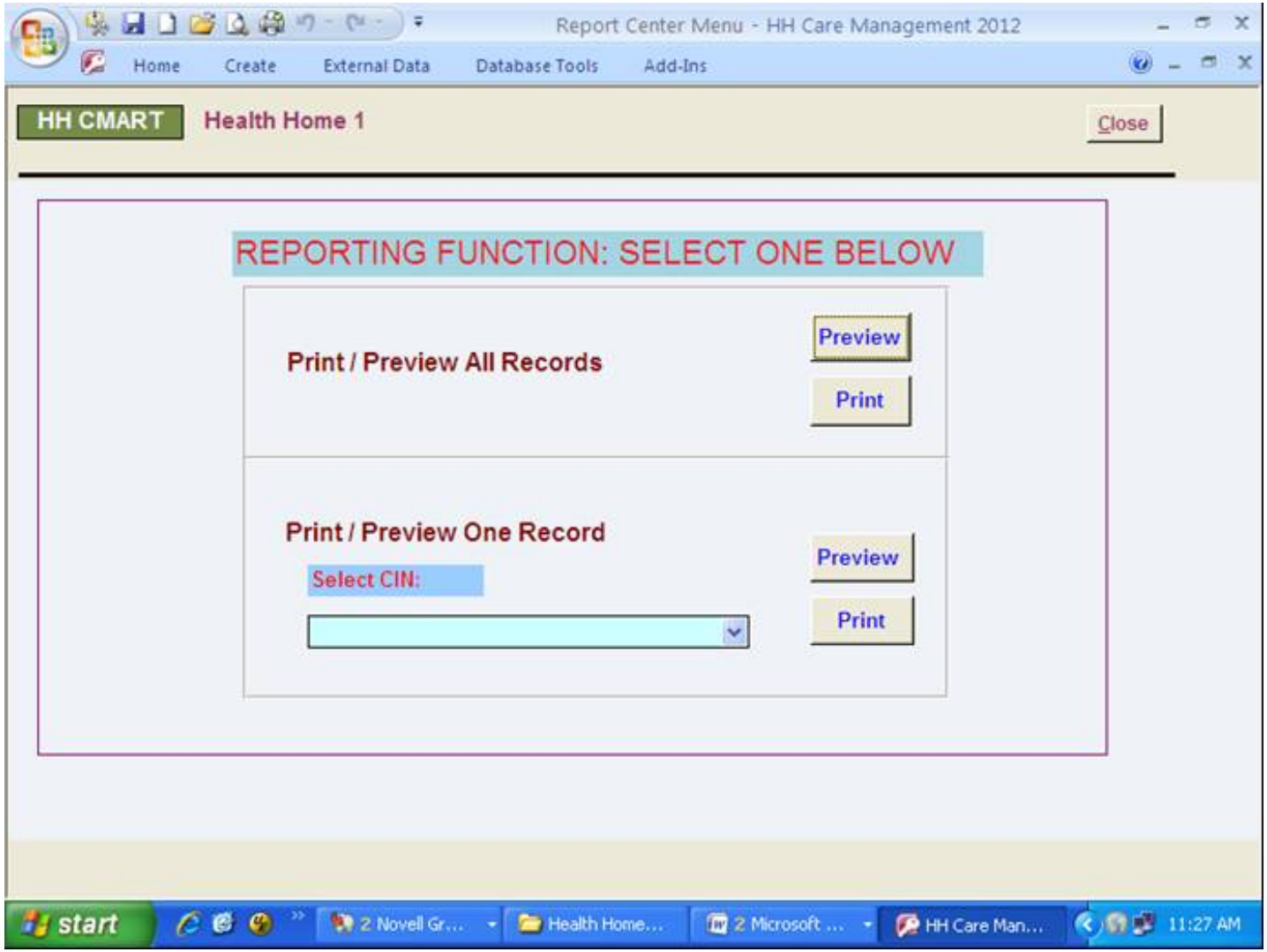
Screen 5: Data Entry Errors Notes

- The tool contains 16 edit checks in the Data Entry Errors feature, which should be used to minimize errors in the data.
- The user can preview or print each report.
- The first report on the screen is a summary of the count of errors per edit check. Each count should be 0.
- The second button “All Error Reports” will print or preview all 16 reports displaying erroneous data.
- Below are buttons corresponding to each individual report.
- If you find errors, return to the data to correct the errors.

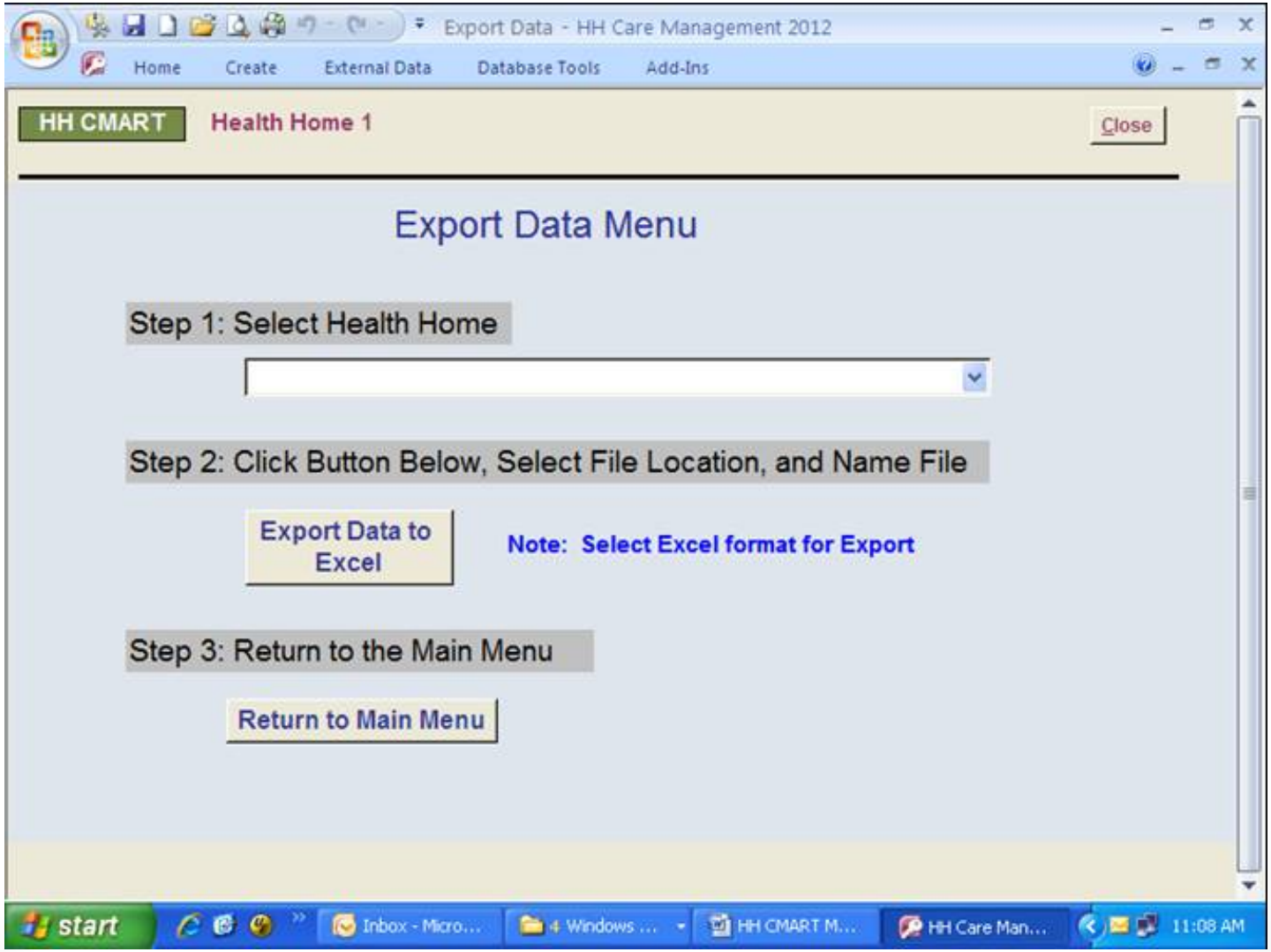
Screen 6: Frequencies – Report Generation



Screen 7: Member-Level Data – Report Generation



Screen 8: Export Data Menu



Screen 8: Export Data Menu Notes

- The 1st step is to select a health home from the drop down box.
- The second step is to click on the button “Export Data to Excel”. A pop up message will appear asking you to choose between 2 options.
- Click YES if you want to automatically export the file into the folder “My Documents” in your C drive with a predefined filename, beginning with the specific Health Home ID you chose, and followed by “HH CMART”.
- Click NO if you want to choose a specific folder and name the exported file yourself.

Logistics

- For any entity using the HH CMART for 2 or more health homes, make a copy of the HH CMART Tool to use for each of the health homes separately prior to entering any data. You should not use the same HH CMART Tool for entering more than one health home's data.
- Since the database was developed with Microsoft Access®, your computer should have Microsoft Access®, version 2000 or later to use this tool.
- To submit the file, a secure file transfer must be used as the file contains member level data.
- For each quarterly submission, use a new version of the CMART.

Any questions about using the tool?

Reminder - Questions should be submitted using the questions section.

Reporting Periods and File Submission Dates

Reporting Period	ReportDate Element	HH-CMART File Submission Date
Calendar Year 2012 (Jan-Dec 2012)	4/2012	Monday, May 13, 2013
First Two Quarters 2013 (Jan- June 2013)	2/2013	Monday, July 8, 2013
Third Quarter 2013 (July-Sep 2013)	3/2013	Monday, October 14, 2013
Fourth Quarter 2013 (Oct-Dec 2013)	4/2013	Monday, January 13, 2014

Reporting Process

Reporting Process

1. Health Homes will collect data from care management providers for the reporting period and import or enter data into a copy of the HH-CMART.
2. Health Homes will review the reports in the tool, correct errors as needed.
3. The completed tool should be saved as the quarter's file (ie. 4Q2012.mdb) and the data can be exported out to be used as the template for importing the next quarter.
4. Completed files are sent through the Health Commerce System (HCS) using the 'Secure File Transfer Application' from the Applications tab. Name the file with the Health Home name and upload the file (ie. CapitalHealth.mdb). Send the file to 'Laura Morris' .

Feedback reports

- Initial Data Questions
  - Issues will be directed to Health Homes for further clarification of elements or care management processes.
  - Files may need some correction and resubmission (using same process as original).
- Data Completeness Reports
  - Once files are in and processed, data completeness reports will be shared showing summary of responses in elements with information about the overall information received from Health Homes.
- Process Measure Reports
  - Information about intake and engagement rates, length of time to engage, modes of interventions and types of care management services.
- Cost and Utilization Reports
  - Inpatient and ED utilization post engagement in Health Homes.

Care Management Analytic Framework

CM Process

OBJECTIVE: Understand the Mechanics of Care Management

Utilization & Cost

OBJECTIVE: Examine the Impact of Care Management on Individual Utilization and Cost

Individual Success

OBJECTIVE: Determine Factors Related to Individual Success in Care Management

Program Effectiveness

OBJECTIVE: Determine Factors Related to Program Effectiveness in Care Management

Trends Over Time

OBJECTIVE: Track Changes Within All Objectives Over Time.

How do you get help if needed?

- Email the Health Home Team at
  HH2011@health.state.ny.us
  with the Subject : HH CMART
- Weekly calls on Wednesdays from
  10 to 11 a.m. starting on February 20, 2013
- Slides from today will be on the web site for Health Homes
  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/meetings_webinars.htm