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

Medicaid and Dual Population 5 million

- High Needs/High Cost Duals/Non-Duals
  - Non Long Term Care
    - Mainstream HMO
      - BH SNP
      - AIDS SNP
    - Long Term Care
      - Mainstream HMO
        - LTC SNP (former MLTCP)
        - Possible Other Model
  - Partial Benefit
    - Mainstream HMO
    - Possible FFS or other TPA
  - Childless Adults
    - Sub population
      - Mainstream HMO

- Children/Families
  - PCMH
  - ACO
  - HH

- Risk Management Approach
  - Care Management Approach
Evaluation of Care Management – Across the Medicaid Program

Episodic Model

Programs
- Mainstream Plans

Process
- Enrollment
- Engagement
- Care Coordination

Outcomes
- Short term outcomes
- Health Literacy/Self Management
- IP and ER Utilization

Continuous Model

Programs
- LTC/MLTC
- HIV SNP
- Heath Home

Process
- Enrollment
- Engagement
- Care Coordination

Outcomes
- Care Management
- Intervention Activities
- Functional Status
- Health Literacy/Self Management
- IP and/or NH Utilization
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

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Element Number</th>
<th>Format</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PlanID</td>
<td>#1</td>
<td>Text Field, 1111111</td>
<td>Managed Care Plan ID or ‘8888888’ for FFS. Required for reporting</td>
</tr>
<tr>
<td>HHID</td>
<td>#2</td>
<td>Numeric</td>
<td>MMIS ID for the Health Home. Required for reporting</td>
</tr>
</tbody>
</table>
| 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

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Element Number</th>
<th>Format</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid CIN</td>
<td>#4</td>
<td>Text Field, AA11111A</td>
<td>Required for reporting</td>
</tr>
<tr>
<td>Last Name</td>
<td>#5</td>
<td>Text Field</td>
<td>DOH will fill in the field using Medicaid data system.</td>
</tr>
<tr>
<td>First Name</td>
<td>#6</td>
<td>Text Field</td>
<td>DOH will fill in the field using Medicaid data system.</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>#7</td>
<td>Numeric Field, MM/DD/YYYY</td>
<td>Member’s date of birth</td>
</tr>
</tbody>
</table>
## Data Elements (continued)

### Initiation and Outreach

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

Assessment, Care Planning and Stratification

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Element Number</th>
<th>Format</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Type</td>
<td>#9</td>
<td>Drop down Program options</td>
<td>Primary focus of care management</td>
</tr>
<tr>
<td>Appropriate CM</td>
<td>#13</td>
<td>Drop down Yes/No</td>
<td>Member’s appropriateness for care management</td>
</tr>
<tr>
<td>Assessed CM</td>
<td>#14</td>
<td>Drop down Yes/No</td>
<td>Member’s needs assessed with care plan</td>
</tr>
<tr>
<td>Assess Date</td>
<td>#15</td>
<td>MM/DD/YYYY</td>
<td>Date the initial assessment and care plan are completed</td>
</tr>
<tr>
<td>Level of Intensity</td>
<td>#20</td>
<td>Drop down High/Medium/Low</td>
<td>Maximum level of intensity needed for the reporting period</td>
</tr>
</tbody>
</table>
## Data Elements (continued)

### Interventions and Monitoring and Evaluation

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Element Number</th>
<th>Format</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EngagedCM</td>
<td>#17</td>
<td>Drop down Yes/No</td>
<td>Member agrees to participate in care management</td>
</tr>
<tr>
<td>EngageCMDate</td>
<td>#18</td>
<td>Numeric Field, MM/DD/YYYY</td>
<td>DOH will complete with ‘Begin Date’ in PTS</td>
</tr>
<tr>
<td>ConsentDate</td>
<td>#19</td>
<td>Numeric Field, MM/DD/YYYY</td>
<td>DOH will complete with ‘Consent Date’ in PTS</td>
</tr>
<tr>
<td>Intervention Counts</td>
<td>#21, 22, 23</td>
<td>3 numeric fields Mail, phone, in-person</td>
<td>Counts of interventions for each mode for the reporting period</td>
</tr>
</tbody>
</table>
## Data Elements (continued)

### Interventions and Monitoring and Evaluation

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Element Number</th>
<th>Format</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CaseClosed</td>
<td>#24</td>
<td>Drop down Closed/Open</td>
<td>Care management segment ended</td>
</tr>
<tr>
<td>ClosureDate</td>
<td>#25</td>
<td>Numeric Field, MM/DD/YYYY</td>
<td>DOH will complete with ‘End Date’ in PTS</td>
</tr>
<tr>
<td>ReasonClosure</td>
<td>#26</td>
<td>Test Field</td>
<td>DOH will complete with ‘Segment End Date Reason Code’ in PTS</td>
</tr>
<tr>
<td>CaseReopened</td>
<td>#27</td>
<td>Drop down Reopened/ Not Reopened</td>
<td>Inactive segment is reactivated with member</td>
</tr>
<tr>
<td>DateReopened</td>
<td>#28</td>
<td>Numeric Field, MM/DD/YYYY</td>
<td>DOH will complete with ‘Begin Date’ following an ‘End date’ in PTS</td>
</tr>
</tbody>
</table>
## Data Elements (continued)

### Care Management Services

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

### Functional Assessment Evaluation

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Element Number</th>
<th>Format</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DateFACTHH</td>
<td>#35</td>
<td>MM/DD/YYYY</td>
<td>Date the assessment was completed.</td>
</tr>
<tr>
<td>ReasonFACTHH</td>
<td>#36</td>
<td>INITIAL, ANNUAL, DISCHARGE</td>
<td>The reason this assessment was conducted.</td>
</tr>
<tr>
<td>PWB</td>
<td>#37</td>
<td>Numeric</td>
<td>Physical Well Being Subscale Score</td>
</tr>
<tr>
<td>SWB</td>
<td>#38</td>
<td>Numeric</td>
<td>Social/Family Well Being Subscale Score</td>
</tr>
<tr>
<td>EWB</td>
<td>#39</td>
<td>Numeric</td>
<td>Emotional Well Being Subscale Score</td>
</tr>
<tr>
<td>FWB</td>
<td>#40</td>
<td>Numeric</td>
<td>Functional Well Being Subscale Score</td>
</tr>
<tr>
<td>FACTGP</td>
<td>#41</td>
<td>Numeric</td>
<td>FACT-GP Total Score</td>
</tr>
</tbody>
</table>
Data Elements (continued)
Functional Assessment Evaluation - continued

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Element Number</th>
<th>Format</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH1 – HH6</td>
<td>#42-#47</td>
<td>Numeric</td>
<td>Health home specific questions</td>
</tr>
<tr>
<td>HHSubscale</td>
<td>#48</td>
<td>Numeric</td>
<td>HH specific questions total score</td>
</tr>
<tr>
<td>HHFACTGP</td>
<td>#49</td>
<td>Numeric</td>
<td>FACT-GP Total + HH specific Total (#41 + #48 = #49)</td>
</tr>
</tbody>
</table>
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
Screen 2: Manual Data Entry - Main Form
Screen 3: Data Entry / Data Editing
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

Step 1: Click "Browse" button to find your Case Management file.

Browse...

Step 2: Click "Import File" button to import your Case Management file.

Import File  Note: File must be an Excel file

Step 3: Return to the Main Menu and enter all information in blue cells.

Return to Main 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.
<table>
<thead>
<tr>
<th>CIN</th>
<th>DOB</th>
<th>Program Type</th>
<th>Able Contact</th>
<th>Contact Date</th>
<th>Outreach Effort</th>
<th>Appropriate CM</th>
<th>Assessed CM</th>
<th>Assess Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB12345C</td>
<td>1/18/1978</td>
<td>HH Behavioral Health</td>
<td>Yes</td>
<td>3/13/2012</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>3/22/2012</td>
</tr>
<tr>
<td>XB78945W</td>
<td>6/3/1954</td>
<td>HH Chronic Adult</td>
<td>No Hiatus Period</td>
<td></td>
<td>No</td>
<td>Not Able to Contact</td>
<td>Not Able to Contact</td>
<td>3/22/2012</td>
</tr>
</tbody>
</table>
Screen 5: Data Entry Errors - Report Generation

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duplicate CINs</td>
<td>Each member should appear only once in the file.</td>
</tr>
<tr>
<td>Missing Data</td>
<td>Required fields Items 1, 2, and 4: PlanID, HHID, CIN.</td>
</tr>
<tr>
<td>Inconsistent Responses</td>
<td>- If AbleContact (#10) = Yes, ContactDate (#11) should be entered.</td>
</tr>
<tr>
<td></td>
<td>- If AbleContact (#10) = No, ContactDate (#11) should be blank.</td>
</tr>
<tr>
<td></td>
<td>- If AssessedCM (#14) = Yes, AssessDate (#15) should be entered.</td>
</tr>
<tr>
<td></td>
<td>- If AssessedCM (#14) = No, AssessDate (#15) should be blank.</td>
</tr>
<tr>
<td></td>
<td>- OptOut (#16) and EngagedCM (#17) have inconsistent responses.</td>
</tr>
<tr>
<td></td>
<td>- If EngagedCM (#17) = No, all remaining items should be blank.</td>
</tr>
<tr>
<td>Format</td>
<td>CIN numbers (#4) are not Valid.</td>
</tr>
<tr>
<td>Response Options:</td>
<td>Values do not match response options of project.</td>
</tr>
<tr>
<td>ProgramType (#9)</td>
<td></td>
</tr>
<tr>
<td>AbleContact (#10)</td>
<td></td>
</tr>
<tr>
<td>AppropriateCM (#13)</td>
<td></td>
</tr>
<tr>
<td>AssessedCM (#14)</td>
<td></td>
</tr>
<tr>
<td>OptOut (#16)</td>
<td></td>
</tr>
<tr>
<td>EngagedCM (#17)</td>
<td></td>
</tr>
<tr>
<td>Intensity (#20)</td>
<td></td>
</tr>
</tbody>
</table>
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

REPORTING FUNCTION: SELECT ONE BELOW

Print / Preview Frequency Tables

Preview
Print
Screen 7: Member-Level Data – Report Generation
Screen 8: Export Data Menu

Step 1: Select Health Home

Step 2: Click Button Below, Select File Location, and Name File

Export Data to Excel

Note: Select Excel format for Export

Step 3: Return to the Main Menu

Return to Main 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

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Report Date Element</th>
<th>HH-CMART File Submission Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year 2012 (Jan-Dec 2012)</td>
<td>4/2012</td>
<td>Monday, May 13, 2013</td>
</tr>
<tr>
<td>First Two Quarters 2013 (Jan-June 2013)</td>
<td>2/2013</td>
<td>Monday, August 5, 2013</td>
</tr>
<tr>
<td>Third Quarter 2013 (July-Sep 2013)</td>
<td>3/2013</td>
<td>Monday, November 4, 2013</td>
</tr>
</tbody>
</table>
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.
OBJECTIVE: Understand the Mechanics of Care Management

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

OBJECTIVE: Determine Factors Related to Individual Success in Care Management

OBJECTIVE: Determine Factors Related to Program Effectiveness in Care Management

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