

**New York State DOH  
Health Home Care Management  
Reporting Tool (HH-CMART)  
Bi Weekly Support Calls – Session #14  
July 10, 2013**



# AGENDA

- ▶ Next Submission Data Requirement
- ▶ Field/Element Review
- ▶ FACT GP & HH Functional Assessment
- ▶ Resources
- ▶ Questions and Answers

# 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
- ▶ We are working on a Question and Answer document that will be posted on the Health Home website under the HH-CMART section

# Next Submission Data Requirement

## What to Submit

- ▶ Data for ALL elements in the HH-CMART tool
- ▶ This will include all data for the first two quarters of 2013 (January – June 2013)
- ▶ The report date field for this report is 2/2013
- ▶ All dates in HH CMART elements (#11, 15, 35) are the actual dates of service

## When to Submit

- ▶ Monday, August 5, 2013

## How to Submit

- ▶ Lead Health Homes will send data on all members in the HH CMART tool using the HCS Secure File Transfer application to 'Laura Morris'

# Billing and the Health Home Care Management Assessment Reporting Tool (HH-CMART)

- ▶ It is important to remember the HH-CMART tool is for data submission purposes only and is not to be intended to be used for billing purposes.
- ▶ There are different parameters for billing for a Health Home service versus collection information within the HH-CMART tool.
  - For the HH-CMART during Outreach: All attempts are counted. Each attempt should be a legitimate attempt to locate the individual. Attempts should be varied.
  - For billing a Health Home service during Outreach: Attempts do not have to be completed in order to bill. As long as each attempt is a successive increase in vigilance and effort to contact the potential HH member and it fits the criteria for a billable Health Home service, it can be billed.

# FACT GP/HH Functional Assessment

- ▶ The Health Home FACT-GP / HH Functional Assessments should be collected to assess every member upon engagement, annually and at discharge.
  - DOH recommends the scores should be tabulated using the FACT-GP and Health Home Questionnaire Scoring Sheet.
  - The scoring sheet scores are entered into the HH CMART tool (using whatever agreed upon method is between the Lead HH & CM Program)
- ▶ **Data Vs. Billing** - The HH-CMART tool is for care management data submission purposes only and is *not* to be intended to be used for billing purposes.
- ▶ **HH CMART completion & Member Tracking System** - Data must be sent in on the Member Tracking System to the Portal, in order for the HH-CMART data to be complete.
  - See elements represented as blue font in Feb. 13, 2013 webinar and descriptions in Technical Specifications document.

# Element/Field Review

- ▶ 13 – **AppropriateCM**: Indicates if the member met criteria for participation in the Health Home.
  - Valid Response Values: Yes; No; Not able to contact.
  - This is determined by doing a short or comprehensive assessment with a review of data
  - Member must meet one of criteria for Health Home ; referenced in Provider Manual Section 1.2
  
- ▶ 14 – **AssessedCM**: Indicates if the member received an initial comprehensive assessment for needs with an initial care plan. An initial review of a priority problem is not a comprehensive assessment.
  - A comprehensive assessment includes: physical/functional, psychosocial, environmental/residential, care-giver capability, medication lists and/or compliance).
  - This does not include the HH FACT GP or HH Functional Assessments which are done initially upon engagement.
  - Valid Response Values: Yes; No; Not able to contact

# Element/Field Review

\*These elements are only filled out for those members engaged in CM

▶ 15 – **AssessDate**: Date when the initial comprehensive assessment with care plan is completed. If the member is not assessed or not able to be contacted, the AssessDate will be blank.

◦Valid Response Values: The date on or after trigger date; 09/09/9999 if member is missing; Leave cell blank if not assessed

◦**\*For converting TCM programs Health Home members only\*** - If the comprehensive assessment has recently been completed, the date of that assessment can be used, provided it is not greater than 3 months prior to engagement into a HH and the most recent care plan. That is the date that is placed in element #15

◦If the comprehensive assessment was done more than 3 months prior to the engagement in HH CM services, then a review and update of that assessment should be completed and that date is placed in element # 15 – AssessDate

# Element/Field Review

- ▶ 16 – **OptOut**: Indicates if member/legal representative/family refused to participate in the Health Home.
  - Valid Response Values: Opted out; Did not opt out; Not appropriate for HH (For members who do not meet eligibility criteria for the Health Homes program)
  - Use 'Not appropriate for HH response for those not able to be contacted
- ▶ 17- **EngagedCM**: Indicates if the member agreed to participate in the Health Home.
  - Engagement is the agreement of the member/ legal rep/ family and care manager that there is a need for care management and the member is willing to participate.
  - Valid Response Values: Yes; No
- ▶ 18 – **EngagedCMDate**: This is the date when the member agrees to participate in the Health Home.
  - DOH will populate this field using Patient Tracking System 'Begin Date'.
  - If the member does not engage in CM (EngagedCM = 'NO'), this element through #34 will be blank.

# Element/Field Review

- ▶ 19 – **ConsentDate**: The date that member or member’s legal representative signed consent to share member’s information
  - DOH will populate this field using the Patient Tracking System ‘Consent Date’.
- ▶ 20 – **Intensity**: The maximum level of intensity of care management for the member during the reporting period.
  - Valid Response Values:
    - High** – CM staff intervention needed **more than weekly**
    - Medium** – CM staff intervention needed **weekly to every other week**
    - Low** – CM staff intervention needed **less than every other week**
    - Missing**
    - Blank Cell** – If member is not engaged
  - Interventions are interacting with member/legal representative/family and health care providers and community based programs to arrange or monitor services and progress.
  - *Does not include* interventions conducted by providers, other organizations, or health plans
  - If frequency of intervention varies during reporting period, the maximum level of intensity should be reported
    - Example: First two months intensity is LOW but remainder of reporting period the intensity is HIGH, element should be reported as HIGH

# Element/Field Review

## ▶ **Defining Interventions (Elements 21, 22 and 23)**

- Interventions conducted as part of outreach (prior to engagement in care management) should be excluded. This will be reported in element # 12.
- Interventions should be specific to the individual member's care or care management needs.
- Include interventions conducted by Health Home care management staff and support staff or care management contracted providers
- Do not include interventions conducted by health care providers, other organizations, or health plans
- Only interventions that were conducted should be counted, attempts should not be counted ( uncompleted attempts are counted in Outreach section)
- Counts of interventions are not cumulative from start of care management – when a new reporting period begins a new count begins
- Each separate intervention should be counted once in the appropriate category of mode
- Include interventions involving the member/ family/ legal representative, health care provider, or other organizations involved in the care plan

# Element/Field Review

- ▶ Elements **21**, **22**, and **23** capture counts of intervention conducted for or with the member during the reporting period. Each intervention should be assigned to one of the three following categories
- ▶ 21 – **CountMail**: Individualized letters or emails sent during reporting period. Mailings or email message or ONLY pre-written materials not specific to individual should not be included
- ▶ 22 – **CountPhone**: Count phone call interactions made during reporting period.
  - Both incoming and outgoing phone call interactions count
  - Automated voice messages, attempted phone calls, or leaving voice mail messages should not be counted
- ▶ 23 – **CountPerson**: Count each in-person interaction during the reporting period

# FACT- GP & HH Functional Assessment

- ▶ **The Health Home FACT-GP / HH Functional Assessments should be collected to assess every member upon engagement, annually and at discharge.**
  - It is recommended that the scores be tabulated using the FACT GP and Health Home Questionnaire Scoring Sheet
  - The scores from the scoring sheet scores are entered into the HH CMART tool or whatever agreed upon method between the Lead HH & CM Program
  - If the FACT-GP+HH Scoring Sheet is not completed for the reporting period for a member, the fields (35-49) will be left blank.
- ▶ 35 – DateFactHH: Date that the FACT-GP+HH Functional assessments were completed
- ▶ 36 – ReasonFACTHH: Indicates the reason the FACT-GP+HH was completed
  - Response Value of either Initial, Annual, or Discharge

# FACT- GP & HH Functional Assessment

- ▶ Each section of FACT GP questions result in a subscore
- ▶ Subscores are added to get the total score
- ▶ 37 – PWB: Physical Well Being subscore
- ▶ 38 – SWB : Social Well Being subscore
- ▶ 39 – EWB : Emotional Well Being subscore
- ▶ 40 – FWB : Functional Well Being subscore
- ▶ 41 – FACTGP : FACT- GP Total Score

# FACT- GP & HH Functional Assessment

- ▶ HH Functional Assessment scoring- each answer is scored, and a score is recorded for each question
- ▶ 42 – HH1: Health Home question # 1 Score
- ▶ 43 – HH2: Health Home question # 2 Score
- ▶ 44 – HH3: Health Home question # 3 Score
- ▶ 45 – HH4: Health Home question # 4 Score
- ▶ 46 – HH5: Health Home question # 5 Score
- ▶ 47 – HH6: Health Home question # 6 Score

# FACT-GP & HH Functional Assessment

- ▶ 48 – HHSubscale: Scoring sheet adds the HH Functional Assessment scores together to = HHSubscale Score
- ▶ 49 – HHFACT GP: Scoring sheet adds the Health Home FACT-GP Total Score + HH Subscale Score = Total FACT GP / HH Functional Assessment Score

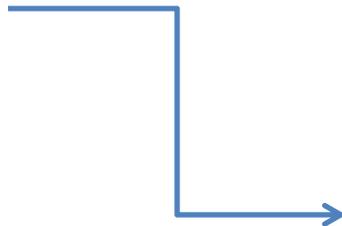
# FACT-GP & HH Functional Assessment

## Element 47- HH6

### ▶ Homelessness scoring on the FACT GP/HH Functional

**Assessment** – Homelessness is scored on a Yes and No basis. A higher score represents better health, a score of “0” indicates that the member was homeless in the last 7 days; if they are housed, the score is “8”.

- **8 points for NO**
- **0 points for YES**



Home Health Functional Questionnaire					
Subscale			Response		Score
Health Home	HH	HH1 dressing	0		4
		HH2 eating	4		0
		HH3 interpretation need	4		0
		HH4 people to help me	4		4
		HH5 go to doctor or clinic	4		4
		HH6 homeless	0		0
For HH 6: Place number in "Response" column appropriate to answer		YES = 0	NO = 8		
				HH Subscale Score:	12

### ▶ Only a value of 0 or 8 should be entered.

- DOH will contact you if any value other than 0 or 8 is entered in element 47 (HH6)

# FACT GP/HH Functional Assessments Resources

▶ The FACT GP and Health Home Functional Assessment Questionnaire are on the Health Home website under the Assessments and Quality Metrics HH-CMART menu at this location:

[http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/assessment\\_quality\\_measures/index.htm](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/index.htm)

▶ The FACT GP Scoring and Health Home Questionnaire Scoring Sheet is located on the same page, or directly at this location:

[http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/assessment\\_quality\\_measures/docs/fact-gp\\_scoring\\_sheet\\_hh\\_locked\\_mod.xls](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/fact-gp_scoring_sheet_hh_locked_mod.xls)

# Question and Answers Since Last Webinar

▶ **Q: For the PlanID (Field #1), if the plan status changes for a client during the reporting period? Do you want the PlanID from enrollment or the most up-to-date PlanID?**

**A:** If plan status changes for a HealthHome Member during the reporting period, provide the most up-to-date Plan ID.

▶ **Q: How should we answer Field 1 –PlanID if we're unable to find a particular PlanID in the HH CMART tool drop down menu?**

**A:** If a PlanID is not in the drop down menu it should be manually entered into the HH-CMART Database. If you are unsure about a PlanID # contact the Department at [HH2011@health.state.ny.us](mailto:HH2011@health.state.ny.us)

\*Remember FFS members are not enrolled in a plan and the field should be filled with '8888888'

# Question and Answers Since Last Webinar

- ▶ **Q: The Contact Date field - For TCM legacy clients who were opened prior to April 1, 2012, should we use April 1st (2012) as the "contact date"?**
- ▶ **A:** You would use the date of initial contact or interaction of when your client started Health Home services. If the initial contact was in 2011 but the member started HH services in April 1 of 2012, then we want you to put down the date there were contacted for HH services - April 1, 2012
- ▶ **Q: Would internet searches for the member (i.e. Google search or reverse look-up to get phone numbers or correct address) be counted as attempts in the Outreach effort field?**
- ▶ **A:** Yes. If found, the member should be contacted. Finding the phone number and calling would be counted only once in this scenario. Attempts to outreach should be varied and increase in degree of 'difficulty of task' with each unsuccessful attempt.

# Question and Answers

- ▶ **Q: Will the Fact GP & Functional Questionnaire influence acuity score?**

**A:** The results of the FACT-GP and HH Functional Assessment will not directly impact the acuity score of the member. We are collecting this information and will be using it to get a more global sense of the population, including understanding the overall health of the population. We will be evaluating the data to determine its future utility in evaluating our members.

- ▶ **Are we required to report outreach activity on members in the hiatus period?**

**A:** DOH requires HH-CMART data to be submitted for the reporting period on all members that you are outreaching to, or have engaged, and if you have activity to report. It is up to the Health Home policy if during the hiatus period, you continue outreach. You may do so if the HH policy supports it. If you do, then we would request the activity be reported in the HH-CMART tool.

# Feedback and Help

- ▶ We encourage your feedback
  - **To aid in Case Scenario development** in order to clarify fields so that there is similar thinking behind how to fill in HH-CMART data similarly across all Health Homes
  - Email the Health Home Team at **HH2011@health.state.ny.us** with the Subject : *HH-CMART*  
*Or Call the Health Home provider line – 518.473.5569*

- ▶ Health Home website, Assessment and Quality Metrics menu, Process Measures section:

*[http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/assessment\\_quality\\_measures/process\\_measures.htm](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/process_measures.htm)*

# Ongoing support

- ▶ For further information, we encourage you to visit our FAQ page located at:
  - [http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/questions\\_and\\_answers.htm#qual\\_metrics\\_evaluation](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/questions_and_answers.htm#qual_metrics_evaluation)
- ▶ Weekly support calls are now **Bi-Weekly**, Wednesdays from 10 a.m. to 11 a.m.
  - The next call will be July 24,2013
- ▶ 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](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/meetings_webinars.htm)