Health Home Performance Management Webinar Q & A
May 11, 2017

1. Q: Will DOH provide Health Homes with member level data?

A: We recognize the value of member level data and are working with the Office of Quality and Patient Safety (OQPS) on this.

2. Q: Will the Health Homes receive baseline data?

A: Yes. Data will be provided that covers the time period of 2012 to 2014. It will be separated by Health Home. 2015 data is in the process of being compiled (6.19.17)

3. Q: Will the analysis take into account how long the member has enrolled?

A: Today, we provided an overview of the measures subset. We are in the process of developing analyses and performance goals. Depending on the goal, we will take into account how long a member has enrolled.

4. Q: Will there be a mechanism to account for outcomes based on social determinants of health?

A: This is an important issue. The lack of data on the social determinants is a barrier. We could expand the HARP Monthly Program Report and ask for more information, but it is a trade-off between the value of the information and the reporting burden.

5. Q: Who is meant by "administrator" under the "data source" column in the tables?

A: Administrative data is data drawn from claims, pharmacy, and/or encounter data. "Administrative" data does NOT require any additional steps or reporting on behalf of the Health Home.

6. Q: If we don't have member level data, how should we target our interventions with our CMAs?

A: That's a great question and the Learning Collaborative (Monday May 15th) will provide a working session that addresses that issue. Pro-active Quality Improvement (QI) plans can help you get ahead of issues before they appear in claims-based data. By using the claims data, you can identify trends and patterns and then implement QI activities to interrupt those patterns.

7. Q: The data sets from the MCOs are incomplete and not standardized. What can DOH do about that?

A: MCO base their data sets and follow-up on required measures based on their networks performance. It is unlikely that the process can be standardized but DOH will follow-up to see if there are areas that can be streamlined.

8. Q: Should Health Homes be building out the ability to track the number of referrals to community-based services as a way to monitor access to, and engagement in, these services?

A: Health Homes are not required to do so. This is an area you could work with your CMAs on.

9. Q: How do admissions to Skilled Nursing Facilities (SNFs) reflect on quality of care management services? In some cases, SNF referral and admission is necessary and appropriate.

A: Agreed. The SNF utilization measures are part of the SPA, so it is tracked. It is specific to admissions to a nursing facility from the community that result in a short-term stay (less than 101 days) during the measurement year. We are working internally to do some benchmarking and figure out what we need to look at in relation to that measure.