

Clinical Risk Group – October 7, 2013

Attendees

Neil Pessin	CCMP
Michelle McElroy	Southern Tier AIDS Program
Jay Dobkin	VNSNY CHOICE SelectHealth
Karen Nelson	Maimonides
Shawna Craigmile	Onondaga Case Management Services
Peggy Leonard	Hudson Health Plan
Brian Maxey	NYC HHC
Lyn Hohmann	NYSDOH Health Homes
Ilyana Meltzer	OASAS
Rob Piculell	OASAS
Dawn Lambert-Wacey	OASAS
Sajidah Husain	HealthPlus Amerigroup
Deirde Astin	NYSDOH

Call began with a request for revisions from the minutes of the last call and review of agenda.

It was suggested that perhaps looking at risk factors as binary qualifiers, as opposed to a scale, might be a way to handle the various factors (in other words “have” or “don’t have” as opposed to a rating for each). Criminal Justice is working on acuity factors and it might be good to try to align this work with the work they are doing, so as to prevent duplication of effort, or alternate conclusions. It was pointed out that that population doesn’t have a lot of claims so it may be a bit different. For this exercise the focus should be on the individual’s history with criminal Justice, not claims, as they will not necessarily have claims data to determine accurate acuity.

Homelessness Discussion:

There are a lot of factors that feed into homelessness (and someone being difficult to house) that aren’t technically considered homeless. It was also suggested that there are many factors involved with homelessness, but not all are necessarily related directly to acuity. It might be appropriate to group them together and classify them, so that corresponding definitions of homelessness to match a three tier system (which can also then correspond to the ICD-9 codes). In this way, a member’s acuity would go down as degree of risk goes down. It was noted that none of these tools currently mentioned are aligned with HUD definition of homelessness which many are in agreement with. It was suggested that perhaps the HUD definitions could be mapped to the v-codes so it’s understood what is meant by the use of each of the three codes?

Discussion of data collection (homelessness) yielded DOH staff relating that the use of ICD-9 codes would be the preferred reporting mechanism. The Health Homes would have to code this into their claims for members. There generated further discussion about how many codes can be attached to a Health Homes claim, as there are concerns that if multiple elements are present for a given member it might not be possible to report all the relevant codes. Also, the question around how the information that care managers observe in the field will be relayed and transferred into coding is a separate element of concern.

Adherence Discussion:

There was some additional discussion around markers of non-adherence and accuracy of information obtained from various sources. While pharmaceutical claims data can indicate when medications are not refilled consistently, they cannot identify (as a care manager would be able to) when a member is filling medications but not taking them as directed or not taking them at all. Additional suggestions around metrics related to missed appointments for follow-ups after inpatient admissions for psychiatric, medical, or substance treatment were mentioned. As these are measures also identified in the SPA, it seems likely that they are important indicators of improved outcomes for individual members as well.

CRG Additional Elements:

S. Craigmile submitted to the group a list of 8 factors that often serve as barriers to adherence (both pharmaceutical and treatment plan), as well as generally increasing the time investment required to effectively care manage individuals. This list was compiled with input from care managers in a converting OMH agency, which is also a lead Health Home. She noted, however, that in the size sample of data they collected this was not a reliable way to predict a member's assigned acuity or their actual level of intensity of need. It was suggested that a larger sample of data might need to be studied in order to find the correlation in these relationships. She did note that the most accurate predictions were found with individuals who had at least two of the identified elements, as well as limited natural supports. K. Nelson also discussed some of the work that the Criminal Justice group has been doing related to acuity and previously incarcerated individuals. She agreed to send along the powerpoint developed by the CJ workgroup, so that group members could incorporate this information into their thoughts about barriers, as well as their selection of important factors for incorporation into the CRG analysis.

Next Steps:

1. Group members will submit their priority list of list of 3-5 items they feel are most important to incorporate into the CRG analysis. These are to be emailed to M. McElroy by 10/15/2013 so they can be compiled and forwarded to L. Hohmann for her meeting with 3M staff member, N. Goldfield.
2. L. Hohmann will conduct follow-up meeting with Norbert (from 3M) on 10/18/2013. She will submit the group's feedback related to important elements. She will also check on the number of codes that can be attached to a Health Homes claim, in order to determine if there is a limit to the coding that can be applied to a single member within a given month.
3. Karen will send out the PowerPoint slide summarizing the criminal justice factors to the entire group.
4. Next call will be on Monday, Oct 21, 2013 at 3:00pm.