CRG Subworkgroup Conference Call with Dr. Norbert Goldfield – August 12, 2013

Group Members: **N. Pessin** (CCMP/VNSNY) & **M. McElroy** (STAP), **K. Nelson** (Maimonides), **B. Maxey** (NYC HHC), **D. Alloy** (Glens Falls Hospital), D. Bux (Montefiore / University Behavioral Associates MATS Program), **J. Dobkin** (VNSNY CHOICE SelectHealth), J. Levine (Bronx Lebanon Hospital Center), **J. Sullivan** (Hudson Health Plan), S. Craigmile (OCMS), **R. Wulf** (CBC/JBFCS), R. Desai (MetroPlus Health Plan), **K. Monti** (Continuum Health Home Network), K. Pecor (Central NY HH), **S. Husain** (HealthPlus Amerigroup)

Other Attendees: **L. Hohmann** (NYSDOH), **M. Leonard** (Hudson Health Plan), **Dr. N. Goldfield** (3M), L. Earle (NYSDOH), **J. Casalone** (3M), **J. Friedman** (NYC DOH), **F. Laufer** (AI), **S. Donahue** (OMH), **S. Essock** (OMH)

Bolded names are individuals who were in attendance on the call.

Attendance was completed. The purpose of the call was to gather background information regarding the CRG analysis and current data items/pools, as well as items that 3M/NYSDOH have been exploring to increase accuracy. The group is tasked with assisting in identifying additional data elements that could be included, to improve predictive accuracy of CRG's ability to segment/assign people and to clarify risk factors.

The call was turned over to Dr. Norbert Goldfield to address questions and concerns his group may have and talk about an approach from the group that would be helpful. Dr. Goldfield's team would like to to identify data sources for non-traditional categories (such as homelessness) of patient characteristics that can be added to the CRG algorithm to enhance the predictive analysis. He encourages the group to start identifying data sources that they think might be useful. His team can begin to analyze it to determine whether it is, in fact, helpful in the predictive model. For example, they have recently been approached by a Federal Agency about looking at bundles of 30 days before an inpatient mental health stay and 60-90 days after, to find if some of the social aspects attributed to these cases would help clarify issues or serve as adequate predictors. Often what happens is you have an intake with a new person, who is in much worse condition that their medical claims would lead one to believe. How can the group and his team work together to better understand resource consumption and outcomes? To clarify, he pointed out that past resource consumption is not useful to predict future resource consumption.

Several questions were posed to Dr. Goldfield -

- What amount of data do you need? For example, one Health Home Collaborative recently decided to begin assessing DLA-20 status for new enrollees. This is a pool of about 5,000 – 6,000 people. Dr. Goldfield indicated that quantity would be plenty to analyze, and went on to say that if there are other groups collecting other kinds of data, they could begin to get some clear answers/direction pretty quickly (within a year or so after the bulk of the data has been collected).
- We often come across people who would be called "difficult to serve" which is a label that has a set of behaviors, and sometimes undiagnosed personality disorders, associated, which can also lead to non-compliance. How could this be quantified in order to collect data? Similarly, how can we differentiate misdiagnosis from under diagnosis, especially with individuals who are not getting consistent care? In this same vein, if we consider using these V code diagnoses (for homelessness and non-compliance),

who will be able to makes this diagnosis (only those allowed by license)? What happens when someone outside the clinical process inserts a diagnosis? Can this diagnosis, perhaps, be added to the member tracking data, rather than through the clinical process? Group members seemed to indicate that submitting some type of V code along with the member tracking seemed like a more plausible solution than trying to have this coding happen in the clinical setting. Dr. Goldfield indicated the necessity of clearly defining what the criteria would be for indicating these codes, should this method be chosen. For example, what definition of homelessness or non-compliance will be used?

- The group also asked about using a variety of types of assessment data (interRAISuite, MDS, DDA, etc.). Dr. Goldfield indicated that the 3M team is happy to work with any tools that group identifies that NYSDOH also agrees is useful. He is looking for 2 – 3 highly meaningful measures that can be collected. L. Hohmann indicated that NYSDOH is using some pieces of interRAI suite in other initiatives, so this should be considered by the group in addition to some of the other tools mentioned. Dr. Goldfield felt it would be important for the group to determine elements worth pursuing. He indicated three main considerations for choosing items:
    - Use measures that will be consistent, and are perhaps already being using across populations.
    - What will provide the greatest ease/difficulty of collecting, in order to make it reasonable.
    - Rank the chosen elements with respect to their importance/perceived impact on ability to serve and how payment will be calculated.

Afterwards, they will try to run the data and see if it yields anything useful and/or significant for prediction. He also suggested taking a broader view and deciding on the elements, plan how to collect the data and start collecting the data. Then they can begin to analyze and assess as a group whether it's effective. Dr. Goldfield is willing to help teach people how to best collect the data. Dr. Goldfield suggests that what's already being done is a good place to start and if it doesn't fit, move one. As soon as there is a data set of any size they're ready to analyze it which can help refine and redirect efforts.

Follow Up Items:

1. The group will suggest initial areas for possible inclusion by email to co-chairs, M. McElroy and N. Pessin by Friday, September 5, 2013. Group members should try to flesh out the identified item(s) as much as possible into a measurable element. These will be compiled and then submitted to Dr. Goldfield for review/feedback.

2. The group will then discuss and start developing working definitions for any identified ambiguous/broad terms (such as homelessness, non-compliance), at the next meeting. This will assist with considering the difficulty in collecting the data elements and their relative usefulness.

2. L. Hohmann was asked to provide the group with a list of assessment tools other initiatives within DOH are using, as a starting point for the group. It was suggested interRAI be included on that list. L. Hohmann will also indicate which tools on the list the state is considering adopting and/or have already been identified as useful in other initiatives.