Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

Title: Quality Assurance and Performance Improvement

Intended Population: Health Home Serving Adults and Children

Effective Date: 03/01/2015

Review Date: 3/1/2021

Date Revised: 2/12/2020

Purpose of Policy

The Adirondack Health Institute Health Home (AHIHH) will take an active role in monitoring the quality of care management services provided within our Health Home network. Periodic review and measurement of process and quality measures, as released and published by NYSDOH in October of 2018, will assist in understanding the value of the overall program, the efficacy of any one component, and will also guide our performance improvement efforts. Various data sources will be utilized to construct quarterly report cards that are inclusive of NYSDOH quality and process measures. Data sources will include, but are not limited to; AHIHH Care Management Record System, MAPP/Salient dashboards, PSYCKES, Medicaid Claims Data, etc.

AHIHH has established a performance improvement program to collect and report on data that permits an evaluation of increased coordination of care and chronic disease management, clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level. AHI Health Home is committed to promoting a culture of learning and continuous quality improvement within the Health Home network.

Scope

1. This policy must be distributed to all AHI Health Home Program staff and all subcontracting Health Home Service Providers.
2. All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions or problems with the policy within ten days of the issue date to the AHI's Health Home program.
3. All questions regarding this policy or its implementation may be directed to the Health Home Director.

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Statement of Policy

AHI shall develop, disseminate, and review periodic performance reports to all Health Home downstream providers to aid in assist each downstream provider in meeting performance goals.

Definitions

AHIHH: AHI Health Home, a designated lead Health Home by the New York State Department of Health

Health Home Participant: A Health Home Candidate who is participating in the AHI Health Home and is assigned to an AHI Health Home Services Provider for care management. Also referred to as a "client".

Health Home Service Provider: An organization that has a fully executed contract (the "Health Home Services Provider Agreement") with the Adirondack Health Institute to provide health home outreach and/or care management services. Also referred to as "Care Management Agencies (CMAs)".

Care Management Record System: A structured information system, maintained by the Adirondack Health Institute Health Home (AHIHH), and made available for Health Home Service Providers and Health Home Network Partners to utilize, as applicable and appropriate to their role in the Health Home.

NYS DOH: New York State Department of Health

Quality Assurance: QA is a process undertaken by an organization that assures care is maintained at acceptable levels in relation to specifications of standards for service quality and outcomes. QA is a continuous process that assesses organizational performance, both prospectively and retrospectively, including where and why performance is at risk or has failed to meet standards

Performance Improvement: PI (also called Quality Improvement–QI) is the continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. PI in the Health Home program aims to improve processes involved in care management service delivery and member quality of life

Background

The Quality Management and Auditing Policy at AHI is intended to facilitate the effective implementation of the processes necessary to meet the Health Home Program standards and requirements as stipulated by the NYS DOH, federal regulations, and best practices. This policy directs that AHI meet these requirements.

Quality Assurance

Monthly Process Reviews

Each month AHIHH will conduct a process review that will measure HHSP compliance with Health Home policy and procedures. If an agency does not have any charts to be selected in a specific category this will be noted by a N/A, which will not count against the CMA. By the 10th calendar day of the month HHSPs will be provided a monthly corrective action report with their process audit results, including any items needing corrective action. Agencies will either meet the Health Home Standards or not meet Health Home Standards. In order to meet Health Home standards, the majority of the records reviewed must meet Health Home Policy Standards. If a HHSP does not meet Health Home standards on two consecutive Process audits for the same category, then a formal training will be conducted.

Monthly Process Audits – Adherence to Policy

- Eligibility
- Consents
- Care Transitions
- Continuity of Care
- Transfers
- Plan of Care
- Disenrollment
- Comprehensive Assessment

Monthly Monitoring

- CANS Assessment
- HARP
- Outreach and Engagement
- Health Home Plus
- Billing and Bi-annual Comprehensive Audit
- Children's HCBS Waiver and annual Comprehensive Audit

See a desk guide for process audit schedule

- **Eligibility and Consents**: AHIHH will select a random sample of cases from each HHSP for members who are in an "enrolled" status. AHIHH will send a corrective action report for any chart found to be missing Quality indicators. Those members found to not have adequate Health Home eligibility documentation and/or consent maybe be subject to voided claims due

to the member not being eligible or properly consented in the Health Home Program. Please see the Health Home Qualifying Conditions Policy for further guidance.

- Quality Indicators:
  - ✓ Health Home eligibility is fully documented in the member's care management record
  - ✓ Member has consented, and record of consent is documented in the members care management record

- **Care Transitions:** AHIHH will select a random sample of cases from each HHSP for members who had admission alerts in the previous 12 months. AHIHH will send a corrective action report for any member found not to have had sufficient discharge support as per AHIHH Care Transitions policy and procedure and Health Home quality metrics.
  - Quality Indicators:
    - ✓ HHCM attempted to contact the facility if the member was admitted
    - ✓ Record of the member's inpatient stay and/or ER visit is documented in the member's care management record
    - ✓ HHCM either participated in or attempted to participate in discharge planning process
    - ✓ followed up with the member post care transition to facilitate any needed follow up appointments

- **Continuity of Care**: AHIHH will select a random sample of cases from each HHSP for members who are/were in Diligent Search status during the previous 12 months. AHIHH will audit to ensure that each HHSP has followed the Continuity of Care Policy and Procedure and that Quality indicators have been met. AHIHH will send a corrective action report for any chart found to be missing Quality indicators. Those members found to not have the adequate number of DSE activities during any given month will be subject to voided claims. Please see the Health Home Continuity of Care Policy for further guidance.
  - Quality Indicators:
    - ✓ 3 diligent search activities were conducted each month diligent search was billed
    - ✓ The correct types of DSE activities occurred
    - ✓ Disengagement was not avoidable

- **Transfers:** AHIHH will select a random sample of cases from each HHSP for members who had a disenrollment end reason of "transferred" in the previous 12 months. AHIHH will review records to ensure that each HHSP has followed the Transfer Policy and Procedure and that Quality indicators have been met. AHIHH will send a corrective action report for any chart found to be missing Quality indicators.
  - Quality Indicators:

- ✓ Correct end reason was selected based on type of transfer
- ✓ Documentation of the transfer is evident in the member's care management record

- **Plans of Care**: AHIHH will select a random sample of cases from each HHSP for members who were actively enrolled for more than 60 calendar days. AHIHH will review records to ensure that each HHSP has followed the Plan of Care Policy and Procedure and that Quality indicators have been met. AHIHH will send a corrective action report for any chart found to be missing Quality indicators. Those members found to not to have had a Plan of Care initiated within the first 60 calendar days of enrollment may be subject to voided claims. All enrolled members must have a Plan of Care started within in the first 60 calendar days of enrollment to bill for Health Home Care Management services. Please see the Plan of Care Policy for Adults and Children for further guidance.
  - Quality Indicators:
    - ✓ Initiation of plan of care within 60 calendar days
    - ✓ Plan of care is signed by the member, parent, and/or guardian
    - ✓ Plan of Care is updated, at minimum, annually for adults and every 6 months for children

- **Disenrollment:** AHIHH will select a random sample of cases from each HHSP for members who were disenrolled within the past 12 months. AHIHH will review records to ensure that each HHSP has followed the Disenrollment Policy and Procedure and that Quality indicators have been met. AHI HH will also monitor disenrollment trends and retention rates for each HHSP. AHIHH will send a corrective action report for any chart found to be missing Quality indicators.
  - Quality Indicators:
    - ✓ The Correct Health Home End reason was selected
    - ✓ Proper withdrawal of consent has been completed and uploaded in the members care management record
    - ✓ The members plan of care was updated prior to disenrollment; including updating/closing outstanding goals/objectives
    - ✓ A discharge plan was made with the member and documented in the members care management record

- **Comprehensive Assessment:** AHIHH will select a random sample of cases from each HHSP for members who were enrolled from more than 60 calendar days. AHIHH will review records to ensure that each HHSP has followed the Comprehensive Assessment Policy and that Quality indicators have been met. AHIHH will send a corrective action report for any chart found to be missing Quality indicators.
  - Quality Indicators:

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- ✓ Completion of the comprehensive assessment within 60 calendar days of enrollment
- ✓ Annual completion of the Comprehensive assessment
- ✓ Areas of need in the Comprehensive assessment were discussed with the member
- ✓ All questions on the comprehensive assessments were asked and answered

- **CANS-NY Assessment:** AHIHH will select cases from each HHSP for members who were enrolled in the Children's Health Home program for more than 60 days. AHIHH will review records to ensure that each HHSP has followed the CANS Assessment Policy and that Quality indicators have been met. AHIHH will send a corrective action report for any chart found to be missing Quality indicators. Those members who have been enrolled in Children's Health Home will not be allowed to bill for Health Home Care Management services in the CANS-NY is not completed within the third month of enrollment. Please see the Health Home CANS-NY Policy for further guidance.
    - Quality Indicators:
        - ✓ Completion of the CANS assessment within the first 60 days of enrollment
        - ✓ If a CANS-NY was completed prior to 6 months, ensure that there is documentation in the chart as to what the significant event was to initiate a new CANS-NY

- **HARP:** AHIHH will monitor all records for members who are HARP enrolled without HCBS eligibility (H1). HHSPs are expected to complete the HCBS Eligibility Assessment as part of the Health Home Comprehensive Assessment process. Therefore, HHSPs must assure that an HCBS Eligibility Assessment has been completed for, at minimum, 75% of their HARP population. AHIHH will review records to ensure that each HHSP has followed the HARP Policy and Procedure and that Quality indicators have been met. AHIHH will send a corrective action report for any chart found to be missing Quality indicators.
    - Quality Indicators:
        - ✓ Completion of the HCBS Eligibility Assessment within 90 days of enrollment
        - ✓ BH HCBS Eligibility Assessment is administered annually
        - ✓ BH HCBS Eligibility Assessment results are uploaded into the EHR
        - ✓ Completion and submission of the HARP Plan of Care for those member's pursuing HCBS services
        - ✓ Member's choice not to pursue HCBS services are noted in the HH Plan of Care
        - ✓ 75% of all HARP members have received the HCBS Eligibility Assessment

- **Outreach and Engagement**: AHIHH will select a random sample of cases from each HHSP for members who had an outreach segment in the previous 12 months. AHIHH will review records to ensure that each HHSP has followed the Outreach and Engagement Policy and Billing Policy and that Quality indicators were met. AHIHH will send a corrective action report for any chart found to be missing Quality indicators.
    - Quality Indicators:
        - ✓ If a second month of outreach was billed, was there a face-to-face contact.
        - ✓ Outreach efforts were progressive and appropriate

- **HH+:** AHIHH will select a random sample of cases from each HHSP who billed for Health Home services at the HH+ rate in the past 12 months. AHIHH will review records to ensure that each HHSP has followed the Health Home Plus and Billing Policies and that Quality indicators were met. AHIHH will send a corrective action report for any chart found to be missing Quality indicators.
    - Quality Indicators:
        - ✓ HHSP met the service level requirements for HH+
        - ✓ HHSP included documentation in the members care management record to support eligibility for HH+ level of service
        - ✓ HHSP met caseload and supervisory requirements

Quarterly Quality Review

Each quarter, AHIHH will distribute performance reports to HHSPs based on claims data. Members will be matched to each metric based on the metric's specific definition. Performance reports will include, but may not be limited to the following metrics;

- Retention Rate
- Enrolled vs. Disenrolled Members
- Discharge Report
- Conversion Rate (Outreach to Enrolled)
- HARP Conversion Rate
- HCBS Eligibility Assessment Completion Rate
- Potentially Preventable ED Visits
- Potentially Preventable ED Visits (BH)
- Potentially Avoidable Readmissions
- PDI 90 - Avoidable Admissions (Pediatric)
- PQI 90 - Avoidable Admissions (Adult)
- Follow Up after MH Inpatient (7 Days)
- Follow Up after MH Inpatient (30 Days)
- Antidepressant Medication Management (Acute)

- Antidepressant Medication Management (Cont)
- Diabetes Monitoring (DM & Schizophrenia)
- Diabetes Screening (Antipsychotic Medication)
- CV Monitoring (CV & Schizophrenia)
- Antipsychotic Medication Adherence
- Child ADHD Medication F/U (Initiation)
- Child ADHD Medication F/U (Continuation)
- Child Access - Primary Care (12 to 24 Months)
- Child Access - Primary Care (25 Months to 6)
- Child Access - Primary Care (7 to 11)
- Child Access - Primary Care (12 to 19)
- Adult Access Preventive (20 - 44)
- Adult Access Preventive (45 - 64)
- Adult Access Preventive (65 and Older)

Annual Site Visit

AHIHH will conduct at least one site visit each year to review compliance with AHIHH Policy and Procedure requirements and facilitate the agencies partnership in Quality Assurance and Performance Improvement process. These on-site reviews may include, but are not limited to:

- Chart Reviews (5% of members or 20 records, whichever is more)
- Understanding and adherence to AHIHH Policy and Procedures
- Review of current staff qualifications and compliance with required/recommended training; including background checks
- Review of staffing structure and turnover rates; including Supervisory roles and responsibilities
- Review of compliance with PHI/HIT security measures and audit of staff HIT access
- Ability to provide 24/7 access to care management
- Review of processes for member engagement/re-engagement
- Caseload Ratio review
- Annual performance trends
- Annual Comprehensive Chart Audit
- Attendance at monthly and quarterly meetings
- Response to corrective action requests
- HARP Performance
- Ability to serve Health Home Plus Population

AHIHH will select a random sample of cases from each HHSP consisting of unique members with either an outreach or enrollment claim in the previous 12 months. Each HHSP will be provided their case list 30-60 days prior to their scheduled visit. HHSP's are encouraged to utilize the chart review tool to

complete a self-assessment prior to their site visit and to implement peer/supervisory reviews as part of their internal quality assurance process.

HHSPs will be provided a corrective action report within 30 days of the annual assessment. HHSPs will be required to complete corrective action within 30 days, unless otherwise specified. If corrective action is not completed within the allotted time, the HHSP will be given a performance correction notice and be placed on a performance improvement plan (PIP). If the HHSP scores below a 50% on the comprehensive audit additional records may be pulled and additional onsite training will be scheduled. If a HHSP scores below 50% on two annual audits a HHSP may be placed on notice of termination.

Note: In addition to the annual site visit, additional site visits may occur at any time, for example, in response to a quality concern or corrective action process.

CMA Quality Audit Dispute Process

If the HHSP does not agree with AHIHH finding, they can submit a request for review by emailing healthhome@ahihealth.org. The HHSP can request a meeting to further discuss the findings.

Performance Improvement Committee

- AHIHH will maintain a Performance Improvement Committee (PIC) which will meet at least quarterly to review overall performance data and to identify, address, and improve quality outcomes of health home members. The PIC committee shall be composed of the following members with the associated roles and responsibilities;
- The Committee Chair will facilitate committee meetings, report on activities and/or findings of the Committee to the Health Home leadership committee and/or AHI leadership.
- The Committee Coordinator will design, direct and oversees implementation of PIC projects to include review of data and performance measures, management of performance improvement plans, oversee performance improvement activities, and monitor progress.
- Other members may include a cross section of community partners that include; medical, behavioral health, substance use providers, criminal justice, housing providers and other community-based organizations that address the social determinants of health.
- Health Home members and/or family members will have opportunities to provide feedback to influence performance improvement processes.
- Other subcommittees/workgroups may be established in response to performance improvement activities.

- The Performance Improvement Committee will define, oversee and monitor objectives and goals of the AHIHH Performance Improvement Strategic Plan. The Performance Improvement Plan shall include;
- Performance improvement goals, benchmark data, and trend analysis
- Will Identify barriers and needed resources to support performance improvement goals
- Will monitor performance improvement for effectiveness
- Inform of recommendations or changes needed in operations to meet performance goals
- Prepare reports for leadership committee(s) that include findings, actions, and outcomes of the Performance Improvement Committee
- The AHIHH Quality and Audit Specialist will meet monthly with the Health Home Director to review program performance metrics, overall quality assurance review results, and recommendations for quality improvement.

Corrective Action Process (CAP) – Level 1

Any audits (process, quality, or annual site visit) can result in a corrective action process (CAP). The CAP process is generally for information and is not punitive in nature. The corrective action process is designed to support the HHSP through the process of resolving deficiencies as discovered during routine quality management processes. As part of the Corrective Action Process, HHSP's will be provided with a report for any items requiring corrective action with specified timeframes and suggestions for resolution. The AHIHH team will offer as much support as needed and/or requested during the corrective action process to achieve agreed upon results. If the Health Home service provider fails to address identified deficiencies within the specified timeframes the Health Home Service Provider will move to a formal Performance Improvement Plan (Level Two).

Performance Improvement Plan (PIP) – Level 2

HHSP's who fail to engage in the Corrective Action Process or who fail to resolve deficiencies in specified timeframes, will be placed on a formal Performance Improvement Plan (PIP). AHIHH may impose sanctions, including suspension or termination, if they fail to comply with the Performance Improvement Plan. When determining the type of sanction to apply for violations of the Health Home Services Agreement and/or AHIHH Policies and Procedures, AHIHH shall consider the following factors:

- Whether the violation was a first time or repeat offense
- The level of culpability of the HHSP
- Whether the violation resulted in harm to a Health Home member or other person
- Whether the violation constitutes a crime under state or federal law

Level 1	Corrective Action Plan (CAP)	Informal/Non-Punitive
Level 2	Performance Improvement Plan (PIP)	Formal/Can be Punitive

Training

AHIHH will provide support and training for all HHSP's to ensure high quality care management services are delivered to all members in our health home network. HHSP's can make training requests by emailing healthhome@ahihealth.org.

Process Audit Schedule

Month	Process Audit
January	Eligibility and Consents
February	Care Transitions
March	Continuity of Care
April	Transfers and POC
May	Disenrollment and Comprehensive Assessment
June	Eligibility and Consents
July	Care Transitions and Comprehensive Billing Audit
August	Continuity of Care
September	Transfers and POC
October	Disenrollment and Comprehensive Assessment
November	Comprehensive Billing Audit
December	Annual Children's HCBS Waiver Audit
Monthly	Outreach Billing
Monthly	HH+ Billing
Monthly	HARP
Monthly	CANS Assessment

Contact Person: Director, Health Home and Care Management

Responsible Person: Lead Health Home and HHSP's

Approved By: Chief Operating and Compliance Officer