Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

Title: Quality Assurance, Performance Improvement, and Compliance

Intended Population: Health Home Serving Adults and Children

Effective Date: 03/01/2015

Date Revised: 2/12/2020, 2/1/2022, 2/1/2023, 10/1/2023, 9/1/2024

DOH Policy: HH0003 and HH0014

**** This replaces the Quality Assurance and Performance Improvement Policy****

Purpose of Policy

The Adirondack Health Institute Health Home (AHIHH) will take an active role in monitoring the quality of the care management services provided within our Health Home network. Periodic reviews 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 provide monthly reports 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.

Scope

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

Statement of Policy

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

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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.

Compliance Standard: Is the contentious process undertaken by an organization to ensure compliance with legal requirements, reducing the risk of penalty, paying fines or losing billing opportunities by not ensuring specific compliance regulations. The AHI HH Compliance Standards will encompass the following: Implementing written policy and procedure, Designation of a Compliance Committee and officer, conduct training and education to the Network, develop and maintain effective lines of communication, and conduct internal monitoring and auditing.

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.

Corrective Action Plan: A step-by-step plan of actions that will be developed to achieve targeted outcomes or resolution to identified errors.

Performance Improvement Plan: A Plan that will be developed and address why a particular CMA is consistently not meeting performance goals. It will cover specific areas of deficiencies, help identify needed skill development or training gaps, and set clear expectations on future performance.

Data Den: Data Den is an online platform comprised of various reports created to support Care Management Agencies with Quality Management. Data Den provides close to real time data at both the supervisory and care management level. Data is pulled from Netsmart, Medicaid Analytics and Performance Portal (MAPP) and other data sources. Data is manipulated on the backend to provide end users with actionable data and due dates that are calculated to adhere to policy guidelines.

Background

The Quality Assurance, Performance Improvement, and Compliance 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

Agencies will be responsible for utilizing Data Den to meet quality standards. Data Den is a proactive tool that provides numerous reports at both the Care Manager and Supervisory level. Reports in Data Den are created by using policy requirements to automatically calculate the status/due dates of various assessments using data pulled from multiple sources such as Netsmart Care Manager and MAPP. The Power-BI platform presents visuals in a user-friendly format to help address Health Home quality and policy requirements.

Users with established access to Data Den through the Health Home can click access the portal here.

Monthly Process Reviews

Each month, AHIHH will conduct a process review that will measure Health Home Service Provider's (HHSP) compliance with Health Home policy and procedures. HHSPs will be provided a monthly corrective action report (Quality Notebook), if applicable, with their process audit results, including any items needing corrective action. The Quality Notebook is a compilation of reports that are sent to HHSP Supervisors on a monthly basis. The Notebook is to be utilized as a tool to support the HHSP in meeting Health Home policy and procedure requirements by providing all overdue items and items requiring action in one place as well as providing a space for the HHSP to provide comments and feedback back to the Health Home.

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Biannual Process Audits

- Eligibility
- Consents
- Care Transitions
- HHSC HCBS Enrolled Members comprehensive audit
- Appropriateness Criteria

Monthly Monitoring and/or Audits

- CANS Assessment
- Health Home Plus
- Children's HCBS Waiver LOC completion
- Continuity of Care
- Plan of Care
- Comprehensive Assessment
- Safety and Emergency Plan for Children
- CES Tool

Process Audit	Month
Health Home Eligibility	March and June
Consents	April and July
Care Transitions	May and August
HHSC HCBS Chart Audit	February and November
Appropriateness Criteria	January and October
Health Home Plus	Monthly Review
CANS-NY Assessment	Monthly Review
HHSC HCBS Level of Care Completion	Monthly Review
Continuity of Care	Monthly Review
Plan of Care	Monthly Review
Comprehensive Assessment	Monthly Review
CES Tool	Monthly Review

Eligibility and Consents: AHIHH will select a random sample of cases and/or pull a report 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 appropriate Health Home Eligibility Documentation or the appropriate Health Home Consents. Those members found to not have adequate Health Home eligibility documentation and/or consent may 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/Informed Consent 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. Consents must be completed correctly, in their entirety, and uploaded in their entirety.
- Member has an electronic Eligibility Assessment in chart assessments
- Member has electronic Consent in chart

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. This will also be reviewed when a Care Transition has occurred and was accompanied by an Incident Report submission. For the Children's population the Safety and Crisis Plan will be reviewed to see if it was updated and/or reviewed with the family, as applicable.

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
- Reviewed Safety and Crisis Plan with the member and family – Health Home Serving Children Only

Continuity of Care: AHIHH will select a random sample of cases and or pull a report from each HHSP for members who are in Diligent Search status. AHIHH will spot audit to ensure that each HHSP has followed the Continuity of Care Policy and Procedure. AHIHH will send a corrective action report for any chart found to be missing proper documentation. 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 separate diligent search activities were conducted across separate days each month diligent search was billed for
- The correct types of DSE activities occurred
- Disengagement was not avoidable

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Plans of Care: AHI HH will provide a monthly report to HHSP's indicating which members have a Plan of Care that is coming due within the next 56 days. AHIHH will also review records to ensure that each HHSP has followed the Plan of Care Policy and Procedure and monitored for quality care planning through Comprehensive Chart Audits. AHIHH will send a corrective action report for any chart found to be missing Quality indicators. All enrolled members must have a Plan of Care Finalized within the first 56 calendar days of enrollment to bill for Health Home Care Management services. Annual Care Plan due dates will also be included in the monthly report. A list of coming due and overdue annual care plans will be listed; those that are out of compliance with their due dates will not be able to bill for 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 children.
- Children's HCBS Plans of Care are updated within 30 days of a completed LOC
- Care plans are person centered and built from the assessment processes, care plans are built in conjunction with the assessment process and have a person-centered focus

Disenrollment/Transfers: 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, retention rates, and the disenrollment of specialty populations for each HHSP. AHIHH will send a corrective action report for any chart found to be missing Quality indicators. Monthly HHSP's serving adults will receive a report indicating those members who have been enrolled at the low-rate code for 12 months or more to support the HHSP's with graduation and disenrollment efforts.

Quality Indicators:

- The Correct Health Home End reason was selected
- Proper notification of cessation of consent has been completed and uploaded in the members care management record
- A discharge plan was made with the member and documented in the members care management record
- For transfers a warm hand off was attempted

Comprehensive Assessment: AHIHH will pull a report for each HHSP for members who do not have a comprehensive assessment, an overdue assessment, or an assessment coming due. AHIHH will send a corrective action report for any chart found to be missing Quality indicators. AHIHH will also review records to ensure that each HHSP has followed the Comprehensive Assessment Policy and Procedure and monitor for quality care planning by reviewing and discussing the needs reflected in the Comprehensive Assessment process through Comprehensive Chart Audits.

Quality Indicators:

- 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 and incorporated into a person-centered Plan of Care

CANS-NY Assessment: AHIHH will review members who were enrolled in the Children's Health Home program for more than 30 days. AHIHH will review records to ensure that each HHSP has followed the CANS Assessment Policy. 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 30 days of enrollment
- If a CANS-NY was completed prior to annually, ensure that there is documentation in the chart as to what the significant event was to initiate a new CANS-NY.
- Where the strengths and Needs from the CANS incorporated into a person-centered Plan of Care.

Health Home Plus: AHIHH will ensure that HHSPs are staying above the OMH threshold of 50% of the attributed Health Home Plus population served. HHSPs that fall below the 50% threshold for 3 months in a row will be asked to provide a summary of plans to improve their percentage of the population served. AHIHH will provide HHSP Supervisors with a monthly HH+ report identifying their organization's eligible HH+ population to include what rate each HH+ eligible member is billed for the month as well as the organizations overall percentage of members billed at the HH+ rate.

At the discretion of the Health Home, member's who have been billed at the HH+ rate code will be pulled by the Lead Health Home for a billing audit. During the billing audit the Lead Health Home will be looking to ensure that the member has a documented SMI or HIV diagnosis and listed as the primary problem in the member's record. Additionally, the Lead Health Home will look for documentation to support the member's appropriateness for HH+ category being billed for. The Lead Health Home will follow up with CMA's whose member's records do not contain the required documentation in order to Bill at the HH+ rate. These members for follow-up will appear on the Monthly Quality Notebooks. Failure to provide the required documentation of either the Diagnosis or Appropriateness for the category billed will result in voided claims.

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Health Home Enrollment Appropriateness Criteria: AHIHH will select a random sample of cases/ and or pull a report 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 appropriateness documentation. Those members found to not have adequate Health Home appropriateness criteria documentation may be subject to voided claims due to the member not being appropriate for the Health Home Program. Please see the Health Home Eligibility and Appropriateness Criteria Policy for further guidance.

Quality Indicators:

- Completion of the Eligibility Assessment in Netsmart
- Documentation in the record that the member meets the following criteria:
  - .. At Risk for an adverse event
  - .. Lack of or inadequate social/family/housing support
  - .. Lack of or inadequate connectivity to the health care system
  - .. Non-adherence to treatment or medications
  - .. Deficits in ADL's
  - .. Recent Release from an incarceration, detention, hospitalization, or other Justice referrals

** Please see the Eligibility Screening Assessment in Netsmart for a full list of appropriateness criteria**

Continued Eligibility Screening Tool (CES Tool): AHIHH monthly will review members who are eligible to have the annual and 6-month CES Tool completed. AHIHH will monitor CMA's to ensure that the tool is being completed on time per policy and that the CMA is adhering to the recommend outcomes from the tool.

Quality Indicators:

- Initial CES Tool is completed with the annual enrollment date
- The CES Tool is completed at 6-month intervals following the initial CES Tool completion (if continued service is recommended).
- Tool was reviewed/Completed by a supervisor
  - CES in draft worklist available in Netsmart for supervisors
- The recommendation is followed by the CMA:

  - ✓ Member disenrolled at the end of 56 days
  - ✓ Tool completed again within the 56 day timeframe if recommended by the outcome

HHSC HCBS Enrolled Members: Member's enrolled in the HCBS Waiver require an enhanced level of oversight by the Lead Health Home and the Supervisors at each CMA. AHI HH will track all member's who

are enrolled in HCBS Waiver and will reach out to CMA's on an as needed basis for quality and compliance concerns. Quality Oversight for this population will be monitored and measured in various ways:

- As part of the Quality oversight for this population AHI HH will review a sample of member's who have an active K Code for a complete comprehensive HCBS chart Audit Review twice a year or more if needed. AHIHH will review records to ensure that the HCBS Waiver Policy and Procedure have been followed. As well as Health Home Serving Children Policy and Procedure. Results will be included in the Quality Notebook that is distributed monthly. CMAs will have 30 days to complete the outstanding items and/or follow up for the record. If the follow up is not completed within 30 days, the CMA will be placed on Corrective Action Plan (CAP).
- Youth enrolled in the HCBS Waiver will also be pulled during a CMA's Annual Comprehensive Audit Review. These members will receive a complete chart audit and the HCBS Waiver Audit. Scores from this audit will be included in the CMA's overall audit scores. AHI Lead Health Home will set a meeting with the CMA to review their findings. Specific areas of deficiency will be given to the CMA to resolve within 30 days. If a CMA fails to resolve deficiencies in those 30 days the CMA will move to a Corrective Action Plan. If the CMA's overall score is below 85% the CMA will automatically be placed on a Corrective Action Plan.
- Due to the enhanced oversight of this population at the Lead Health Home Level and the time sensitivity of the work surrounding this population the Lead Health Home assesses for compliance monthly. During the month the Lead Health Home is checking to ensure chart compliance, policy compliance, and quality oversight of HCBS by the Health Home Care Manager. The Lead Health Home will reach out to CMA's, HHCM's, and supervisors for required follow up. It is expected that the area of concern will be addressed as soon as possible to ensure policy compliance. If a CMA's, HHCM, or Supervisor fail to follow up on the areas on concern within a timely manner the CMA will be placed on a Corrective Action Plan.

For Corrective Action Plans the CMA will be given a list of deficiencies that need to be addressed within a certain timeframe. The timeframe for a CAP is typically 30 days, however due to the time sensitivity of the work surrounding this population the timeframe may be shortened. Failure to complete the items noted in the CAP will result in a Performance Improvement Plan (PIP) being developed.

What may be included in a Corrective Action Plan or Performance Improvement Plan for HCBS:

- Technical Assistance calls
- Required Traning
- Required Supervisor Training
- Requirement to use additional tools to support compliance
- Hold on the ability to accept referrals for youth who are enrolled in HCBS
- Development of an internal CMA Audit Plan
- Attestation by the Supervisor that all Policy has been reviewed

Comprehensive Chart Reviews

AHI HH will conduct comprehensive chart reviews. To review overall chart quality and adherence to policy and procedure. Each month individual service providers will be selected for review. Once per year all Health Home Service Providers will receive a full comprehensive audit.

- Chart Reviews (10% of members)
- Understanding and adherence to AHIHH Policy and Procedures
- Review overall quality of care
- Trends in Disenrollment's; High Risk populations
- Billing spot audits to ensure members are being billed at the correct rate
- Monitor HHSC HCBS Enrolled members

Additionally, AHI HH will review:

- Current staffing qualifications and compliance with required and recommended trainings.
- Review of staffing structure and caseloads
- Ability to provide 24/7 access to care management
- Overall Performance trends
- Response to corrective active requests
- CMA Attendance at AHI HH Monthly Office Hours
- Periodic CMA billing spot audits to determine whether Health Home members have appropriate documentation on file in Netsmart CareManager to billing acuity

AHIHH will select a random sample of cases from each HHSP consisting of unique members with either a Disenrollment or enrollment claim in the previous 12 months. This sampling will include a cross section of adult and children including specialty populations served. For those CMA's serving children and youth enrolled in the HCBS Waiver those scores will be factored into the overall chart audit score for that individual. HHSP's are encouraged to utilize the chart review tool to complete a self-assessment and to implement peer/supervisory reviews as part of their internal quality assurance process.

HHSPs will be provided a corrective action report following the comprehensive chart review (if applicable). 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 85% on the comprehensive audit additional records may be pulled and additional training will be scheduled. If a HHSP scores below 85% on two comprehensive audits, a HHSP may be placed on notice of termination.

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Note: In addition to the comprehensive chart audit and monthly audits, additional audits 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.

Quality Notebook – Level 1

The Quality Notebook is generally for information and is not punitive in nature. Due dates for items in the quality notebook are outlined by a 30-day window presented in Quality Notebook Due Date column. If items are not resolved within 45 days, items will be on a Corrective Action Plan (CAP) provided by the lead HH in an effort to collaborate and assist with quality management metrics.

Included in the Quality Notebook:

- Summary – indicates any items out of compliance and due dates
- Overdue Plan of Care (initial and annual)
- Overdue Comprehensive Assessment (initial and annual)
- Members in DSE (continuity of care)
- CES Tool
- Missing and/or incorrect Consents (per Data Den – pulled bi-annually)
- Missing and/or incorrect Eligibility Assessment or documentation (per Data Den – pulled bi-annually)
- Missing appropriateness criteria for HH enrollment (bi-annually)
- Care Transitions (pulled bi-annually)
- Children's HCBS Compliance Audit (bi-annually)
- Comprehensive Chart Audit (annually)

Corrective Action Plan (CAP) – Level 2

The corrective action plan is intended to support the HHSP through the process of resolving deficiencies as discovered during routine quality management processes (Quality Notebook). As part of the Corrective Action Plan, HHSPs will receive a targeted summary of outstanding items that were not resolved within the established timeframe in the Quality Notebook. The AHIHH team will offer as much support as needed and/or requested during the corrective action plan process. AHIHH will initiate a meeting with the HHSP to discuss the targeted summary of outstanding items. The HHSP will be required to respond in writing with their plans for resolution within the timeframe provided by the lead Health Home. HHSP's that have a CAP will be required to have agency representation at scheduled monthly office hours. 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 Three).

Performance Improvement Plan (PIP) – Level 3

HHSP's who fail to engage in the Corrective Action Plan process, or who fail to resolve deficiencies in specified timeframes, will be placed on a formal Performance Improvement Plan (PIP) for a timeline to be determined by AHIHH. AHIHH may impose sanctions, including suspension or termination, if they fail to comply with the Performance Improvement Plan.

Examples of potential sanctions include but are not limited to:

- Halt of referrals/new member enrollments
- Entire agency re-training refresher
- Monthly technical assistance (TA)calls
- Netsmart retraining
- Targeted micro-trainings
- Recoupment and forfeiture of Medicaid payments

Level 1	Quality Notebook	Informative
Level 2	Corrective Action Plan (CAP)	Informal/Non-Punitive
Level 3	Performance Improvement Plan (PIP)	Formal/Can be Punitive

Member Outcomes

AHI HH will also place a quality focus on member outcomes in addition to the compliance audits. These member outcomes can be measured and monitored from multiple data sources (MAPP, DOH, Netsmart, MCO reports, PSYCKES, and internal data reporting tools). AHI HH will continue to work directly with Health Home Service Providers to help support and train the network on closing gaps in care, assessing and closing gaps in Social Determinates of Health, as well as the utilization of other reports that effect Health Home Quality Measures. AHI HH will utilize the below measures to help support member outcomes.

- Monitor Gaps in Care closure rates
- Social Determinates Health Outcome
- Reducing the total cost of care of our members
- Reducing ED and inpatient utilization

A list of NYS Health Home Performance metrics can be found that the Department of Health Website:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/performance/

Training

Quality and Compliance Management Committee (QCM) Committee

AHI HH will facilitate meetings with a Quality and Compliance Management Performance (QCM) Committee. The committee is a multidisciplinary team with various backgrounds that will help support the Network's quality, performance, and compliance initiatives. With feedback from committee members, AHIHH will work to provide support and training initiatives to help HHSPs meet quality initiatives.

Compliance Committee

Quarterly the AHI Compliance Committee meets to discuss compliance concerns that may have been raised in conjunction with a quarterly review of incidents and complaints. This committee will assess trends amongst an individual CMA and/or the Network.

Should a CMA and/or induvial HHCM suspect a compliance concern or suspect Fraud, waste, or abuse please contact the AHI Health Home's confidential compliance number:
518.480.0111, ext.109

Office Hours

Attendance is strongly encouraged in order for the HHSP to have the most up to date information on Policy and quality efforts, as well as allowing for an open forum of Q&A. Should a representative from a HHSP not be able to attend, office hours are recorded and should be reviewed at a later date. If a HHSP is not meeting AHI's Quality threshold they may be required to attend the scheduled live office hours monthly. All AHIHH Policy and Procedures are reviewed annually and reviewed during Health Home Office Hours. Attendance at Health Home office hours is required for CMA supervisors in order to have the most up to date information to inform their staff. If you cannot attend office hours, you are required to listen to the recorded version on AHIHH's website. It is the CMA Supervisor's responsibility to disseminate information to their staff.

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.

Contact Person: Health Home Compliance and Quality Performance Manager

Responsible Person: Lead Health Home and HHSP's

Reviewed By: Director, Health Home and Care Management

Approved By: Chief Compliance Officer