Health Home Outcomes and Quality Assurance

The health home provider is accountable for reducing avoidable health care costs specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes. Outcomes will be measured based on the NYS and Center for Medicare and Medicaid Services (CMS) required core quality measures and goal-based quality measures.

Core Quality Measures

In order to monitor the effectiveness of Health Home Care Management services, CMS has created a Core Set of Quality Measures:

- Adult Body Mass Index (BMI) Assessment
- Ambulatory Care admission
- Care Transition
- Follow up after hospitalization for Mental Illness
- Plan All-Cause Readmission Rates
- Screening for Clinical Depression and follow-up plan
- Initiation and Engagement of Alcohol and other drug dependence treatment
- Controlling High Blood Pressure
- Prevention Quality Indicator- Chronic Conditions Composite

Goal-Based Quality Measures

NYS has developed a set of Goal-Based Quality Measures against which Health Homes will be evaluated. These measures include:

- Reduce utilization associated with avoidable and/or preventable inpatient stays
- Reduce utilization associated with avoidable emergency room visits
- Improve outcomes for persons with mental illness and/or substance abuse disorders
- Improve disease-related care for chronic conditions
- Improve preventive care

For each of these goals, indicators in the following categories have been or are being developed:

- Clinical outcomes
- Experience of care
- Quality of care
HHUNY Initiative

HHUNY has created a Quality Assurance and Performance Management Program that will improve the outcomes for clients and monitor and support the success of Care Management Agencies in meeting the identified Quality Measures. This program identifies areas of success as well as areas for improvement in practice. The program shares feedback with Care Management Agencies and provides guidance and training focused on improving the quality and effectiveness of services provided.

Procedures included as part of the initiative are:

- Audit of Charts
- MAPP Performance Reports
- HHUNY Specific Performance Reports
- Problem Provider Documentation and Follow Up
- Quality Improvement Projects
- Reporting
- Effective Practices Training

Audit of Charts

Audits will be completed annually and the results will be shared with each Care Management Agency. The audit includes these areas of focus:

- Completeness and quality
- Use of person-centered practices
- Appearance of the golden thread between assessment, problem statements and care plan development
- Appropriate documentation of billable services
- Timeframes for documentation, assessments, care plans and crisis plans

See the HHUNY Audit Tool for a more detailed outline of what information will be reviewed during an audit.

Care Management Agencies with performance areas identified as needing improvement will be requested to develop plans of correction.

See the HHUNY Audit Outcome Letter for an example of corrective actions required.

MAPP Performance Reports

The Medicaid Analytics Performance Portal (MAPP) is a performance management system that will provide tools to the Health Home network to support providing care management for the Health Home population.
HHUNY will set expectation concerning the timely review of the process and outcome measures found on MAPP for Care Management Agencies once this information becomes available. HHUNY will review the QA measures and request Care Management Agencies with performance issues to develop plans of correction.

**HHUNY Specific Performance Reports**

HHUNY will utilize information from Netsmart and other sources to provide additional performance feedback to Care Management Agencies and Health Home Hubs. Reports will be reviewed quarterly by HHUNY and any Care Management Agencies with performance issues will be requested to develop plans of correction.

**Problem Provider Documentation and Follow Up**

When providers display performance issues related to meeting HHUNY day-to-day operational expectations, HHUNY Operations staff will follow up with the provider and share the concern. If the problem is not readily resolved by the provider, the issues will then be shared with the HHUNY Leadership Team and the Health Home Provider Leads, when appropriate.

**Quality Improvement Projects**

Every two months, HHUNY will identify and pursue a quality improvement project. Topics will be driven by the outcomes identified in performance reports, audits and operational areas. Any results from a quality improvement project will be shared with all Care Management Agencies.

**Reporting**

A report will be submitted quarterly to Health Home Provider Leads summarizing the findings from various initiatives and suggested recommendations for follow up.

**Effective Practices Training**

As information is collected through record reviews and performance reports, training programs will be developed to support improved Health Home Care Management outcomes.

Practice areas of focus will include:

- Community Outreach and Engagement
- Completion of Assessment
- Developing and Utilizing a Multi-disciplinary Care Team
- Communication with Managed Care Organizations
- Creation and Utilization of a Care Plan
Health Homes of Upstate New York

HHUNY-Central (Onondaga Case Management Services)
HHUNY-Finger Lakes (Huther Doyle Memorial Institute)
HHUNY-Southern Tier (Chautauqua County Department of Mental Hygiene)
HHUNY-Western (Lake Shore Behavioral Health)

Health Homes of Upstate New York

<table>
<thead>
<tr>
<th>Policy/Procedure:</th>
<th>Quality Assurance and Performance Management Practices</th>
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<tr>
<td>Reviewed and Accepted by:</td>
<td>HHUNY Health Home Advisory Committee</td>
</tr>
<tr>
<td>Approved by:</td>
<td>NYCCP Board of Directors</td>
</tr>
<tr>
<td>Date of Issue:</td>
<td>July 30, 2015</td>
</tr>
<tr>
<td>Date Revised/Reviewed:</td>
<td>September 9, 2015</td>
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</table>

Policy:
In order to monitor the effectiveness of Health Home Care Management services, the Center for Medicaid and Medicaid Services (CMS) has created a Core Set of Quality Measures:

1. Adult Body Mass Index (BMI) Assessment,
2. Ambulatory Care - Sensitive Condition Admission,
3. Care Transition – Transition Record Transmitted to Health care Professional,
4. Follow-up after Hospitalization for Mental Illness,
5. Plan- All Cause Readmission,
6. Screening for Clinical Depression and Follow-up Plan,
7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment,
8. Controlling High Blood Pressure
9. Prevention Quality Indicator- Chronic Conditions Composite

For more information, go to the following link:


New York State has also developed a set of goal-based quality measures against which Health Homes are to be evaluated. These measures include:

   Goal 1: Reduce utilization associated with avoidable (preventable) inpatient stays

Policy/Procedure: Quality Assurance and Performance Management Practices

Reviewed and Accepted by: HHUNY Health Home Advisory Committee

Approved by: NYCCP Board of Directors

Date of Issue: July 30, 2015

Date Revised/Reviewed: September 9, 2015

Policy:
In order to monitor the effectiveness of Health Home Care Management services, the Center for Medicaid and Medicaid Services (CMS) has created a Core Set of Quality Measures:

1. Adult Body Mass Index (BMI) Assessment,
2. Ambulatory Care - Sensitive Condition Admission,
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9. Prevention Quality Indicator- Chronic Conditions Composite

For more information, go to the following link:


New York State has also developed a set of goal-based quality measures against which Health Homes are to be evaluated. These measures include:

   Goal 1: Reduce utilization associated with avoidable (preventable) inpatient stays
Goal 2: Reduce utilization associated with avoidable (preventable) emergency room visits
Goal 3: Improve outcomes for persons with Mental illness and/or Substance Use Disorders
Goal 4: Improve disease-related care for chronic conditions
Goal 5: Improve preventive care

The purpose of the HHUNY Quality Assurance and Performance Management Program is to monitor the success of the practice of care management by its affiliated agencies in order to improve outcomes for members. It identifies areas of success and well as areas for improvement in practice. The Program shares performance feedback with the Care Management Agencies and provides guidance and training focused on for improving the quality and effectiveness of the services provided.

Procedures:

Audit of Charts:
• Annual audits of charts will be conducted to assess the completeness; the use of person-centered practices; the appearance of a golden thread between assessment, problem statements and care plan development; as well as the appropriate documentation of billable services
• Results of audits will be shared with each Care Management Agency as well as the Health Home Quality Assurance and Performance Management Committee.
• Health Home Quality Assurance and Performance Management Committee, as appropriate, will request CMAs with performance issues to develop plans of correction

MAPP Performance Reports:
• HHUNY will set expectations concerning the timely review of the process and outcome measures found on MAPP for CMAs once this information becomes available.
• Health Home staff will review the QA measures and summarize findings to share with Health Home Quality Assurance and Performance Management Committee.
• The Quality Assurance and Performance Management Committee, as appropriate, will request CMAs with performance issues to develop plans of correction

HHUNY Specific Performance Reports:
• HHUNY will provide additional performance feedback to CMAs using data in NetSmart and other sources. Reports will include metrics such as: Percentage of Care Management records with a care team and Percentage of records with a Crisis Plan?
These HHUNY Reports will provide measures for both the CMAs as well as the Health Home hubs as a whole. The Performance Reports will be shared on a quarterly basis with the HHUNY Quality Assurance and Performance Management Committee. The Quality Assurance and Performance Management Committee, as appropriate, will request CMAs with performance issues to develop plans of correction.

**Problem Provider Documentation and Follow up:**
- When performance issues tied to meeting HHUNY day-to-day operational expectations are identified, HHUNY Operations staff will follow up with provider and share concern.
- These performance issues will be shared with the HHUNY Leadership Team when the problem is not readily resolved by Care Management Agency.
- If deemed appropriate, HHUNY will share these performance concerns with both the Quality Assurance and Performance Management Committee and the Health Home Provider Leads.

**Quality Improvement Projects:**
- Every 2 months, the Quality Assurance and Performance Management Committee will identify and pursue a Quality Improvement project with the topic driven by opportunities observed in the above Performance Reports, audits and operational problems identified.
- The results of the QI study would be shared with all CMAs.

**Reporting:**
- In addition to the reporting already described, the Quality Assurance and Performance Management Committee will submit a quarterly report to the Health Home Provider Leads summarizing the findings from the various initiatives and making recommendations for follow up.

**Effective Practices Training:**
As information is collected through record reviews and performance reports, training programs will be developed to support improved Health Home Care Management outcomes.

**Policy Review:**
This policy and its procedures will be reviewed yearly and updated as necessary to ensure that its general purposes are being effectively met.
Dear Care Manager Agency:

As you are aware, New York State created Health Home Care Management as a method for providing additional support and coordination for High Need Medicaid recipients. Outcomes anticipated by the State as a result of this investment include improved member health status along with a reduction in inpatient and emergency department rates. The State is not only interested in these outcomes; they are working with a company called Salient to deploy their Medicaid claims and encounter database to provide feedback to Health Homes and the Care Management Agencies within the Health Home on their success in achieving these outcomes. HHUNY recently saw a demonstration of the Salient Health Home Module and understand that inpatient and ER rate reports will be available to us in the not too distant future.

As a new undertaking, HHUNY has devoted a great deal of its administrative resources to assuring compliance with the State’s Tracking and CMART requirements over the last few months. We are now at a point in the organization’s growth and development where energy needs to be devoted to assuring that the caliber of care management provided through HHUNY meets the State’s outcome expectations.

To this end, HHUNY Leadership has created a Four Step Approach for engaging Care Management Agencies in a way that will best position HHUNY for success. The steps are as follows:

- Review of Care Management Agency procedures to assure that critical HHUNY Care Management practices are taking place
• Record review, including review of Health Home Care Plans
• Development, distribution and review of CMA Performance Reports
• Care Management training.

To begin this very critical HHUNY Outcome Initiative, we are asking that the following information be sent to Chris Mangione (cmangione@hhuny.org) HHUNY’s Clinical Director by xx/xx/xxxx:

1. The name and contact information of your agency’s champion for the HHUNY Outcome Initiative.

2. Copies of the polices and procedures you have in place to make sure that practices critical to the success of Health Home Care Management are taking. The specific areas of interest at this time include:
   • Policies and practices tied to Health Home Community Outreach.
     o What are the expectations placed upon the care managers when doing outreach to find and speak with an individual on your assignment list (steps to be taken, time frames, etc.)?
     o What expectations are placed upon care managers when a community referral is received from an individual currently in the hospital (steps, time frames, etc.)?
   • HHUNY expects that the assessment will be completed within 30 days of enrollment. Please provide a copy of the policy and procedure that is in place to support this expectations
   • The NYS Health Home program expects that Multi-Disciplinary Care Teams will be created to support the needs of the member. Provide the procedure that describes the expectations tied to the creation of the team, including: who is to be invited, meeting frequency, agenda development, documentation as well as mode of communication.
   • It is the expectation that members sign off on the Health Home Care Plan. What is the procedure for assuring that the member signs off, not just on the initial care plan but when any changes to plan are made.
   • It is the expectation that Care Management Agencies provide coverage 24 hours per day, 7 days per week. Please provide the associated Policy and Procedure for assuring this coverage is available.
   • Document how your agency makes sure that care managers are made aware of the evolving array of community resources available to support the needs of Health Home members.
   • Document the practices in place to facilitate communication with a Managed Care Plans when a member is a part of that Managed Care Plan.

3. To begin the record audit process, we request that for each Care Manager within your agency, you provide:
• Three recent Care Plans
• Two recent Crisis Plans.

As a reminder:
• A Care Plan is person centered; it is based around the needs and strengths of the individual and reflects their preferences and diversity.
• A Care Plan shows evidence of collaboration with the individual and providers.
• A Care Plan reflects the capacity to address the “full continuum of beneficiary needs, including medical, behavioral, and long-term services and supports”.*
• A Care Plan can be understood by the individual, families, service providers and community agencies.

* Center for Medicare and Medicaid Services

Upon receipt of the above information, the Clinical Director and her team will review this material and then follow up with written recommendations. The next step in our initiative will be to complete record reviews. We will let you know in advance of this audit, but have attached a copy of the audit tool so you may be fully aware of the focus of the record review when they occur later in the year..

We hope that you recognize the critical importance of this quality initiative and how significant it will be to the long term success of Health Homes of Upstate New York and each Care Management Agency. Thank you in advance for your prompt response to this request.

Sincerely,

Adele Gorges       Christine Mangione       John Lee
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<thead>
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<th><strong>Initial Documentation Completion</strong></th>
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<td>Comprehensive Assessment</td>
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<tr>
<td>FACT-GP/Functional Assessment</td>
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<tr>
<td>Initial Care Plan</td>
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<tr>
<td>Care Plan is representative of identified needs/priorities from Comprehensive Assessment</td>
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</table>
Objectives and Interventions are person-centered and are developed around the client's needs

Each Problem is identified on the Care Plan and addressed within an objective (or there is a note why it is not addressed at this time)

Client and Care Team Members are indicated as participants on documentation

CareManager notes clearly document the activities that took place to address the identified Intervention

CareManager notes document active and progressive movement towards attainment of Objectives and overall goal

CareManager notes identify services that are denied, unavailable, or the client's non-adherence to participate

CareManager notes demonstrate the Care Manger's efforts in obtaining needed services

CareManager notes show evidence of the Care Manager working with other service providers

CareManager notes shows evidence that the Care Manager shared the Care Plan with other service providers and/or social supports

Appropriate justification for discharging the client is evident

Problems are referred to Providers

Social Support Contacts are documented

Medicaid CIN is accurate and active

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Comments:
Care Management Agencies

Heath Homes of Upstate New York (HHUNY) recently conducted a record audit of all Care Management Agencies (CMAs) within the HHUNY Network. The focus of this audit was on required documentation, meeting identified timeframes and person centered practice. This focused audit was done with the intention of assessing the quality of care provided to the individuals served within the HHUNY Network and the ability of the CMAs to meet the Department of Health and HHUNY Standards for Care Management. The information obtained from the audit will be shared with the individual agencies as well as with the Provider Leads for each HUB.

The HHUNY audit process is as follows:

- A random sample of active enrollees within the HHUNY Network is identified.
- All agencies are informed of the upcoming audit and provided with the template of the audit tool.
- Audits of records are completed and each record is assigned a score.
- Each agency’s individual record scores are combined and the agency is provided their average score.
- Provider Leads are notified of the audit results for each agency within their HUB.
- A combined HUB score generated from all scores within each HUB will be tallied. Provider Leads are notified of the combined score.

The audit reports are computed as follows:

**Agencies scoring 85 – 100%**
- Each agency in this category will be informed of their score and advised that no corrective action is necessary. Individual care manager scores will be provided upon request.

**Agencies scoring 70 – 84%**
- Each agency in this category will receive a letter informing the agency of their average score and range of scores.
- Individual scores for Care Managers will be provided.
- Opportunities for improvement will be identified.
- Corrective action plans will be required for each Care Manager scoring below 70% on any of their records audited; plans to be submitted within 4 weeks of receiving the letter from HHUNY.
- Each agency in this category will be advised that a follow up audit will occur three (3) months from the date the letter was issued.
Agencies scoring 69% and below

- Each agency in this category will receive a letter informing the agency of their average score and range of scores.
- Individual scores for Care Managers will be provided.
- Opportunities for improvement will be identified.
- Agencies in this category will be required to submit a corrective action plan within 4 weeks from the date the letter was issued.
- Each agency in this category will be advised that a follow up audit will occur three (3) months from the date the corrective action plan was received. The scores for the follow up audit must be 70% or higher in order for that CMA to receive DOH assignments or Community Referrals.
- Agencies with scores below 70% will be assessed by the Lead Health Homes for continued participation in the HHUNY Network.

HHUNY would like to thank our Care Management Agencies for their cooperation during the audit process. Record audits will continue as a standard component of HHUNY’s quality improvement initiative. HHUNY’s Clinical Director will be sending out reports in the next few weeks to our network agencies.

If you have any questions regarding the audit process or results, please do not hesitate to contact Helen Warnick, HHUNY Quality and Marketing Coordinator at hwarnick@hhuny.org or 585-613-7678.

Sincerely,