Bassett Healthcare Network
Community Health Navigation

Policy Title: **Health Home Quality Assurance & Performance Program**	**DOH Policy Name: Health Home Quality Management Program** **DOH Reference Number: HH0003** **Effective Date: 06/01/2017**
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POLICY STATEMENT

The Bassett Community Health Navigation Health Home (BCHNHH) will develop and maintain a Quality Management Program in alignment with Health Home Standards and Requirements that objectively, systematically, and continuously assess, assure, monitor, evaluate, and improve the quality of processes, activities, and services provided to Health Home members.

The Health Home is responsible for assuring members receive appropriate and effective care management services to: prevent avoidable inpatient stays and emergency room visits; improve disease-related care and outcomes for individuals with Serious Mental Illness (SMI), HIV/Aids, or chronic conditions including Substance Use Disorders (SUD); improve preventative care; and, lower Medicaid costs.

BCHNHH will ensure its partnering Care Management Agencies (CMA) provide timely, comprehensive, high quality Care Management services using the 'person-centered' approach to care. BCHNHH will maintain an environment that fosters quality improvement strategies. This is achieved through implementation of a Quality Management Program (QMP), a system to monitor and objectively evaluate Health Home quality, efficiency, and effectiveness.

BCHNHH will collect, analyze, and report on data in a way that measures the effectiveness of care coordination and chronic disease management on individual-level clinical outcomes, member satisfaction, and quality of care outcomes at the population level.

SCOPE

QMP supports the development of a quality culture in which all staff assume responsibility for quality and engage in quality management at all levels. This includes: clinical and administrative areas of Health Home operations and other entities involved in Health Home activities; care management agencies and staff; NYS Department of Health; State Partners; and other stakeholders (e.g., members and family).

OBJECTIVES

The purpose of this policy is to provide guidance on the practice of quality management and an overview of the components, requirements, best practices, and activities associated with a Health Home Quality Management Program (QMP). To promote a culture of learning and continuous quality improvement, monitoring, and oversight within the Health Home Network.

DEFINITIONS

Quality Management Program (QMP)
QMP is a system that documents processes, procedures, and responsibilities for achieving quality practices and objectives. It is a proactive approach rather than reactive, identifying and resolving issues before they occur. An effective QMP not only evaluates the ability of the Health Home and care management agencies to provide quality services to members, but also the impact of the services on health outcomes for members.

There are two aspects of an effective QMP: Quality Assurance and Performance Improvement (QAPI)

Quality Assurance/Performance Improvement (QAPI)
QAPI is the coordinated application of two mutually-reinforced aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving quality and processes within the Health Home program while involving all care management agencies in practical and creative problem solving.

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.

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. PIC in the Health Home program aims to improve processes involved in care management service delivery and member quality of life.

The Health Home Care Management Assessment Reporting Tool (CMART)
Core services specified by Centers for Medicare and Medicaid Services (CMS) which include comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services, and use of health home information technology to link services.

ROLES AND RESPONSIBILITIES

Health Home Administration Responsibilities
BCHNHH will provide a system that will assess, monitor, evaluate, and review effective quality improvement strategies by ensuring each CMA has a system in place for a Quality Management Program. BCHNHH will ensure that all staff is trained on effective member care. BCHNHH will provide a selected amount of case reviews per month to assess scores and provide informational data to help improve quality.

CMA Supervisor Responsibilities
Each CMA is responsible for the implementation of trainings on each policy and procedure and ensure a Quality Improvement Plan is in place for each staff to complete. The CMA will ensure staff is maintaining their yearly trainings and understands each policy and procedure while implementing additional training when necessary.

Care Manager Responsibilities
CM will ensure that all policies and procedures are being followed, that they understand each component and are implementing these into their everyday practices. The CM will work with BCHNHH to review any audited charts or QIP's and ensure that any corrections needed are being completed, and any questions are being asked to assure the maximum scores are being achieved.

PROCEDURES

This policy and procedure outlines the components of an effective Quality Management Program. These components will include the following:

1. Define the organization's mission and how a QMP will be integrated.

2. Identify the individual who will have overall responsibility for the daily operation of the QMP.

3. Assure involvement of leadership and/or management in QMP processes. Effective support from senior management/leadership is critical to the success of a QMP.
    a. QMP activities to leadership/management must occur quarterly. QMP Committee minutes will include all reporting to leadership.
    b. BCHNHH will assure that a QMP system will be in place that includes organizational leadership to support a culture of quality and secure resources necessary to conduct quality improvement efforts. Reporting on QMP activities to leadership/management must occur no less than quarterly.

4. BCHNHH will monitor CMAs providing one of the first 5 core functions (excludes HIT) to each member per month to meet billing standards.
    a. The HH-CMART is a tool for the collection of standardized care management data for members enrolled within Health Homes. The data requirements include submission of specified data about care management services provided to members in Health Homes.
    b. BCHNHH is required to provide NYS DOH with the following information submitted via the HH-CMART.
    c. When completing notes, Care Managers should be identifying the most appropriate core service their activities/services/interventions with the member. The following are the 5 core services available:
        i. **Comprehensive Care Management**: to be used when completing a comprehensive assessment/reassessment, completing/revising a Plan of Care, consulting with member's multidisciplinary team about the members needs, conducting client outreach and engagement activities, and preparing client crisis intervention plans.
        ii. **Care Coordination and Health Promotion**: to be used when coordinating with service providers and health plans as appropriate, linking members to needed services to support care, conducting care reviews with interdisciplinary team, advocating for services, coordinating with treating clinicians, revising care plans/goals, and monitoring/supporting/accompanying members to medical appointments.
        iii. **Comprehensive Transitional Care**: used when following up with hospitals/ED upon notification of admission or discharge, facilitating discharge planning, notification/consultation with treating clinicians, linking member with community
            1. supports, and following up post discharge with the member or family to assist with needs/goals.

iv. **Member and Family Support**: used when developing/reviewing/revising the members plan of care with the member/family, consulting with members family/caretaker on advanced directives and client rights, meeting with the member and family and other providers, referring member/family to peer supports, support groups, and social services, and collaborating/coordinating with community-based providers to support effective utilization of services based on member/family need.
v. **Referral and Community & Social Support Services:** used when identifying resources and linking members with community supports, and collaborating with community-based providers to support utilization of services based on member/family need.

5. BCHNHH will identify individuals to serve on a QMP Committee.
    a. The QMP Committee must be multi-disciplinary, adequately representing of all key departments, with clearly defined roles and responsibilities. The Quality Management Committee monitors the ongoing effectiveness of the Quality Management Program.

6. **QMP Committee Chair:** facilitates committee meetings, reports on activities and findings of the Committee to leadership and/or management;

7. **QMP Coordinator:** designs, directs and oversees implementation of QMP projects to include review of data and performance measures, manage work plans, oversee performance improvement activities, and monitor progress.

8. **Note:** The QMP Chair and Coordinator are responsible to provide the oversight needed to run an efficient QMP.

9. **Various other entities:** The BCHNHH will consider representation on the QMP Committee by other entities that service the Health Home population. This may include: medical, clinical, technical, financial operations, Care Management Agencies, stakeholders such as PPS, housing providers, criminal justice, etc.
    a. Health Homes must obtain feedback from members and family members and apply their input into QMP processes.

10. **Other subcommittees:** Subcommittees/teams may be established in response to various QA activities.

11. Define Responsibilities and Activities of the QMP Committee:
    a. The Committee is responsible for defining, overseeing, and monitoring the objectives and goals of the QMP. This includes:
        i. prioritizing performance improvement efforts to utilizing strategic goals, aggregating and analyzing performance and benchmark data, and trend analysis;
        ii. identifying barriers and needed resources to support PI implementation;
        iii. monitoring performance improvement efforts for effectiveness;
        iv. making recommendations for changes in service provision or operations; and,
        v. preparing written reports to leadership that include findings, actions, and outcomes of the Quality Management Program.

12. Establish a process and frequency for approving, revising and evaluating QMP activities. Consideration should be given to the availability of resources that may be needed to support improvement activities.

13. Hold QMP Committee meetings, at least quarterly, or more frequently as defined by the Health Home's network or governance.

14. Describe a process for the Health Home to notify the QMP Committee of any critical issues identified (e.g., a significant trend or pattern in member incidents governed by the Complaint/Incident policy) to identify root cause(s), implement and monitor corrective action plans, and implement quality performance improvement strategies to prevent recurrence.

15. Document QMP Committee activities that promote continuous quality improvement and support the objectives and goals of the QMP. Such activities include, but are not limited to: audit findings and outcomes; Performance Improvement Plans (PIP) with outcomes of success or corrective action; and, outcomes of policy change requests. Health Homes may choose to report on quality goals through quality report cards, dashboards, monitoring reviews, or any other quality reporting tool(s) determined by the Health Home.

16. Include a clear quality statement with specific expectations integrated into each appropriate Health Home policy to assure continuous quality improvement within that domain.

17. Maintain the components of confidentiality in compliance with State and Federal laws to protect information obtained and utilized in QMP activities.

18. Review of the QMP annually to evaluate progress towards objectives and goals, identify any needed improvements/revisions in QMP processes, and determine topics for the coming year. Summaries of the evaluation are provided to the appropriate leadership for review.

19. Identify how negative outcomes will be addressed through the use of a Performance Improvement Plan (PIP), a written document that clearly and objectively identifies:
    a. areas where performance expectations and standards have not been met, including examples to clarify the patterns or severity of performance issues, and the impact of the unmet performance;
    b. root cause of analysis
    c. expectations for improvement using measurable goals;
    d. timeline for improvement to be reached;
    e. assignment of tasks to appropriate staff;
    f. the need for staff training or support;
    g. expectations for reviewing progress including any barriers; and,
    h. sanctions that may be imposed if improvements are not made.

20. Maintain QMP records that include but are not limited to: minutes of all QMP Committee activities, administrative reporting, quality assurance strategies, performance improvement activities, corrective actions taken and outcomes, and annual QMP review.

21. BCHNHH will inform and engage staff in quality-related activities. This is important to the success of the QMP. BCHNHH will provide training regarding the QMP to new staff, and ongoing as needed to support successful quality outcomes through staff inclusion. In addition, BCHNHH will ensure that Health Home Care Management Agencies receive QMP training to support a culture of quality, for example: inclusion in core curriculum provided by Health Homes for their Care Management Agency Network; and, review key principles at the onset of each quality improvement initiative.

COMMUNICATION/TRAINING/IMPLEMENTATION

BCHNHH will provide trainings on all new policies and as necessary to CMA staff. BCHNHH will utilize the Quality Assurance Tool to collect data to ensure charts have all necessary documentation and members have Person-Centered Comprehensive Assessments and Plans of Care in place. The data collected will be brought back to the QMP Committee to analyze and inquire if further training is needed or if new procedures need to be implemented. This data will help assess the quality of services being provided to members. This will provide information on whether or not a Performance Improvement Plan needs to be implemented.

Quality Management & Performance Improvement

BCHNHH will audit a minimum of 30 charts each month (including enrolled members, discharged members, and HARP/HH+ members) creating a score for each chart utilizing the Quality Assurance Tool. This score will assist the Health Home with implementing any additional trainings that may be identified from the scores. Any data collection identified will be utilized to ensure that members are receiving appropriate and effective care management services.

Monthly QA Review of Care Management Records

1. BCCHNHH will review at least 30 Member Care Management Records each month, it will be assured that the total cases reviewed include a combination of:
    a. Standard Health Home Members, HARP & HH+
    b. Opted-Out/Disenrolled Members

2. BCHNHH will complete 30 (or more) monthly audits to ensure policy adherence in the following areas:
    a. Eligibility, Consents, Care Transitions, Continuity of Care, transfers, & Plans of Care Comprehensive Assessment & Person-Centered Care Planning, Supporting Notes & Documentation, Billing Standards and Disenrollment.

3. BCHNHH will complete Care Management Record Reviews using the Bassett CHN Care Management Record/QA Review Tool to check each case for compliance with all current Bassett CHN, Federal, and NYS Policy and Guidance for Medicaid Health Home Services, Billing, and Quality Standards.

RELATED FORMS

- *BCHNHH QA Review Tool*