POLICY: 1.022 QUALITY MANAGEMENT

In order to monitor the effectiveness of Health Home Care Management services, the NewYork-Presbyterian Hospital will adopt the Center for Medicare and Medicaid Services (CMS) Core Set of Quality Measures. In addition the NYPHH will collaborate and adopt hospital-wide quality metrics in accordance with NewYork Presbyterian Care Coordination strategies and projects.

CMS Core Set of Quality Measures:

- Adult Body Mass Index (BMI) Assessment
- Screening for Clinical Depression and Follow-up Plan
- Plan All-Cause Readmission Rate
- Follow-up After Hospitalization for Mental illness
- Controlling High Blood Pressure
- Care Transition-Timely Transmission of Transition Record
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Chronic Condition Hospital Admission Composite-Prevention Quality Indicator

(For further information on CMS Core Set of Health Care Quality Measure for Medicaid Health Home Programs, please see following link: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-home-core-set-manual.pdf).

New York State has also developed a set of goal-based quality measures against which Health Home are to be evaluated. These goal based quality measures provided in the State Plan Amendment (SPA) include:

- Reduce utilization associated with avoidable (preventable) inpatient stays
- Reduce utilization associated with avoidable (preventable) emergency room visits
- Improve Outcomes for persons with Mental Illness and/or Substance Use Disorder
- Improve Disease-related Care for Chronic Conditions
- Improve Preventive Care

(For further information on NYS Health Home SPA metrics, please see following link: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/statewide_hh_quality_measures.pdf)

The purpose of the NYPHH Quality Management Plan is to:

- ensure standards and requirements are being met;
- monitor quality and outcomes of care management services
- evaluate the quality of the care management services provided; and
- identify opportunities to train and educate;
- to improve delivery of care management services and patient health outcomes.

To meet this purpose, the NYP Health Home will engage in a set of activities as detailed in our Procedures. NYP Health Home will adopt the PDSA of Quality Improvement (QI) (see *Appendix R* for an overview).

Procedures include:

- Audit of Patient Charts
- Performance reports
- Review Documentation Issues and Follow-up
- Quality Improvement projects
- Trainings

Quality Management Program (QMP) Committee

The NYP QMP Committee monitors the ongoing effectiveness of the Quality Management Program. The Committee is responsible for defining, overseeing and monitoring the objectives and goals of the QMP. This includes:

- prioritizing performance improvement efforts utilizing strategic goals, aggregating and analyzing performance and benchmark data, and trend analysis;
- identifying barriers and needed resources to support PI implementation;
- monitoring performance improvement efforts for effectiveness;
- making recommendations for changes in service provision or operations; and,
- preparing written reports to leadership that include findings, actions, and outcomes of Quality Management Program.

The QMP Committee will include:

- QMP Committee Chair
- QMP Coordinator
- Various other entities
- Other Subcommittees

PROCEDURES

Audit of Charts:

1. Annual audits of charts will be conducted to assess the completion of required assessments; the use of person-centered practices; the connection between identified needs in the assessment to patient-centered goals in the Care Plan; the implementation of Care Plans and delivery of care management services; as well as the appropriate documentation of billable services.
2. Results of audits will be shared with each Care Management Agency as well as the NYPHH Policy Committee.
3. The NYPHH QMP Committee, as appropriate, will request CMAs with performance issues to develop a corrective action plan.

Performance Reports:

4. NYP Health Home will provide additional performance feedback to CMAs using data in AllScripts Care Director, BTQ, MAPP, CMART and other sources.
5. Allscripts Care Director Reports will provide data and trends on the completion of required assessments and documentation as established by the NYSDOH, in addition to data regarding the amount of services provided and quality of care management interventions.
6. BTQ reports will provide billing data, errors and trends.
7. MAPP, CMART, and other NYSDOH reports will be provide view on performance and measures regarding Health Home enrollment, outreach, HARP, and other state specific factors.
8. These NYPHH performance reports will provide findings and analysis for the CMAs.
9. The Performance Reports will be shared on a quarterly basis with the NYPHH Policy Committee.
10. The NYP Health Home QMP Committee, as appropriate, will request CMAs with performance issues to develop corrective action plans.

Review Documentation issues and Follow up:

1. When performance issues related to NYPHH day-to-day operations are identified, the NYPHH Leadership Team will follow up with the CMA and share their concern.
2. The NYP Health Home Leadership Team will work with the CMA to develop a corrective action plan.
3. If deemed appropriate, NYPHH will share these performance concerns with the NYPHH QMP Committee and Community Population Health Quality committees.

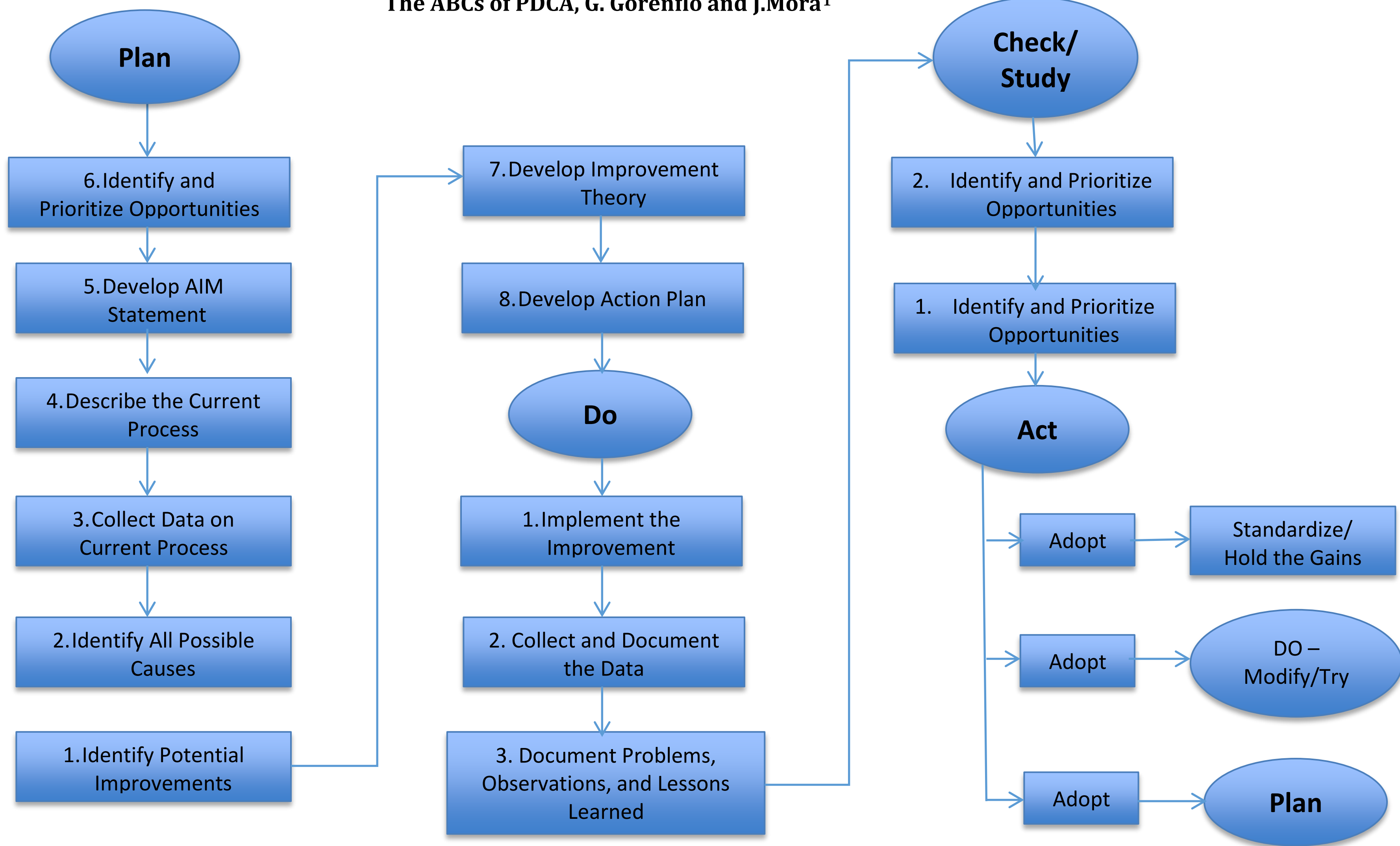
Quality Improvement Projects:

1. Every quarter, the NYPHH QMP 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.
2. The results of the QI study would be shared with all CMAs and NYP Leadership.

Trainings:

1. As information is collected through record reviews and performance reports, training programs will be developed to support improved Health Home Care Management outcomes.
2. NYPHH will inform, via email, CMAs of training opportunities provided by The Community Technical Assistance Center of New York (CTAC) and the Managed Care Technical Assistance Center of New York (MCTAC), NewYork-Presbyterian Hospital Performing Provider System (PPS), Allscripts Care Director, AIDS Institute, NYS OMH/OASAS/DOH, and other network providers.

APPENDIX R. PDSA of Quality Improvement WorkFlow Overview



[1] *Obtained from*: Gorenflo, G. and Moran, J.W. "The ABCs of PDCA." Accessed on December 12, 2016 from http://www.phf.org/resourcestools/Documents/ABCs_of_PDCA.pdf.