FISCAL YEAR 2014

QUALITY MANAGEMENT PLAN

July 1, 2013  Alliance Behavioral Healthcare Quality Management Department
PURPOSE

The purpose of this Quality Management Operations Plan is to provide a systematic method for continuously improving the quality, efficiency, and effectiveness of the services managed by Alliance Behavioral Healthcare for enrollees served. This plan also encompasses internal quality and effectiveness of all MCO processes.

MISSION AND VISION

Alliance’s Mission Statement: We pursue a community effort dedicated to supporting the lives of citizens affected by mental illness, developmental disabilities, and substance abuse by assuring a collaborative, accessible, responsive, and efficient system of services and supports.

An overlying philosophy of Alliance Behavioral Healthcare is to be an organization whose management focuses on its responsibility to maintain a fiscally sound agency, but will never permit this focus to undermine its responsibility to the delivery of exceptional care to those in need.

Alliance’s Vision: We are a community with energy and momentum that embraces people with disabilities as equal partners and valued citizens. We believe that when citizens with disabilities reach their full potential, the entire community benefits.

Our Customers
Alliance Behavioral Healthcare upholds the highest integrity for the staff, enrollees, families, providers, and all other stakeholders to ensure that enrollees receive:

- Access to high quality clinical and human services
- Best practice programs and innovative ideas to shape and trend services, outcomes, and community needs
- The highest level of customer service to address needs

On February 1, 2013, the Alliance Behavioral Healthcare Managed Care Organization (MCO) began managing a state Medicaid behavioral health and I/DD services contract for Cumberland, Durham, Johnston, and Wake Counties in North Carolina. The four counties that make up Alliance Behavioral HealthCare are racially and ethnically diverse. A greater percent of racial and ethnic minorities live in Durham and Johnston Counties, as compared to the rest of the state. Fifty-four percent (54%) of residents identified themselves as non-white or as multiracial, as compared to 32% of all North Carolinians who self-identify as non-white or multiracial.

The world as we have it is a process of our thinking. It cannot be changed without changing our thinking.

~Albert Einstein~
### 2011 Race and Ethnic Demographics

% and Total Number Reflected Based On 2011 US Census Estimates

<table>
<thead>
<tr>
<th>Race/Ethnic Category</th>
<th>Cumberland</th>
<th>Durham</th>
<th>Johnston</th>
<th>Wake</th>
<th>Alliance Catchment Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>54.6%</td>
<td>53.5%</td>
<td>80.9%</td>
<td>70.0%</td>
<td>65.5%</td>
</tr>
<tr>
<td>Black</td>
<td>36.9%</td>
<td>38.5%</td>
<td>15.8%</td>
<td>21.3%</td>
<td>26.5%</td>
</tr>
<tr>
<td>American Indian and Alaska Native</td>
<td>1.7%</td>
<td>1.0%</td>
<td>0.9%</td>
<td>0.9%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Asian</td>
<td>2.4%</td>
<td>4.7%</td>
<td>0.7%</td>
<td>5.6%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Hawaiian and Other Pacific Islander</td>
<td>0.4%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.16%</td>
</tr>
<tr>
<td>Two or more races</td>
<td>4.0%</td>
<td>2.2%</td>
<td>1.6%</td>
<td>2.2%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>9.9%</td>
<td>13.5%</td>
<td>13.0%</td>
<td>10.0%</td>
<td>10.8%</td>
</tr>
<tr>
<td>White, not Hispanic</td>
<td>47.5%</td>
<td>42.5%</td>
<td>69.5%</td>
<td>62.0%</td>
<td>56.9%</td>
</tr>
</tbody>
</table>

**Population Characteristics**

The total population for the Alliance catchment area for calendar year 2011 was estimated to be 1,700,652 (US Census Bureau, State and County QuickFacts, 2011 [http://quickfacts.census.gov](http://quickfacts.census.gov)). The chart below shows the breakdown of population by county in contrast to the Medicaid population.
### 2011 Population Estimates – US Census Bureau

<table>
<thead>
<tr>
<th>County</th>
<th>Child</th>
<th>% of Total County Pop.</th>
<th>Adult</th>
<th>% of Total County Pop</th>
<th>Total</th>
<th>% of Total Alliance Pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>113,385</td>
<td>34.9%</td>
<td>211,500</td>
<td>65.1%</td>
<td>324,885</td>
<td>19.1%</td>
</tr>
<tr>
<td>Durham</td>
<td>82,564</td>
<td>30.2%</td>
<td>190,828</td>
<td>69.8%</td>
<td>273,392</td>
<td>16.1%</td>
</tr>
<tr>
<td>Johnston</td>
<td>60,408</td>
<td>35.0%</td>
<td>112,187</td>
<td>65%</td>
<td>172,595</td>
<td>10.1%</td>
</tr>
<tr>
<td>Wake</td>
<td>305,898</td>
<td>32.9%</td>
<td>623,882</td>
<td>67.1%</td>
<td>929,780</td>
<td>54.7%</td>
</tr>
<tr>
<td><strong>Alliance Total</strong></td>
<td><strong>562,255</strong></td>
<td><strong>33.1%</strong></td>
<td><strong>1,138,397</strong></td>
<td><strong>66.9%</strong></td>
<td><strong>1,700,652</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The Medicaid eligibles listed in the table below include all Medicaid eligibles, including individuals that are not covered under the PIHP waiver program. The Medicaid populations as a percentage of the total population vary from a low of 8.24% in Wake County to a high of 15.46% in Johnston. Due to the overall size of Wake County within the catchment area, the average number of Medicaid eligibles is about 11% of the total population.

### September 2011 Medicaid Eligibles for Alliance Catchment Area

<table>
<thead>
<tr>
<th>County</th>
<th>Total Medicaid Eligible</th>
<th>Total Population 2011</th>
<th>Medicaid Eligibles as % of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>48,092</td>
<td>324,885</td>
<td>14.8%</td>
</tr>
<tr>
<td>Durham</td>
<td>35,562</td>
<td>273,392</td>
<td>13.0%</td>
</tr>
<tr>
<td>Johnston</td>
<td>26,677</td>
<td>172,595</td>
<td>15.5%</td>
</tr>
<tr>
<td>Wake</td>
<td>76,651</td>
<td>929,780</td>
<td>8.3%</td>
</tr>
<tr>
<td><strong>Alliance Total</strong></td>
<td><strong>186,982</strong></td>
<td><strong>1,700,652</strong></td>
<td><strong>11.0%</strong></td>
</tr>
</tbody>
</table>
What Gets Measured Also Gets Managed

According to Kari Miller (2013)\(^1\), a quality culture is an attitude. Quality in the organization must be a shared value system that starts with leadership who practice what is preached. As the Alliance Behavioral Healthcare Managed Care Organization (MCO) embarks on its vision and mission February 1, 2013, staff will need to change how information is thought about and processed. The Alliance MCO should operate as an innovator in terms of providing quality services to the people served.

Clearly defined values, goals, and objectives help to establish a positive quality culture. With the inclusion of teamwork, a focus on process, open communication, access to data that is meaningful, and lessons learned, Alliance will move into a new realm of quality and efficiency.

Quality Management (QM) has a misnomer of solely being about crunching data, when in fact; it is about process and process improvement. Accurate, timely data is only one component of an effective quality management program. Everyone in the “value chain” (agency, providers, enrollees, other stakeholders) are key to this process.

There are four main assumptions that the MCO should embrace to encourage a quality culture within the value chain:

- **To understand that it is better to prevent errors than to fix them**
- **To detect defects for early prevention**
- **To reduce testing and audit processes to reduce costs**
- **To determine root causes of errors and problems as they occur**

In the next year and forward, a major focus of Alliance Behavioral Healthcare will be to continue meeting contractual requirements, performance standards, and the identification and remediation of issues.

Quality Management will play a major role in ensuring the MCO has well established and evaluated processes for the timely identification, response, reporting, and follow-up to consumer incidents and stakeholder complaints about service access and quality. Alliance must ensure that its employees and the provider staff of its Provider Network are fully compliant with critical incident and death reporting laws, regulations, and policies, as well as event reporting requirements of national accreditation organizations. QM, along with the MCO Medical Director and/or designees, shall review, investigate, and analyze trends in critical incidents, deaths, and take preventive action to minimize their occurrence with the goals of improving the behavioral healthcare system, behavioral healthcare access, and consumer and provider outcomes.

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**Continuous Quality Improvement demands that staff and providers answer three basic questions:**

1. **Are we doing the right things?**
2. **Are we doing things right?**
3. **How can we be certain that we do things right the first time, every time?**

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\(^1\) Miller, Kari (2013). *Crafting a Quality Culture Always Comes Down to Process Improvement*, Quality Digest.
Experts in the quality management field agree that one of the most complex challenges related to quality management and improvement is how to maximize quality and outcomes given economic constraints. One method to meet this challenge is the collaborative quality management life cycle. Questions that are continually asked in this process are: *When do we delay action? How do we act early on? What are the costs to errors and barrier? Can we deliver services on time and in a quality manner?* Below is the structure of this life cycle:

Quality management is a lifecycle activity that affects everyone involved in a project. Having data stored in one central location that all staff can utilize assures accuracy and consistency. Instead of different department staff each individually completing an analysis or report, and possibly duplicating efforts, the collaborative cycle can reduce time and costs related to project development, analysis and utilization.

This cycle ensures accuracy of the data – as long as quality management staff is involved in every aspect of planning, testing, and production of reports. This requires support from senior leadership in the entire lifecycle.

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Quality Management Goals

The Quality Management Department’s ongoing goals mirror many of the goals of the Medicaid Waiver. While Quality Management will play a major role in ensuring Alliance is successful at meeting performance outcomes and contract requirements, the goals listed below are of particular focus due to direct involvement of QM staff and organization-wide QM activities.

1. To ensure the allocation of the most resources to individuals with the greatest disabilities;
2. To transition local systems toward treatment with effective practices that result in real life recovery outcomes for people with disabilities, as possible;
3. To promote community acceptance and inclusion of individuals with disabilities; to provide outreach to people in need of services; to promote and ensure accommodation of cultural values in services and supports; and to serve people in their local communities wherever possible;
4. To provide for easy access to the System of Care;
5. To ensure quality management that focuses on health and safety, protection of rights, achievement of outcomes, accountability, and that strives to both monitor and continually improve the System of Care;
6. To empower consumers and families to set their own priorities, take reasonable risks, participate in system management, and to shape the system through their choices of services and providers;
7. To empower Alliance Behavioral Healthcare – to build local partnerships with individuals who depend on the system for services and supports, with community stakeholders, and with the providers of service; and
8. To demonstrate an interactive, mutually supportive, and collaborative partnership between the State agencies and Alliance – in the implementation of public policy at the local level and realization of the State’s goals of healthcare change.
To ensure that these goals are met and that improvements in the system occur and are maintained, the six aims for improving healthcare identified by the Institute of Medicine (Crossing the Quality Chasm, 2011)\(^3\) are a good start. To achieve quality healthcare, systems improvement, and improved patient outcomes, healthcare must be:

1. **Safe**: avoiding injuries to patients from the care that is intended to help them.
2. **Effective**: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
3. **Patient-Centered**: providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.
4. **Timely**: reducing wait times and sometimes harmful delays for both those who receive and those who give care.
5. **Efficient**: avoiding waste, including waste of equipment, supplies, ideas, and energy.
6. **Equitable**: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

While QM and the MCO will have a multitude of contract requirements, performance outcomes, metrics, data sets and systems that will be of important focus and central to the work being done, keeping a set of guiding principles or aims throughout is essential.

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\(^3\) Institute of Medicine article *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001; the National Academy of Sciences.
FISCAL YEAR 2013:

During the first year of operations as an MCO, QM has and will be tasked with assisting MCO staff members with producing reports and using them appropriately for planning, decision-making, and improvements. The reports will analyze and summarize patterns and trends related to consumers, providers, and MCO operations including, but not limited to:

1. **Consumer trends**: critical incidents, client rights (from complaints data and Client Rights Committee), quality of care (from Quality of Care tracking and Complaints), personal outcomes (from NC-TOPPS), use of state facilities and local crisis access points (community hospitals, crisis facilities, mobile crisis,) utilize claims data for use with emergency departments (from CONK, the 4 sites, and claims data), service utilization rates (from ALPHA and UM), and perceptions of care (from surveys);

2. **Local service system trends**: service capacity (from claims and Network Operations), access to care for each population group and underserved groups (from Customer Service/STR), barriers to care (Network Capacity Study, complaints), local system performance (various sources), assessments of provider quality (Provider Report Card), results of audits and monitoring activities (Provider Network Database), technical assistance and trainings (tracked by QM), and use of evidence-based practices (Provider Network);

3. **MCO operations and trends**: tracking and monitoring of action plans determined from daily/weekly meetings and site deficiencies found, management of state funds (Risk Management Reports), trends in volume and cost of services per consumer (Rate Volume Variance Reports), Screening, Triage, and Referral processes (ALPHA and ATCOM), response to consumer requests for service (STR data), complaint response, and choice of providers (STR data);

4. **Access to primary care**: linkage to medical home and evidence of a preventative health exam, with collaboration with Community Care of North Carolina (CCNC) and other entities and stakeholders (data from CCNC and NC-TOPPS);

5. **Service patterns**: Utilization patterns and costs for high cost/high risk individuals (CCNC and ALPHA) and Medicaid recipients with unstable medical and MH/DD/SA diagnoses will be tracked and analyzed (CCNC and ALPHA).

Alliance Behavioral Healthcare will utilize the Continuous Quality Improvement Team and its subcommittees focus on program/provider improvement, appropriateness and effectiveness of care and services, integration of healthcare efforts, high-risk and high-cost factors, and utilization of evidence-based practices in the care continuum. Decisions are determined by this committee based on input and feedback from committees, staff, and stakeholders. The following organizational chart further defines reporting and processing relationships:
Committee Organizational Chart:

Additional sub-committees might be created during the fiscal year as Alliance progresses with improvements, and other areas of focus will be determined.
Alliance Behavioral Healthcare CQI Team and Sub-committee Descriptions:

Global Quality Management Committee (QMC) Authority and Composition
The Global QMC is the standing committee that is granted authority for Quality Management by the MCO. The QMC reports to the MCO Board of Directors, which derives from General Statute 122C-117. The Alliance Board of Directors Chairperson appoints the Quality Management Committee, which consists of five voting members—three Board members and two members of the Consumer and Family Advisory Committee (CFAC). Other non-voting members include at least one MCO employee and one provider representative from each county. The MCO employees typically assigned include the Director of the Quality Management (QM) Department, who has the responsibility for overall operation of the Quality Management Program; the MCO Medical Director, who has ultimate responsibility of oversight of quality management; and other staff as designated.

The Global QMC meets at least quarterly each fiscal year and provides ongoing reporting to the Alliance Board. The Global QMC approves the MCO’s annual Quality Improvement Projects, monitors progress in meeting Quality Improvement goals, and provides guidance to staff on QM priorities and projects. Further, the Committee evaluates the effectiveness of the QM Program and reviews and the QM Plan annually.

Continuous Quality Improvement Leadership Team (CQI)
The CQI Leadership Team is the internal review venue for the assessment and review of all data for the MCO. This committee is composed of the MCO Director, Deputy Director, Medical Director, Director of Corporate Compliance, Director of Utilization Management, Director of Care Coordination, Director of Customer Service, Director of Contracts Management, Director of Finance, Director of IT, MCO Site Directors, and Director of Quality Management. The Director of QM and the Medical Director Co-chair CQI meetings. Agendas and minutes are recorded. The CQI meets at least bi-monthly to review clinical and provider network performance data. The CQI is responsible for the development, implementation and evaluation of the MCO Quality Management Plan, monitoring of quality improvement goals and activities and identifying opportunities for improvement within the provider network. This committee examines data and information for further distribution and action, both internally and externally. Information reviewed with strategies for improvement and/or changes is then taken to the Global Quality Management Committee for additional review, feedback, recommendations and approval mechanisms. Each subcommittee determines thresholds and benchmarks for each year based on review of data at each meeting. Committees that report to the CQI Leadership Team are described below.

Subcommittees of the CQI Leadership Team:

**Budget and Finance Committee (B&F)** – The Budget and Finance Committee exists for the purpose of providing an internal review of expenditures, allocations, trends, and an overall financial picture of the agency in regards to services and programs. It also assures a fair system is in place for allocating or de-allocating funds. The Committee acts as the recommending body to the Chief Financial Officer (CFO) as to the manner in which funds should be distributed or de-allocated by reviewing financial/service data and reports. The Committee prevents one sole authority, namely the CFO, from having a programmatic or service impact to the community without input from key stakeholders such as Senior
Management, Clinical, Quality Management, and local sites. The B&F Committee is a mandatory committee comprised of representatives from Clinical Operations, Network Operations, Quality Management, and local sites.

**Community Relations Committee (CRC)** – This committee discusses community relations issues and concerns, and brainstorms on systemic solutions. The committee takes input from the Community Advisory Committee(s) to problem solve and submit requests through the CQI and/or leadership for approval. The Community Relations Director Chairs this committee.

**Corporate Compliance Committee (CCC)** - This committee consists of senior level and legal staff to review and evaluate organizational and network achievements based on indicators designed to monitor compliance to applicable state and federal regulations. Committee membership includes representatives from Contracts Management, Customer Service, Quality Management, Care Coordination, Utilization Management Departments, and Site Directors. It is chaired by the Corporate Compliance Officer and reports matters of significant non-compliance such as fraud and abuse to the Continuous Quality Improvement Leadership Team. This committee meets at least monthly.

**Clinical Care Management Team (CCMT)** – This committee consists of senior level and clinical staff and meets at least bi-monthly to enhance lateral communication for all Alliance Behavioral Healthcare clinical functions. A major responsibility of the committee involves reviewing consumer deaths, serving as a mortality/morbidity committee, and conducting root cause analyses related to death and other serious incidents. CCMT also provides the clinical oversight of UM/UR/Access center; assures that authorizations and clinical reviews are conducted properly; oversees problem cases of denials and appeals; identifies Best Practices to include in Clinical Guidelines; and monitors clinical data including high risk/high cost enrollees. Other responsibilities include reviewing cases of concern referred to the MCO or elicited by MCO staff, conducting case conference for complex clinical cases, providing group clinical supervision for clinical department heads, ensuring care coordination to improve quality of care, and exercising clinical oversight of licensed supervisory staff within the MCO. This committee is chaired by the Medical Director.

**Utilization Management Committee (UMC)** - This committee consists of senior level, clinical and QM staff to evaluate the utilization of services with the goal of ensuring that each enrollee receives the correct services, in the right amount, and in the most appropriate time frames to achieve the best outcomes. This is a collaborative, dynamic process by which over or under utilization of services can be detected, monitored and corrected. The committee serves as a vehicle to communicate and coordinate quality improvement efforts to and with the CQI Leadership Team. It is chaired by the UM Director and Co-Chaired by the Medical Director.
**Provider Network Management Committee (PNM)** – This committee meets at least quarterly. The primary charge of this committee is to review provider related data, identify and address service gaps, explore trends and make policy recommendations based upon this information.

Additionally, the Provider Network Management Committee examines the implications of state and federal funding changes on the services that are provided within the community and makes recommendations on how to address these issues from a system and network perspective. All significant findings and recommendations are sent to the CQI Leadership Team. At least quarterly, the Provider Network Management Committee is chaired by the Provider Network Director.

**Community Advisory Committee** – The Community Advisory Committee is a stakeholder group that informs the Community Relations Committee of concerns and issues, and assists the MCO with obtaining input from stakeholders in each community. This committee may review crisis, engagement, and other data that relates to the health of the respective communities. This committee is chaired by the MCO Crisis Services Manager, or designee.

**Clinical Advisory Committee (CAC)** – This group consists of external medical and clinical directors of provider agencies in the continuum of care. Meetings are chaired by MCO's Medical Director and co-chaired by the Director of Clinical Operations. The group meets at least quarterly to discuss medical appropriateness of treatment, treatment issues that have been identified by MCO's committee process and/or by staff, medication adherence, and other health issues determined to be performance criteria such as BMI, medications and adverse reactions in certain populations (e.g., the elderly).

**Provider Advisory Committee (PAC)** – This committee meets at least quarterly to serve as a venue for leadership of provider agencies to discuss concerns and to strategize with MCO on improvements to the continuum of care. This committee provides a voice for providers with MCO and is chaired by MCO's CEO and co-chaired by the Deputy Director.
**Contract Requirements:**

In coordination with Provider Network, Utilization Management, Care Coordination and other Alliance departments, QM staff shall work to ensure that Alliance’s network providers collect and submit complete, accurate information on consumers, as required by MOAs, contracts, and state mandates.

As issues, needs, changes, or other items are identified, QM – in coordination with other departments – shall provide information, training, and support to internal staff, CFAC members, and Network Providers to encourage their review and use of data collected for improvement of service quality and effectiveness. While risk and fiscal management will be a major concern, no interest shall outweigh consumer safety or the availability of medical necessary services provided to consumers.

To ensure Alliance receives and maintains required National Accreditation (URAC), QM shall work with Corporate Compliance to confirm full compliance of its staff and its provider network. QM and Corporate Compliance will collaborate to ensure that all are fully compliant with security, privacy, and confidentiality of all individually identifiable health information in conformance with HIPAA, 42 CFR, Part 2, and G.S. 122C-52 and other state and federal laws.

**Quality Improvement Projects (QIPs):**

Utilizing feedback from discussions with Continuous Quality Improvement (CQI) Leadership Team and the Quality Management Committee (QMC) members, QM shall work to identify and address opportunities for improvement of MCO operations and the local service system. Responses of the MCO and its network providers will be reviewed along with system concerns and problems, identifying and addressing opportunities for improvement of Alliance and its service system. The QM Department will manage Quality Improvement Projects (QIPs) approved by the QMC and provide summaries of these studies to the Area Board, CFAC, DMA, DMH/DD/SAS, Alliance’s National Accrediting Body, and other entities as requested/required. Per the DMA, DMH/DD/SAS, and URAC requirements a minimum of 3 QIPs are to be conducted each fiscal year; however, Performance Improvement Projects (PIP’s) may be assigned as specific issues needing attention are identified. QIPs selected must be designed to meet the following:

1. Reduce the need for psychiatric inpatient admissions to community hospitals for Medicaid recipients with primary MH/DD/SAS diagnoses, by ensuring provision of appropriate levels of community-based care; and
2. Reduce the number of Medicaid recipients who required 3 or more episodes of crisis service use, including facility based crisis, mobile crisis, and emergency department services, by ensuring appropriate crisis planning and community-based services. (see attachment 1 for more detailed requirements)
**Fiscal Year 2013 QIPs:**

**Intensive In-Home (IIH) Project - Present**

The IIH Project examines the use of evidence-based treatment modalities in the requests for IIH services based on the provider agency, the youth’s diagnoses, and other complicating factors. Outcome data is compared from providers using best practices to providers who are not. If needed, chart reviews are conducted from a random sample of providers to gather more accurate pre- and post-intervention data. Training is provided with technical assistance to providers who are not adhering to best practice guidelines. After LME/MCO intervention, use of best practices is tracked and noted in requests and Quality of Care concerns received by QM. This project was selected due to the substantial number of Intensive In-Home (IIH) requests in Durham that have been referred to QM, by UM Care Managers, as Quality of Care Concerns. In the 2nd Quarter of FY 12, 45 authorization requests for IIH were referred to QM as a concern, representing **half** of all concerns and 7% of all IIH requests. In comparison, IIH requests make up only 15% of all mental health and substance abuse authorization requests. Some of the concerns involved consumer safety, including suspected sexual aggression or abuse victimization.

**First Responder - Present**

This project consists of test calls to crisis phone numbers of enhanced services providers. Data obtained includes response time, hours available, and instructions available (at a minimum). Providers not following best practice protocols and state requirements will be referred to Compliance Committee and findings will be presented to CQI, QMC, and Management Team as they consider “right-sizing” the network. The project was selected because of complaints and reports of providers not following through with responsibilities to their consumers and the impact of the providers’ neglect on EDs and crisis facilities.

**Mystery Caller - Present**

This project is designed to improve Call Center and Care Coordination response to individuals requesting assistance. In addition to testing STR calls, the Mystery Caller project will be expanded this year to include Care Coordination to test the consistency of communication and information to consumers and providers and staffs adherence to established Alliance policies and procedures. The project was selected because STR is typically an individual’s portal of entry into the public behavioral health system. It is critical that the initial experience be positive to ensure consumers continue with needed treatment. Care Coordination was added because of it is a critical function within the MCO and importance in reducing crisis episodes of high risk individuals.
**Inter-Rater Reliability - Present**

The project tests consistency in decision-making among Call Center staff and UM Care Management staff. Alliance needs to maintain a high-level of reliability between UM Managers and Call Center staff to support the quality of their decision-making. Discrepancies detected during a reliability study can highlight areas that require clinical discussion and consensus or, at the very least, checks of UM and Call Center activity against published standards.

**Reducing Emergency Room Visits - Present**

This project implements and evaluates the intensive care coordination model for high risk individuals who repeatedly present at local Emergency Departments. The model includes more frequent contact between the LME/MCO and the provider and consumer, along with flexible spending to allow for individualized and creative means to engage and motivate high risk consumers. The project is expected to reduce hospitalizations (at community and state hospitals), in addition to EDs. This project was chosen because the total number of consumers presenting, particularly in Cumberland County, and the care our consumers receive are concerning, as evidenced from complaints and quality of care concerns. Additionally, Alliance will be responsible for paying for visits directly related to a Medicaid consumers' behavioral health disorder.

It was decided by the Alliance Behavioral Healthcare QMC to continue with the above referenced QIPs for FY 2014, given that they are system level studies, and are important for the provision of trending data for the LME/MCO leadership, board of directors, and staff, in order to make decisions related to quality of care in the provider continuum.
QM Department Staffing:

Following is the QM Department staffing organizational chart for FY 2014. Staffing may change during this fiscal year due to resources and/or needs that might not have been accounted for.

Staffing Structure:

Major Functions for

4 Counties

- Incident Reporting & Analysis, NC-SNAP, NC-POPs, NC-TOPPS
- Trending Analysis, PIPs, Innovations Reports, Review Projects, Daily Census, ad hoc reports, Survey Projects, Residential Data Tracking
- Grievance Management, Reporting, Analysis, PIPs, Review Projects, Audits
- Review, Analysis, Trouble Shooting, Training, Communication with Providers & State re: NC-TOPPS.

- QIPs, PIPs, URAC, Provider Audits, Provider performance monitoring, agency contract requirements, Appeals Tracking and Appeals Audits, Credentialing Audits, Quality of Care Analysis, Service Utilization and Trends, Innovations Trending, Training, System and Gaps Analysis. Site Specific Action Plans.

Conducts QA Testing for IT, writes data specifications for automating reports, liaison between QM, all other Departments/Sites & IT.

Conduct provider monitoring, on-site reviews, health and safety checks, and monitor performance of providers. Ensure providers adhere to best practice models, guidelines and required Statutes.
QM Staffing and Job Duties:

The Chief of Program Development and Evaluation oversees the QM Department, with collaboration and guidance from the MCO Medical Director.

**Quality Management (QM) Director** – Responsible for managing the agency Quality Management Department. The QM Director is involved with overseeing internal and external quality improvement activities throughout the established geographic area. The QM Director develops and designs measurement tools for meeting contractual performance criteria and accreditation requirements. Efficiency is a priority related to processes and automation of reporting. Written and oral presentations and reports for a variety of internal and external audiences are developed. Processes are implemented and monitored to ensure provider quality improvement. Works closely with the agency IT Department to develop and/or design reports for other departments and staff to streamline data collection and reporting processes. Oversees organizational and provider assessments, measurements, and research when applicable and/or necessary. Develops and implements policies and procedures to ensure compliance with regulatory requirements related to quality improvement, outcome monitoring, and evaluation of services and programs. The QM Director manages a Quality Management Department and works closely with all internal departments, sites, boards of directors, CFACs and other external entities as required.

**Quality Review Manager** – Manages the Quality Improvement processes to ensure appropriate type and number according to URAC and contracts. Implements Performance Improvement Projects (PIPs) as identified. Monitors by accuracy of QIPs, timeliness and correct process flows to ensure the QIPs are completed on time and are accurate. Manages the accreditation process for the URAC Core, Call Center, and Health Network Standards. Ensures that the MCO obtains and maintains URAC accreditation. The QR Manager ensures contract requirements for PCP reviews, quality audits, Inter-rater reliability, certain survey projects, committee reviews of the data, and collaboration with other MCO departments are met. Ensures that analyses and write-ups to are accurate and professional. Responsible for overall supervision of all unit employees. The QR Manager oversees the coordination of the MCO Strategic Planning Process, and/or Network Capacity Studies by working with Department and site Directors, QM staff, QM Director and external stakeholders. Oversees the Credentialing Reviews/Audits and processes.
**Quality Review Coordinators** – QR Coordinators are responsible for the evaluation of services delivered to consumers to ensure that services delivered are consistent with funding requirements, best practices, provider contracts and federal/state rules and regulations. They work with staff, consumers, providers and other stakeholders to evaluate the entire system of health, behavioral health, and I/DD delivery as determined by DMH/DD/SAS, DMA, DHHS, CMS, accrediting bodies and other necessary regulatory entities. Develop surveys and conduct focus groups. Each QR Coordinator is assigned to at least one Quality Improvement Project each year to gather, analyze and process data related to the QI Projects.

They work closely with Provider Network, Care Coordination, and UM staff to determine and track gaps and needs in the service continuum. They conduct quality reviews and create presentations that identify trends/patterns that impact service/system quality, and then implement interventions aimed at addressing these trends/patterns with the outcome of services delivered to consumers at the highest degree of quality.
TYPICAL TASKS FOR EACH QUALITY REVIEW COORDINATOR POSITION

QR Coordinator-Accreditation Coordination (50%)/Quality Reviews:

- Coordination of URAC accreditation – coordinates agency activities to maintain accreditation, works closely with other units to prepare for additional accreditation, provides training on accreditation standards, assists with internal reviews of compliance with standards, writes reports of findings, and tracks and implements action items.

- Coordination of QIO-Like accreditation – coordinates agency activities to maintain accreditation, prepares and submits application for internal review and approval, updates information on annual basis, assists with internal reviews of compliance with standards and writes reports of findings.

- Reviews and edits policies and procedures for alignment with all accreditation standards.

- Quality Improvement Projects - participates in Quality Improvement Project development and design, lead for at least one Quality Improvement Project from development to completion, identifies and manages project team to oversee design and implementation, writes report of findings and recommendations, and tracks and implements action items until completion. FY 13 – lead for First Responder QIP.

- Quality reviews – assists with reviews of internal processes, writes reports of findings and recommendations, tracks and implements action items.

- Program evaluation – assists with MH/SA program evaluation as assigned, creates tables and graphs as needed to illustrate findings, creates and delivers presentations of data, writes reports (when requested) of findings and recommendations, tracks and implements action items.

- Report development and submission – works with other units and sites to compile data, inserts data onto report templates, checks data for accuracy, submits required reports to designated contact at state no later than deadline.

- Committee representation – actively participates in internal committees as assigned, creates and delivers presentations, and follows up on action items. FY 13 – UM Committee to provide update on URAC.
QR Coordinator – MH/SA Evaluation & Reviews:

- MH/SA care coordination evaluation – identifies appropriate performance measures and data sources, evaluates data, creates tables and graphs as needed to illustrate trends, creates and delivers presentations of data, writes reports (when requested) of findings and recommendations, tracks and implements action items.

- MH/SA program evaluation - evaluates data, creates tables and graphs as needed to illustrate trends, creates and delivers presentations of data, writes reports (when requested) of findings and recommendations, tracks and implements action items.

- Report development and submission – works with other units and sites to compile data, inserts data onto report templates, checks data for accuracy, submits required reports to designated contact at state no later than deadline.

- Quality Improvement Projects - participate in Quality Improvement Project development and design, lead for at least one Quality Improvement Project from development to completion, identifies and manages project team to oversee design and implementation, writes report of findings and recommendations, and tracks and implements action items until completion. FY 13 – lead for Intensive In-Home QIP.

- Quality reviews – assists with reviews of internal processes related to MH/SA services (such as PCP & QM Plan reviews), writes reports of findings and recommendations, tracks and implements action items.

- Training – provides quality improvement training and technical assistance to internal staff, CFAC, Area Board, and providers as assigned.

- Performance Improvement Projects – projects are usually short-term and focused to address immediate concerns identified within MH/SA programs, assists with gathering data, conducts qualitative interviews (if necessary), identifies root causes of concerns, writes brief summary of findings and recommendations to address concerns, and tracks and implements action items.

- Committee representation – actively participates in internal committees as assigned, creates and delivers presentations, and follows up on action items. FY 13 – MH/SA Care Coordination.
QR Coordinator – I/DD Evaluation & Reviews:

- Quality reviews – assists with reviews of internal processes related to I/DD services (ISP reviews), writes reports of findings and recommendations, tracks and implements action items.

- I/DD care coordination evaluation– identifies appropriate performance measures and data sources, evaluates data, creates tables and graphs as needed to illustrate trends, creates and delivers presentations of data, writes reports (when requested) of findings and recommendations, tracks and implements action items.

- I/DD program evaluation - evaluates data, creates tables and graphs as needed to illustrate trends, creates and delivers presentations of data, writes reports (when requested) of findings and recommendations, tracks and implements action items.

- Report development and submission – works with other units and sites to compile I/DD data, inserts data onto report templates, checks data for accuracy, submits required reports to designated contact at state no later than deadline.

- Quality Improvement Projects - participate in Quality Improvement Project development and design, lead for at least one Quality Improvement Project from development to completion, identifies and manages project team to oversee design and implementation, writes report of findings and recommendations, and tracks and implements action items until completion. FY 13 – lead for Mystery Caller QIP.

- Training – provides quality improvement training and technical assistance to internal staff, CFAC, Area Board, and providers as assigned.

- Performance Improvement Projects – projects are usually short-term and focused to address immediate concerns identified within I/DD programs, assists with gathering data, conducts qualitative interviews (if necessary), identifies root causes of concerns, writes brief summary of findings and recommendations to address concerns, and tracks and implements action items.

- Committee representation – actively participates in internal committees as assigned, creates and delivers presentations, and follows up on action items. FY 13 – I/DD Management Meeting (care coordination).
QR Coordinator – Crisis/Cross-System Evaluation:

- Crisis continuum evaluation - evaluates data, creates tables and graphs as needed to illustrate trends, creates and delivers presentations of data, writes reports (when requested) of findings and recommendations, tracks and implements action items.

- Cross-system and System of Care program evaluation - evaluates data, creates tables and graphs as needed to illustrate trends, creates and delivers presentations of data, writes reports (when requested) of findings and recommendations, tracks and implements action items.

- Strategic Planning - develops surveys, disseminate and collect surveys; conducts focus groups; works with Provider Network staff regarding GIS mapping of services and demographics; writes survey results.

- Quality Improvement Projects - participate in Quality Improvement Project development and design, lead for at least one Quality Improvement Project from development to completion, identifies and manages project team to oversee design and implementation, writes report of findings and recommendations, and tracks and implements action items until completion. FY 13 – lead for Reducing ER Visits QIP.

- Training – provides quality improvement training and technical assistance to internal staff, CFAC, Area Board, and providers as assigned.

- Performance Improvement Projects – projects are usually short-term and focused to address immediate concerns related to crisis services or System of Care activities, assists with gathering data, conducts qualitative interviews (if necessary), identifies root causes of concerns, writes brief summary of findings and recommendations to address concerns, and tracks and implements action items.

- Committee representation – actively participates in internal committees as assigned, creates and delivers presentations, and follows up on action items. FY 13 – CCMT, Crisis Collaborations in Wake and Durham (when requested).
PROCESSES

Accreditation Coordination

- Compile list of relevant standards, along with progress in meeting standards, persons responsible for compliance with standards, and due date.
- Communicate list of standards to URAC contacts in each unit.
- Track completion of activities related to standards.
- Provide technical assistance to co-workers in meeting standards.
- Provide training on CORE standards to all staff and training on specific modules to staff within affected units and other staff who need the training (for example, QM staff).
- Prepare applications for additional modules.
- Submit updates, as needed and required, to accreditation bodies.
- Coordinate and assist with internal reviews of compliance with standards, assist with creation of review tools, write brief summary findings and recommendations, track implementation of action items, and report back to UM Committee or cross-unit team who requested report.
- Coordinate agency preparation for on-site reviews by accreditation bodies to ensure all units are prepared. Communicate and record notes from meetings/conference calls with accreditation contact. Notifies agency of date/time and agenda for visit.

Committee Representation

- Regularly attends, unless excused, internal committees as assigned.
- Actively participate in committees by preparing fully for discussion, creating agenda and taking minutes (if requested), and reviewing previous minutes for follow up on action items.
- Create presentations typically one week prior to meeting for review by supervisor, deliver presentations to committee, incorporate edits to presentations as recommended by committee, and research issues/red flags discussed at committee meeting.
- Prepare abbreviated presentations, along with edits, to CQI; include findings from research of red flags in presentations; deliver presentations focusing on key issues only.
- Track and report back to CQI and CQI subcommittee on action items.
Performance Improvement Projects

• Create brief action plan for projects and submits to supervisor/committee for review.
• When approved, implement and track progress on action plan.
• Assist with gathering quantitative and qualitative (if necessary) data to identify root causes of concerns.
• Write brief summary of findings and recommendations to address concerns and submits to supervisor for review.
• Create presentations typically one week prior to meeting for review by supervisor, deliver presentations to committee, incorporate edits to presentations as recommended by committee, and research issues/red flags discussed at committee meeting.
• Prepare abbreviated presentations, along with edits, to CQI; include findings from research of red flags in presentations; deliver presentations focusing on key issues only.
• Track and report back to CQI and CQI subcommittee on action items.
• Reevaluate data to ensure interventions have been successful in addressing problem.
• Report back to CQI and CQI subcommittee on findings from reevaluations. Repeat steps above if issue is still not addressed.

Program Evaluation

• Research the most appropriate tools/measurements for evaluating programs and processes.
• Create protocols and report templates (if necessary), in collaboration with Provider Networks and other units and sites, to collect data. Review with supervisor.
• Gather and check accuracy of all relevant data from multiple data sources, including Alpha, the BI system, and provider reports. Check data against authorizations, paid claims, and outcome reporting to ensure consistency.
• Evaluate data noting major trends. Evaluation should be grouped into functional areas, not necessarily by separate programs. For example, engagement in treatment services for a specific population should be compared across programs to identify trends, norms, and red flags.
• Create presentations typically one week prior to meeting for review by supervisor, delivers presentations to committee, incorporates edits to presentations as recommended by committee, and researches issues/red flags discussed at committee meeting.
• Prepare abbreviated presentations, along with edits, to CQI; include findings from research of red flags in presentations; deliver presentations focusing on key issues only.
• Track and report back to CQI and CQI subcommittee on action items.
• Reevaluate data to ensure interventions have been successful in addressing problem.
• Report back to CQI and CQI subcommittee on findings from reevaluations. Repeat steps above if issue is still not addressed.
Quality Improvement Projects

- At least five Quality Improvement Projects are identified each fiscal year. QI Project ideas are forwarded to the Quality Review Manager based on concerns identified by data. Projects must meet requirements of DMH/DD/SAS contract, Division of Medical Assistance-MCO contract, and URAC. Details may be found in Requirements for Quality Improvement Projects document (attached).
- QR Coordinators will assist in writing brief descriptions of project scope, population, requirements met, resources needed, estimated project time frame, and other relevant information. Quality Review Manager will present ideas to QM Team and CQI for input. Ideas approved by teams will be presented to Alliance’s Global Quality Management committee.
- Global Quality Management Committee must approve QI Projects.
- Those approved will be assigned a QR Coordinator to lead project. Each QR Coordinator will be assigned lead for at least one Quality Improvement Project from development to completion.
- QR Coordinator identifies and manages project team to oversee design and implementation, including performance measures, intervention implemented, data, and the multiple sources of data. Project team ensures all staff affected by projects are informed of roles, responsibilities, and scope.
- Gather baseline data and background research. Present initial findings to project team and supervisor. Check accuracy of all relevant data from multiple data sources, including Alpha, the BI system, and provider reports. Check data against authorizations, paid claims, and outcome reporting to ensure consistency.
- If samples will be used to evaluate data, then ensure sample sizes are adequate, follow policies and procedures for conducting valid samples, and adhere to elements found in Requirements for Quality Improvement Projects document (attached).
- Evaluate follow up data to determine effectiveness of intervention. Present findings to project team and supervisor.
- Create brief report and presentations 2 – 3 months prior to deadline (July 31) to ensure adequate internal review prior to submission to state. Ensure supervisor receives report and presentations one week prior to CQI subcommittee that will receive information, deliver presentations to committee, incorporate edits to presentations as recommended by committee, and research issues/red flags discussed at committee meeting.
- Prepare abbreviated presentations, along with edits, to CQI; include findings from research of red flags in presentations; deliver presentations focusing on key issues only.
- Track and report back to CQI and CQI subcommittee on action items.
- Create final report after being reviewed by CQI and CQI subcommittee. Report will be forwarded to Global QMC for review and discussion. After review by GQMC, then report will be submitted to state no later than July 31 for previous calendar year.
- Reevaluate data to ensure interventions have been successful in addressing problem.
- Report back to CQI and CQI subcommittee on findings from reevaluations. Repeat steps if issue is still not addressed.
- Continue to evaluate data on regular schedule until state approves termination.
Quality Reviews

- Assemble review team, if necessary, and identify staff person to take Lead (if lead person has not already been designated).
- Identify total population and appropriate sample size.
- Create sample using random sampling techniques or other techniques outlined in sample policy and procedures.
- Create, in collaboration with review team or supervisor, review tools.
- The Lead for the quality review will conduct training on tool and a brief inter-rater test prior to the review.
- If inter-rater test reveals problems with the tool, then the tool shall be revised to address concerns. Lead will conduct a brief training on revised tool.
- Conduct review using tool within deadline.
- Review major findings with review team or supervisor.
- Write brief summary of findings and recommendations to address concerns and submit to supervisor for review.
- Create presentations of findings typically one week prior to meeting for review by supervisor, deliver presentations to committee, incorporate edits to presentations as recommended by committee, and research issues/red flags discussed at committee meeting.
- Prepare abbreviated presentations, along with edits, to CQI; include findings from research of red flags in presentations; deliver presentations focusing on key issues only.
- Track and report back to CQI and CQI subcommittee on action items.
- Reevaluate data to ensure interventions have been successful in addressing problem.
- Report back to CQI and CQI subcommittee on findings from reevaluations. Repeat steps above if issue is still not addressed.

Report Development and Submission

- List of required state reports will be updated and maintained by QM leadership (or QM Business Analyst).
- Communicate and remind other units and sites to gather data no later than deadline for provider reports. Units and sites, who receive provider reports, should check data for accuracy against other data sources, including additional provider reports, authorizations, paid claims, and outcome reporting.
- Gather and check accuracy of totals and information. If inaccuracies are found, then QR Coordinator shall communicate with co-worker who forwarded report immediately to correct problems.
- Once data has been verified, insert total figures for all counties onto report templates.
- Compile signatures of responsible parties, if necessary. If person is located at a local site, obtain scanned version of signature page via email.
- Email completed report, and required signatures and signature pages, to designated contact at state no later than deadline.
- If inaccuracies are discovered after report has been submitted, then QR Coordinator shall re-submit revised report to state contact within 10 business days of receiving corrected information.
**Strategic Planning** – The QM Department and cross-functional teams participate in strategic planning efforts as required and deemed by LME/MCO leadership.

**QM Data Manager** – The QM Data Manager manages the daily/weekly/monthly data processes, such as Incident Reporting and Analysis (IRIS), NC-TOPPS, NC-SNAP, SIS, and Utilization Management, Call Center Statistics, daily crisis continuum census reports, network monitoring, and the grievance process. Accuracy and timeliness must be within the DMH required standards. Ensures reports are accurate with professional charts/graphs and analysis. Manages and coordinates and/or participates in survey projects such as: Consumer, provider and stakeholder satisfaction. Creates charts, graphs and develops reports for stakeholder input. Ensures the automation of management reports. The QM Data Manager works closely with the IT Department to facilitate implementation of reports to be automated. The Grievance Reporting requirements and staff assigned to the grievance reporting process are managed by the QM Data Manager. As requested to coordinate and/or assist with other data analyses/processes/reports. This may include assistance with the strategic planning and/or the provider capacity study process. Ensures contract requirements for Innovations Health and Safety measures, access to care, incidents, and complaints. Ensures that analyses and reports are accurate and professional. Responsible for overall supervision of the Quality Assurance Unit.

**TYPICAL TASKS FOR EACH DATA MANAGEMENT POSITION**

**QM Quality Assurance Analysts – Incident Reporting and Analysis:**

**Duties include:**

- Monitoring of IRIS system for new incidents. As incidents come in they are reviewed for accuracy and completeness. Providers are often contacted for additional or corrected information. This information can vary, but include requesting PCPs and crisis plans for review and analysis, and regulatory agency documentation. Per day/per county average 5-10 new incidents, process average of 15 - 20 incidents that can be closed each day. Wake county has the largest volume and load and requires one FTE for that county alone.

- Data Entry into internal tracking system (Access Database). The State reporting from IRIS is not reliable; incident information is entered into an access database to provide accurate information related to Alliance incidents. In addition to daily entry, Level 1 incidents are entered on a quarterly basis and this takes between 5 and 7 business days per staff to complete.

- Technical Assistance to providers in various forms. Staff conduct quarterly trainings, on site requested trainings and daily technical assistance for providers. Assistance is frequently related to coaching providers through the IRIS system to ensure accurate data entry/correction.

- Notification and research of Level III deaths. This includes internal notification, request for supporting documentation, reporting to regulatory agencies like DSS, DHSR, medical examiner offices by county, law enforcement and health care registry boards, following up on these requests, preparation of materials for CCMT (monthly) and Corporate Compliance (bi-monthly)

- Communication with other Alliance Teams to ensure comprehensive consumer care. Includes grievances, care coordination, care management and provider networks

- Input and investigation of incident trends for quarterly reports.
• Preparation and analysis of Call Center and UM data on a monthly basis (this task has grown exponentially with the addition of each county). The individual analyzing this information must be able to present at any time and to calculate the data on a daily, weekly and monthly basis.
• Preparation and analysis of Incident data on a quarterly basis (this task has grown exponentially with the addition of each county).
• Preparation and analysis of ED & Inpatient claims data on a weekly basis. ED and crisis continuum daily census are collected, analyzed and managed here.
• Compliance trending (Plans of Correction, Referral to DMA, Post Payment Reviews) varies, but will become more time consuming due to contractual requirements.
• Preparation and analysis of Appeals data (monthly)
• Preparation and analysis of Clients Rights (varies)
• Trending Finance (cost per consumer, rate analysis per consumer, funding source, over/under billing) (varies) as costs pertain to service utilization and issues derived from complaint and quality of care concerns.
• Grievance Trending. Data to be analyzed weekly for the management report and monthly/quarterly for DMH/DD/SAS and DMA.
• Unduplicated count of consumers (varies)
• Unit Dashboards (Call Center, UM, Compliance, Provider Network) (quarterly)
• Occupancy/Residential use analysis and tracking
• NC-POPS analysis and reporting
• NC-TOPPS outcomes analysis

I/DD Quality Assurance Analyst:

• Preparation and analysis of Innovations reports (Discharge from ICF/MR, Plan of Care meetings, LOC evaluation, Provider Monitoring, Crisis plans, service review, monitoring of Slot Tracking and Waitlist) varies, and more to come as DMH/DD/SAS and DMA have indicated.
• Preparation and analysis of Provider Monitoring
• Assistance with Mystery Caller and other QIPs/survey projects, as capacity and time allows. Staff will be given opportunities to participate in different ways.
• NC SNAP Technical assistance, monitoring and entry
**Quality Assurance Analysts – (Grievance Management and Analysis):**

- Review, track and follow up on all grievances reported both internally and externally for all 4 counties.
- Provide training and technical assistance to providers and stakeholders about the grievance process.
- Review records, policies and procedures, QM Committee minutes, Medical Examiner reports, peer reviews, state audits, and other documentation as necessary to investigate specific concerns regarding all levels of grievances, and compliance with quality of service standards.
- Coordinate with the QM Data Manager and/or the Compliance Officer regarding providers that are out of compliance with regulatory standards/statutes/regulations, etc.
- Monitor the grievance process, providing technical assistance and reporting to the Corporate Compliance Committee and Clinical Care Management and other committees until the actions are closed.
- Serve as a liaison between the Quality Management Department and select committees (e.g., Corporate Compliance, Human Rights, QM Committee, and others).
- Work with the QM Data Manager, other departments at TDC, DHHS, DMH/DD/SAS, DMA and other agencies in distributing, tracking, and collecting consumer, provider and other stakeholder information.
- Represent the LME on various community and State committees (e.g. NC Council QI Forum, DMA, DMH/DD/SAS, etc.).
- Participate in the collection and review provider quality improvement plans each year. Review plans for accuracy and quality.
- Collect and analyze aggregate data and produce reports as directed by the QM Data Manager and other Department staff for internal and external validity and use (e.g. Grievance Reports).
- Review data as requested by the QM Data Manager, create spreadsheets as necessary, and compile charts for reporting.
- Work in conjunction with the IT Department to ensure reports are efficient and troubleshoot as needed for data projects related to grievance management.
- Participate in the maintenance and development of LME policies and procedures related to Quality Management.
- Participate in the development of quality improvement activities for the Department.
- Participate in the development of the Quality Management internal Department and agency policy and procedures.
- Participate in the Strategic Planning and/or Provider Network Capacity Study process.
**Grievance Resolution Process:**

The following outlines the procedures for resolving a grievance. Categories of the different steps taken to address each grievance follows on page 31. A flow chart of the grievance resolution process follows on page 33.

A. **Review Grievance**
   - Enter grievance in Alpha (if not already entered)
   - Check/Research available records (PCP, ITR, ORF, etc.)
   - Research Regulations/statutes of service program
   - Determine regulatory authority: LME/MCO; DHSR; DSS; DMA; other authority
   - Determine amount of information that can be released to complainant and provider (confidentiality)
   - Document actions taken in Alpha.
   - Review with QM Grievance Specialists

B. **Contact Parties Involved**
   - Complainant
     - Confirm issues
     - Explain process
     - Confirm permission to use name
     - Establish desired resolution
   - Provider
     - Notify provider of grievance
     - Obtain perspective
     - Request information
   - Review with QM Grievance Specialists
   - Acknowledgement letter sent to complainant within five business days of grievance date
   - Document actions taken in Alpha

C. **Consult with internal departments: Care Coordination, UM, Provider Networks, Quality Management.** Document actions taken in Alpha

D. **Consult with external agencies: DSS, local law enforcement, DMA, DMH, DHSR, other LME/MCO.** Document actions taken in Alpha

E. **Update Letter/Information Needed Letter sent if going beyond 15 business days**
   - Unable to receive information in a timely manner
   - Unable to contact complainant/provider
   - Document actions taken in Alpha
   - Review with QM Grievance Specialists
F. Referral-Recommendation
   o Care Coordination
   o Legal
   o UM (for grievances concerning authorizations)
   o Compliance
     ▪ Gather information to support the need for an investigation/monitoring (i.e. checking Medicaid Paid Claims)
     ▪ Investigation by LME/MCO must be completed within 30 calendar days of the grievance and resolution letter sent within 15 calendar days of completion
   o Report accordingly to appropriate regulatory authority.
     ▪ Investigation by outside regulatory authority requires follow up within 80 business days
   o Document actions taken in Alpha
   o Review with QM Grievance Specialists

G. Resolve
   o Develop a resolution within authority of the LME/MCO (i.e. complainant demanding financial reimbursement could not be enforced)
   o Notify involved parties of resolution
   o Resolution letter within 15 business days of grievance
   o Document actions taken in Alpha
   o Track in Alpha
   o Review with QM Grievance Specialists
Grievance Flow Chart:

Grievance received by Alliance Behavioral Healthcare and documented in Alpha

Grievance reviewed by QM to determine responsible regulatory authority

- **Yes**
  - Corporate Compliance Committee
    - Investigation?
      - **Yes**
        - Complainant notified in writing of investigation within 5 working days of grievance
      - **No**
        - Complainant notified in writing of informal process within 5 working days of grievance

- **No**
  - Alliance Behavioral Healthcare
    - Grievance reported directly to appropriate regulatory authority by Alliance
  - DHSR, DSS, Other LME/MCO
    - Special Investigations Unit
      - Possible fraud, waste, abuse?
        - **Yes**
          - Complainant notified in writing of report to external regulatory authority within 5 working days of grievance
        - **No**
          - Complainant notified in writing of outcome within 80 working days of grievance

Complainant notified in writing of resolution and appeal rights within 15 working days

Provider Network Evaluators complete investigation within 30 days of receipt of the grievance

Results submitted by Provider Network Evaluators to Corporate Compliance Committee for disposition

Report sent to provider by Corporate Compliance Committee or Provider Network Evaluators within 15 calendar days. Report sent to complainant by QM within 15 calendar days. Provider and complainant advised of appeal rights.
Quality Assurance Analyst (State Reporting Systems):

Tasks:

- Complete regular checks of NC-TOPPS System for Updates Needed, sending encrypted reminders and notifications to providers with updates due and/or out-of-compliance
- Send notification to QM Director, Data Manager, Compliance Director, and Provider Networks of providers with outstanding NC-TOPPS compliance issues.
- Provide technical assistance to internal staff on all issues related to NC-TOPPS and trouble shoot potential problems with assistance from NC-TOPPS Helpdesk
- Work with providers to ensure only current and appropriate staff have access to the NC-TOPPS system and remove users and/or agencies that should no longer have access to the system.
- Trouble-shoot issues identified by provider agencies, providing telephonic or electronic (i.e., e-mail) support within one business day.
- Collaborate with multiple departments, including, but not limited to, Utilization Management, Information Technology, Provider Network Operations, and Compliance to ensure provider agencies are getting the information needed to submit updates and that LME-MCO NC-TOPPS requirements are being met and/or exceeded as evidenced by State Performance Reports.
- Provide technical assistance regarding the utilization of NC-TOPPS data and other functions.
- The QM staff member working on NC-TOPPS is largely responsible for ensuring Alliance Behavioral Healthcare meets and/or exceeds the LME-MCO Responsibilities for NC-TOPPS, as detailed in the NC-TOPPS Implementation Guidelines (http://www.ncdhhs.gov/mhddsas/providers/NCTOPPS/nc-toppsguidelinesjuly12.pdf). The LME-MCO Responsibilities include the following: Local Oversight, Provision of Identification Numbers, Verification of Provider Agencies, Training, and Change of QP Access when an individual is transferred from a level of care at one provider agency to a different provider agency at a level of care that still requires NC-TOPPS completion.

- **Local Oversight** includes ensuring that all of the provider agencies of publicly-funded mental health and substance abuse services in its catchment area meet NC-TOPPS requirements; ensuring that NC-TOPPS Interviews are fully completed for required substance abuse consumers by substance abuse Qualified Professionals (QPs) and for required mental health consumers by mental health QPs; and training, guiding, and monitoring its provider agencies on how NC-TOPPS is implemented within its service area.

- **Provision of Identification Numbers** includes ensuring provider agencies receive the six-digit LME-MCO Assigned Consumer Record Numbers as soon as a Consumer Admission Form is received from the provider agency. Provider agencies must have the Consumer Record Number to complete NC-TOPPS. While not directly responsible for issuing the Consumer Record Number, the staff member must work across multiple systems to verify correct Record Numbers, work with the appropriate staff to correct the incorrect record number/s, and notify the required parties of the corrected error/s.
• **Verification of Provider Agencies:** The NC-TOPPS staff person will be charged with verifying agencies that do not already exist in the NC-TOPPS system, as well as verifying and approving that staff members of existing agencies that do not have an agency SuperUser. The expectation is that the verification process is completed quickly to ensure that the registration process is efficient and there are not delays with interview completions and submissions.

• **Training:** The NC-TOPPS staff person is largely/solely responsible for ensuring that the provider agencies are trained on the web-based NC-TOPPS tools and protocols. The NC-TOPPS staff person is solely responsible for providing internal training to staff on NC-TOPPS requirements.

• **Change of QP Access:** When a consumer transfers to a new provider agency, the NC-TOPPS staff person is responsible for changing the QP for that consumer in order to give the new provider agency access to the consumer’s previous NC-TOPPS submissions completed during the current episode of care. Ensuring smooth transfers of responsibility from one provider agency to another requires good communication among the NC-TOPPS staff person, service authorization unit, and the provider agencies involved.

**QM Business Analyst:**

**Tasks:**

- Review business workflows for Alliance Behavioral Healthcare departments, as well as sites, if applicable.
- Develop processes and key data elements in order to automate specified reports for the MCO.
- Works closely with IT staff to provide content and context to the automated report process.
- Write specifications and develop reports independently and/or with IT assistance, whichever is applicable.
- Develop required Business Intelligence charts, graphs, and other Report formats as required by management. Works with IT staff to ensure the data elements and desired outcome of the BI tools are accurate.
- Conducts Quality Assurance testing on IT projects as they apply to reporting, data collection, and analyses.
- Create databases as required by the QM Director, and other management staff.
- Develops enhancements for Alpha as staff identify data issues.
- Serves as liaison between departments and IT to coordinate data automation efforts.
**QM Research Assistant:**

**Tasks:**

- Develop reports, databases, spreadsheets, and surveys.
- Develop maps specific to requests from QM and Provider Network.
- Develop required Business Intelligence charts, graphs, and other Report formats as required by the QM Director.
- Analyze data for QM Department such as claims data, residential capacity and utilization, DHSR findings, and Quality of Care Concerns tracking.
- Work with QM Director and managers to facilitate survey and other quality improvement studies/projects, such as the NCI state project, Perception of Care surveys, and provider capacity surveys across counties in the catchment area. Help coordinate, manage survey dissemination, tracking, analysis.
- Creation, enhancement and other support regarding data and research tracking projects as needed.

**Provider Network Evaluation Manager** - The Provider Network Evaluator Manager is responsible for managing the provider monitoring activities performed by the Provider Network Evaluators. This position will provide leadership, mentoring and clinical oversight to Evaluators to ensure the monitoring activities adhere to MCO rules and guidelines so that sufficient, safe, and effective services are being provided to consumers who have been identified as having Mental Health, Intellectual/Developmental Disabilities or Substance Abuse needs. The Provider Network Evaluator Supervisor will ensure that staff has the necessary assistance, support, training, and education to perform effective monitoring and review activities so that providers can succeed and continue to serve consumers. The Provider Network Evaluator Supervisor will assist the Director of Quality Management and Chief of Network Development and Evaluation to develop policies, procedures and quality indicators for the Provider Network and to ensure that all required monitoring data is maintained.
TYPICAL TASKS FOR EACH EVALUATOR POSITION

Provider Network Evaluator I - The Provider Network Evaluator I, will be responsible for the provider adherence to MCO rules and guidelines in order to ensure sufficient, safe, and effective services are being provided to consumers who have been identified as having Mental Health, Developmental Disabilities or Substance Abuse needs. The Provider Network Evaluator I will uphold the integrity of the organization by monitoring in a fair, impartial manner, while providing technical assistance as appropriate to assist providers in delivery of quality services. The Provider Network Evaluator I will perform routine monitoring, performance profile reviews, and investigate instances of concerns so that this objective can be met by the providers. The Provider Network Evaluator I will perform these duties for the benefit of the MCO and the health and wellness of the consumers being served under the MCO.

Provider Network Evaluator II - The Provider Network Evaluator II will be responsible for the provider adherence to MCO rules and guidelines in order to ensure sufficient, safe, and effective services are being provided to consumers who have been identified as having Mental Health, Developmental Disabilities or Substance Abuse needs. The Provider Network Evaluator II will uphold the integrity of the organization by monitoring in a fair, impartial manner, while providing technical assistance as appropriate to assist providers in delivery of quality services. The Provider Network Evaluator II will employ clinical knowledge and skills to ensure that services are provided in a manner that meets clinical coverage requirements and best practice. The Provider Network Evaluator II will perform these duties for the benefit of the MCO and the health and wellness of the consumers being served under the MCO.
BUSINESS SOLUTION PROCESS:

Alliance Behavioral Healthcare has identified a need to have rapid turn-around time for report development and processes in order for senior leadership to make appropriate business decisions in a timely manner. This Business Solution Process is bi-fold, meaning that the Quality Management and IT Departments will work in tandem with other management staff to use data in “real time” for quick decision making in order to mitigate risk for the agency. At the same time, trending reports and other data collection methods will be used for long-range detection and planning processes.

A Business Intelligence Team will be established as a cross-functional team to discuss additional reports needed on a regular basis and to prioritize current requests. Timelines will be determined by the committee. This team will meet regularly, depending on the load of reports to be developed. The Chair will be a member of senior leadership.

MANAGEMENT REPORTING PROCESS:

1. **Monthly:** A Management Report has been developed that tracks the following. Each Manager/Director has access to the report and specific elements within Alpha.

   a. Inpatient statistics to include: average daily census, admissions per thousand, days per thousand, average length of stay, cost per day/patient, total dollar, category of population (MH, Innovations, by age AFDC, foster children), PRTF, behavioral residential. SA data to be determined at this time.
   b. New ED admissions and ED census for the week before, by hospital, and cost per hospital.
   c. Crisis facility, mobile crisis, Walk-in admissions/events the day before, by age group, county and costs.
   d. UM reviews that are 2 days or more out of compliance for turnaround time.
   e. Call volume/abandonment, types of calls
   f. Fraud/Waste/Abuse allegations by provider (anything that seems egregious)
   g. Service quality red flags (Level III incidents, Grievances, Quality of Care Concerns) trends
   h. Monthly claims paid out by provider and type of service (claims statistics and processing reports).

2. **Monthly and Quarterly:** A monthly CQI report has been developed that tracks the above but in aggregate format, in addition to the following:

   a. Total inpatient costs for the month and costs per thousand/unit/days
   b. Average daily census for the preceding month
   c. ED and crisis continuum admissions by site/provider and consumer
   d. ED lengths of stay and wait times
   e. Provider trends re: providers with the most consumers showing at EDs/hospitals/crisis facilities and who have higher per unit costs
   f. Utilization trends matched with claims to determine costs and over/under utilization by service, provider, and consumer
g. Call statistics (screenings by payer source, age) and timeliness, abandonment rates, call volume.
h. UM approvals, denials, TAT by service and payer source.
i. UM appeals disposition (upheld, overturned, withdrawn, modified).
j. Waitlists by county (IPRS)
k. Provider network stats (provides credentialed, any capacity issues)
l. Agency and site monthly data per site and department dashboards
m. Provider patterns – mix of providers, severity of diagnoses served by provider and county—GEO mapping results
n. Enrollment statistics.

3. Each month determine action steps on problem areas:
   a. Identify problem areas and document (QM will document).
   b. Develop quick action plan/steps.
   c. Implement for a determined amount of time (one week, two weeks, a month, etc.).
   d. QM to track implementation and report out results to management.
   e. Management determines next action steps.
   f. Priority is given to high cost consumers and high cost providers.
   g. Productivity of Care Coordination staff.

OBJECTIVES FOR SERVING A CULTURALLY DIVERSE MEMBERSHIP:

It is the goal of the Alliance Behavioral Healthcare MCO to ensure that cultural competence is integrated through the accessibility, availability, appropriateness, and quality of care provided to individuals of all races, ethnicities, and cultures. A Cultural Competence Plan has been developed and a cross-functional team addresses the following:

- Training and education related to cultural competence
- Increasing the diversity of staff of the MCO to better match the communities served
- Enhance community resources to meet the needs of the individuals served from various backgrounds
- Ensure there is a representative number of staff who speak Spanish
- Train staff about community resources that are person and recovery centered
- Develop more community contacts to outreach to more individuals who need behavioral health services
# Requirements for Quality Improvement Projects

**Definition of Quality Improvement Projects (QIPs)-per URAC:** Projects that involve initial measurement that measures some dimension of performance (baseline=whole # or %); AND, creation of a goal measured in the same units as baseline that would mark improvement within timeframe.

<table>
<thead>
<tr>
<th>Elements</th>
<th>Required By:</th>
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<tr>
<td><strong>At least THREE quality improvement studies:</strong></td>
<td>DMA-MCO Contract, FY 13 LME contract with DMHDSSAS, URAC</td>
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<tr>
<td>• Summaries of studies provided to Board, CFAC, and, on request, DHHS:</td>
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<tr>
<td>o Projects designed to reduce need for psychiatric inpatient admissions to community hospitals for Medicaid recipients with primary MH/DD/SAS diagnoses by ensuring appropriate levels of care in the community AND</td>
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<tr>
<td>o Reduce # of Medicaid recipients who require 3 or more episodes of crisis service use, including facility-based crisis, mobile crisis, and ER services by ensuring crisis planning and community-based services.</td>
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<td>• Results of <strong>two performance improvement projects</strong> (one with focus on a clinical area and the other with focus on a non-clinical area) reported to DMA following end of 2013, three reported to DMA following end of 2014</td>
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<tr>
<td>• <strong>A minimum of 2 QIPs per URAC accredited program (UM, Call Center, and Health Network) for a total of 3 QIPs. All 3 must focus on clinical quality and at least one of the 3 must focus on consumer safety</strong> (prevention of harm to consumers). Documentation must be available for on-site visit by URAC reviewer:</td>
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<td>o Reduce errors or improve performance related to accredited services (UM, Call Center, and Health Network)</td>
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<td>o At least one of the projects MUST address consumer safety for population served, one clinical, and one non-clinical</td>
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<td>o Clinical project MUST involve senior clinical staff person (MD) in judgments about the use of clinical quality measures and clinical aspects of performance</td>
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<td>o Organizations accredited for multiple programs may opt to have the same QIP program goals for</td>
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Reports on all performance improvement projects shall be submitted to DMA no later than July 31st of each year (following the end of the calendar year of data; for example, QIP report for data collected Jan-Dec 2013 is due July 31, 2014).
multiple QIP programs
- Summaries provided to Board, CFAC, and DHHS (if requested).

| Establish baselines in the first year of each project and set measurable benchmarks and goals for each project based on currently accepted standards (defined in advance by CMS or DMA), past performance data, or available national data to improve performance. Design and implement strategies to improve performance. | DMA-MCO Contract, URAC |
| Establish projected time frames and interventions for meeting goals. Measure changes in performance and benchmarks, continue measurement, and sustain improvement for at least one year after the desired level of performance is achieved. Obtain the approval of DMA before terminating any of the required performance improvement projects. | DMA-MCO Contract, URAC |
| Topics identified through continuous data collection and analysis by MCO. | DMA-MCO Contract |
| Topics measured using one or more quality indicators--changes in health status, functional status, or satisfaction, and indicators for which data are available that allow comparison of the [MCO]’s performance to that of similar Plans or to local, state, or national benchmarks. Improvement should be reasonably attributable to interventions undertaken by MCO. | DMA-MCO Contract |
| Provide opportunities for Enrollees to participate in the selection of project topics and the formulation of project goals. | DMA-MCO Contract |
| Samples must be random and sufficiently large enough to detect the targeted amount of improvement. | DMA-MCO Contract |
| Use multiple data sources. | DMA-MCO Contract |
| Conduct analysis if the performance goals are not met. Use findings, along with comparative data (if available) to project future performance and drive innovation. | URAC |
| Findings from QIPs should analyze the delivery of services, quality of care, over and underutilization of services, disease management strategies, and outcomes of care. | DMA-MCO Contract |
| (d) Performance improvement projects. (1) MCOs and PIHPs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following: | 42 CFR §438.240 (d) |
(i) Measurement of performance using objective quality indicators.
(ii) Implementation of system interventions to achieve improvement in quality.
(iii) Evaluation of the effectiveness of the interventions.
(iv) Planning and initiation of activities for increasing or sustaining improvement.

(2) Each MCO and PIHP must report the status and results of each project to the State as requested, including those that incorporate the requirements of §438.240(a)(2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

Projects must be determined jointly by DMA and MCO (from DMA-MCO Contract, URAC) from the following list:

- a. Primary, secondary and/or tertiary prevention of acute mental illness conditions;
- b. Primary, secondary and/or tertiary prevention of chronic mental illness conditions;
- c. Care of acute mental illness conditions;
- d. Recovery/outcome measures;
- e. Care of chronic mental illness conditions;
- f. High-volume services;
- g. High-risk services;
- h. Continuity and coordination of care;
- i. Availability, accessibility, and cultural competency of services;
- j. Quality of provider/patient encounters; or
- k. Appeals and grievances.

Ideas for projects (URAC):

- Sentinel events tracking
- Comparison of treatment to guidelines
- Discharge planning
- Report to facilities or customers
- Referral
- Identify consumer safety & health promotion opportunities
- Incorporate consumer safety issues into guidelines
- Define consumer safety triggers to enable early identification
- Include consumer safety issues as part of routine screening and assessment
- Decrease in medication errors or interactions
DHHS Quality Management Expectations for LME-MCOs: A Reference Guide

The table below is a synopsis of the DMA and DMH/DD/SAS Performance Contract requirements (it is not all inclusive as measures and requirements change during the year).

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<thead>
<tr>
<th>Items/Functions</th>
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<th>Expectation</th>
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<tbody>
<tr>
<td><strong>1. QM Program Description</strong></td>
<td>DMH Contract: Att I - 1.5, 9.0&lt;br&gt;DMA Contract: Att B - 7.1</td>
<td>QM Plan&lt;br&gt;The QM Plan is comprehensive in addressing CMS Quality Framework components and established waiver, block grant and State requirements for all disabilities. It addresses all administrative and clinical functions in the body of this document, and ensures that QM is integrated into all areas of organization. The plan is updated at least annually to include goals, objectives, outcome measures with targets, and timelines based on a thorough service gap analysis, performance review, and community needs assessment.</td>
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<td>DMH Contract: Att I - 9.0&lt;br&gt;DMA Contract: Att B - 7.1</td>
<td>QM policies and procedures&lt;br&gt;Written policies and procedures guide and detail how all QM functions are to be performed in and coordinated across each unit of the LME-MCO and the provider network.</td>
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<tr>
<td><strong>2. QM Infrastructure and Resources</strong></td>
<td>DMH Contract: Att I - 1.5, 7.1, 9.4&lt;br&gt;Att II - 2.0&lt;br&gt;DMA Contract: Att B - 6.5, 6.13, 7.1</td>
<td>QM Committee Structure&lt;br&gt;The QM Committee structure, including responsibilities and membership, monitors clinical and administrative quality across functional areas and ensures that the LME-MCO and its provider network are accountable and practice continuous improvement. Its scope covers internal operations and functions of the LME-MCO, service system capacity, quality of care and stakeholder and community perceptions.</td>
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<tr>
<td>Items/Functions</td>
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<td>QM Partnerships</td>
<td>DMH Contract: Att I - 1.2, 1.3 DMA Contract: Att B - 6.13</td>
<td>Consumers, providers, Area Board members, and System of Care partner agencies are regularly informed about system performance and QM initiatives. There are ongoing mechanisms for them to have input into QM activities. The LME-MCO works with its CFAC(s), provider council, Board and CCNC partners to develop and improve the QM Program.</td>
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<tr>
<td>IT System</td>
<td>DMH Contract: Att I - 3.0-3.6 DMA Contract: Att B - 7.9, 8.1, 9.2 Att M - 9.2 Att Y</td>
<td>The IT system provides timely, accurate reports to all LME-MCO units to monitor, coordinate and improve internal operations and to evaluate areas of need and successful performance. The IT system produces reports and EDT files for encounter/shadow claims, Consumer Data Warehouse information, and other reports required by DHHS.</td>
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<tr>
<td>QM Staff</td>
<td>DMH Contract: Att I - 1.5, 7.1 DMA Contract: Att B 6.9k</td>
<td>The organizational chart, capacity, hiring, orientation and training ensure appropriate resources to implement the QM Program. Staff includes skilled analysts with direct access to data sources. [Note: Staff with QM responsibilities may be situated in various units of the LME-MCO.]</td>
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<tr>
<td>LME-MCO Staff Training on QM</td>
<td>DMH Contract: Att I - 1.5 DMA Contract: Att B - 7.1</td>
<td>All LME-MCO staff are trained on the QM Program and implement QM activities in their daily operations.</td>
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<td>Items/Functions</td>
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<tr>
<td>3. Internal Quality Monitoring</td>
<td><strong>DMH Contract:</strong>&lt;br&gt;Att I - 3.5, 9.1- 9.3&lt;br&gt;Att IA&lt;br&gt;Att II - 2.0</td>
<td><strong>Administrative Performance Monitoring</strong>&lt;br&gt;The LME-MCO develops and implements standards, processes, and reports for monitoring internal performance in all functional areas and as required by contracts (e.g. authorizations are turned around in 14 days). Standards and processes include mechanisms to monitor cross-team coordination.</td>
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<td><strong>DMA Contract:</strong>&lt;br&gt;Att B - 1.5, 9.5</td>
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<td><strong>DMH Contract:</strong>&lt;br&gt;Att III</td>
<td><strong>Corporate Compliance</strong>&lt;br&gt;The LME-MCO has an effective process for monitoring corporate compliance that takes into account potential conflicts of interest. The LME-MCO has Internal controls to account for appropriate use of funds and to prevent and detect fraud.</td>
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<td><strong>DMA Contract:</strong>&lt;br&gt;Att B - 6.1.g, 9.5</td>
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<td><strong>DMH Contract:</strong>&lt;br&gt;Body - 10.0(8,11-12,15), 12.0;&lt;br&gt;Att I - 1.2, 1.3, 3.1, 3.3, 3.6, 6.3, 7.2.7, 7.3.5, 8.4, 9.3, 9.4&lt;br&gt;Att II - 2.0&lt;br&gt;Att III</td>
<td><strong>External Reporting</strong>&lt;br&gt;The LME-MCO reports information to Area Boards, CFACs, IMT, DMHDDSAS and DMA to meet contract requirements. This includes data submitted electronically by providers and LME-MCO staff, all information listed in the DMHDDSAS Reporting Requirements (<a href="http://www.ncdhhs.gov/mhddsas/statspublications/Contracts/index.htm#requirements">http://www.ncdhhs.gov/mhddsas/statspublications/Contracts/index.htm#requirements</a>), and periodic requests for additional information needed by funding agencies.</td>
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<td><strong>DMA Contract:</strong>&lt;br&gt;Att B - 6.1, 6.4, 7.2, 9.3, 9.6, 10.6&lt;br&gt;Att M&lt;br&gt;Att W</td>
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<td>DMH Contract:</td>
<td><strong>Accreditation</strong></td>
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<td>Body - 11.0</td>
<td>LME-MCO achieves and maintains accreditation with a DHHS-approved national agency.</td>
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<td>DMA Contract:</td>
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<td>...RFA Requirement</td>
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<tr>
<td>4. Consumer Health, Safety and Rights</td>
<td>DMH Contract:</td>
<td><strong>Consumer Complaints, Grievances and Appeals</strong></td>
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<tr>
<td></td>
<td>Att I - 8.4, 9.1</td>
<td>Policies and procedures ensure timely processing, reporting, and response to complaints, grievances, and appeals from Medicaid and uninsured consumers. The QM structure ensures review of trends and identifies areas for improvement.</td>
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<td>DMA Contract:</td>
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<td>Att B - 7.1, 7.5</td>
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<td>Att O - Section B</td>
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<td>DMH Contract:</td>
<td><strong>Incidents</strong></td>
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<tr>
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<td>Att I - 8.4, 8.5, 9.1</td>
<td>The LME-MCO ensures timely reporting of all adverse consumer events to the DHHS Incident Response Improvement System (IRIS) and adequate response by providers. The ME-MCO reviews all incidents, ensures consumer safety, and monitors, refers, and/or investigates providers per DHHS policies. The QM structure ensures review of trends, identifies areas for improvement, and provides technical assistance and training as needed.</td>
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<td>Att II - 2.0</td>
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<td>DMA Contract:</td>
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<td>Att M</td>
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<td>DMH Contract:</td>
<td><strong>Quality of Care Flags and Alerts</strong></td>
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<tr>
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<td>Att I - 7.3.1</td>
<td>The LME-MCO identifies and tracks high-cost and high-risk consumers and persons with outpatient commitment and uses the information to improve care. The LME-MCO monitors and acts on qualitative and quantitative indicators of poor quality. The QM structure ensures regular review of trends and patterns regularly, identifies emerging issues and uses the information for system improvement.</td>
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<td>DMA Contract:</td>
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<td>Att B - 6.13, 7.1</td>
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</table>
| 5. Consumer Progress & Experience | DMH Contract: Body - 10.0(11-12); Att I - 1.2, 1.3, 3.1, 3.3, 3.6, 5.1, 6.3, 8.4, 9.2, 9.3, 9.4; Att II - 2.0 | **MH/SA Consumer Outcomes (NC TOPPS)**  
QM staff work with providers to ensure complete and accurate reporting of MH/SA consumer progress and outcomes through NC-TOPPS and use of information in developing and monitoring person-centered plans. LME-MCO uses trends in consumer data as part of its service gap analysis and consumer needs assessment to make system improvements. |
<p>|                                 | DMA Contract: Att II - 2.0           |                                                                             |
|                                 | DMH Contract: Att I - 9.2 – 9.4      | <strong>MH/SA Consumer Surveys</strong>                                                 |
|                                 | DMA Contract: Att B - 7.1            | QM staff work with DHHS to coordinate the annual collection of consumers' perceptions of access to and quality of care using a statewide survey. The LME-MCO uses the information as part of its service gap analysis and consumer needs assessment to make system improvements. |
|                                 | DMH Contract: Att I - 9.2 – 9.4      | <strong>IDD Consumer Surveys (National Core Indicators)</strong>                         |
|                                 | DMA Contract: Att B - 7.1            | QM staff work with DHHS to coordinate annual interviews with IDD consumers and surveys of IDD family members using statewide tools. The LME-MCO uses the information as part of its service gap analysis and consumer needs assessment to make system improvements. |
| 6. Provider Oversight           | DMH Contract: Att I - 5.4.3, 5.6     | <strong>Provider Agency Training on QM</strong>                                          |
|                                 | DMA Contract: Att B - 7.4, 7.8       | All provider agencies are trained on QM activities (using train-the-trainer model) and implement QM in their daily operations. Areas of training include QM principles, processes and expectations, QM requirements for Gold Star Providers, collection and submission of consumer data required by the LME-MCO and DHHS and internal use of data for ensuring high quality care and good consumer outcomes. |</p>
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<tr>
<th>Items/Functions</th>
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<tbody>
<tr>
<td><strong>Provider Peer Reviews</strong></td>
<td><strong>DMH Contract:</strong>&lt;br&gt;Att I - 5.5&lt;br&gt;&lt;br&gt;<strong>DMA Contract:</strong>&lt;br&gt;</td>
<td>The LME-MCO participates with DHHS in coordinating peer reviews among provider agencies, including SAPTBG-funded peer reviews.</td>
</tr>
<tr>
<td><strong>Provider Performance Monitoring</strong></td>
<td><strong>DMH Contract:</strong>&lt;br&gt;Body - 10.0(9), 12.0, 13.0&lt;br&gt;Att I - 3.3, 5.4.3, 5.5, 7.2.7, 9.1&lt;br&gt;Att II - 2.0&lt;br&gt;&lt;br&gt;<strong>DMA Contract:</strong>&lt;br&gt;Att B - 6.4, 6.5, 7.1, 7.4&lt;br&gt;Att P - Items B19 &amp; D</td>
<td>LME-MCO implements DHHS Gold Star Provider Profiling and monitors providers accordingly. The LME-MCO audits providers’ use of service funds, monitor and investigates consumer complaints and incidents, as needed, and addresses problems through plans of correction or other actions, as appropriate.</td>
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<tr>
<td><strong>Service Fidelity</strong></td>
<td><strong>DMH Contract:</strong>&lt;br&gt;Att I - 7.5.1&lt;br&gt;&lt;br&gt;<strong>DMA Contract:</strong>&lt;br&gt;Att B - 7.1</td>
<td>The LME-MCO participates with the DHHS in monitoring provider fidelity to established best practice standards.</td>
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<td>Items/Functions</td>
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<tr>
<td><strong>7. System Performance Monitoring and Improvement</strong></td>
<td> </td>
<td><strong>Provider Complaints, Grievances and Appeals</strong></td>
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</table>
|  | DMH Contract: Att I - 5.7  
DMA Contract: Att B - 6.7 | **Provider Complaints, Grievances and Appeals**  
The LME-MCO ensures timely processing, reporting and response to provider complaints. The LME-MCO reviews trends in provider issues to identify areas needing improvement and areas of successful performance. |
|  | DMH Contract: Att I - 3.5, 9.1 - 9.3  
Att II - 2.0, 3.0  
DMA Contract: Att B - 7.1 | **Performance Analytics**  
The LME-MCO tracks and monitors DMH/DMA-defined performance measures and develops and implements local measures to evaluate LME-MCO operations, system quality and consumer outcomes. Information to be monitored tracks Medicaid and state-funded activities separately, where applicable, and includes trends in access to services, service utilization and coordination, consumer incidents, outcomes, and experiences in the system and relationships with community partners. The LME-MCO uses trends and patterns in the information to guide policy decisions and annual improvement goals. |
|  | DMH Contract: Att I - 3.5  
Att IV  
DMA Contract: Att B - 6.13, 7.1, 7.4 | **Service Utilization Trends and Patterns**  
The LME-MCO partners with CCNC to monitor services to identify persons in need of care coordination. The LME-MCO tracks and monitors use of Medicaid and state-funded services to evaluate and improve system capacity in each county and consumers’ access to appropriate types, amount and duration of services. |
|  | DMH Contract:  
DMA Contract: Att M - C1 | **Provider Satisfaction Surveys**  
The LME-MCO conducts an annual DHHS-approved survey to gather provider feedback on the LME-MCO’s performance and system needs. The LME-MCO uses the information to guide policy decisions and make system improvements. |
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<tbody>
<tr>
<td><strong>System Gap Analysis &amp; Needs Assessment</strong>&lt;br&gt;DMH Contract:  &lt;br&gt;Att I - 5.1, 5.2, 5.5  &lt;br&gt;Att II - 2.0  &lt;br&gt;DMA Contract:  &lt;br&gt;Att B - 6.4  &lt;br&gt;Att M – B4  &lt;br&gt;Att P - Item D</td>
<td>LME-MCO conducts an annual analysis of service capacity gaps and community needs using DHHS-approved guidelines and tools and uses the information to guide business planning and performance improvement projects. The gap analysis includes assessment of needs in each county of the catchment area for Medicaid and uninsured populations and incorporates input from community partners and system stakeholders.</td>
<td></td>
</tr>
<tr>
<td><strong>Performance Improvement Projects (PIP)</strong>&lt;br&gt;DMH Contract:  &lt;br&gt;Att I - 9.4  &lt;br&gt;DMA Contract:  &lt;br&gt;Att B - 7.1  &lt;br&gt;Att N</td>
<td>LME-MCO implements at least one clinical and one non-clinical PIP that can have a significant impact on consumer care (per Att N) and a third PIP, based on local choice, and evaluates results. Where possible, PIPs must separately track impact for Medicaid and uninsured populations. PIP selections are based on analysis of clinical and administrative data and input from system stakeholders. PIP plans include goals, baseline data and performance targets, timelines, strategies/activities to be undertaken, responsible staff and mechanisms for collecting, reporting and reviewing data to evaluate the results of improvement efforts.</td>
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</table>
Performance Contract Reports for DMA Due Each Fiscal Year (Current)

DMA contract #28172, signed and dated 2/3/13 (ATT L, page 80) reads:

“Alliance shall submit data and measurements to DMA annually for quality of care and service measures may be phased in over the term of the contract at the discretion of DMA.”

“Alliance shall complete and submit the quarterly and annual reports described below to DMA by June 30 of each year; or as designated by DMA. The annual reports submitted shall contain data collected from January 1 through December of the preceding calendar year.”

<table>
<thead>
<tr>
<th>Report Name</th>
<th>Report Description</th>
<th>Contract Reference</th>
<th>Data Source and Status</th>
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</thead>
<tbody>
<tr>
<td><strong>Ambulatory Follow-up within 7 calendar days of discharge for Mental Health</strong></td>
<td>Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of mental health disorders, who were continuously enrolled for 7 days after discharge (without gaps) and who were seen on an ambulatory basis. The number and proportion of adult enrollees, ages 18-20 and age 21 and over with a mental health diagnosis who have a visit within 7 calendar days of discharge from a substance abuse facility. The number and percentage who have a visit within 30 calendar days of discharge from a mental health facility.</td>
<td>DMA contract - Attachment L- Item A.4.</td>
<td>Claims Data</td>
</tr>
<tr>
<td><strong>Ambulatory Follow-up within 7 calendar days of discharge for Substance Abuse Facility</strong></td>
<td>Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of substance abuse disorders, who were continuously enrolled for 7 days after discharge (without gaps) and who were seen on an ambulatory basis. The number and proportion of adult enrollees, ages 18-20 and age 21 and over with substance abuse diagnosis who have a visit within 7 calendar days of discharge from a substance abuse facility. The number and percentage who have a visit within 30 calendar days of discharge from a substance abuse facility.</td>
<td>DMA contract - Attachment L- Item A.3.</td>
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<tr>
<td>Report Name</td>
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</table>
| Call Abandonment                    | Assesses the percentage of calls received by the member services call center (during operating hours) during the measurement year that were abandoned by the caller before being answered by a live voice.  
|                                    | N: Number of calls abandoned before answered  
|                                    | D: Total number of calls                                                                           | DMA contract - Attachment L-Item B.3.       |                                                |
| Call Answer Timeliness              | Assesses the percentage of calls received by member services call centers (during the member services operating hours) during the measurement year that were answered by a live voice within 30 seconds.  
|                                    | N: Number of calls answered by a live voice within 30 seconds  
|                                    | D: Total number of calls                                                                           | DMA contract - Attachment L-Item B.2.       |                                                |
| CC Advises on Available Services    | Proportion of participants reporting their Care Coordinator helps them to know what waiver services are available  
|                                    |                                                                                                                                                                                                                   | D                                           |                                                |
| Chemical Dependence Utilization     | Summarizes the utilization of inpatient chemical dependency services, stratified by age and sex. Medicaid and all other enrollees, reported separately.  
| Inpatient Discharges and Average Length of Stay | N: # of consumers using inpatient services by measurement (age, sex)  
|                                    | D: total number of consumers using inpatient services                                              | DMA contract - Attachment L-Item D.3.       |                                                |
| Chemical Dependency Utilization     | Reports the number & percent of Medicaid enrollees and all other enrollees, reported separately, receiving chemical dependency services during measurement year in inpatient, day/night care and ambulatory services and provides an overview to extent it uses the different levels. Report which services are included in each category.  
|                                    | Percentage of members receiving Inpatient, Day/Night Care, Ambulatory and other support services  
|                                    |                                                                                                                                                                                                                   | DMA contract - Attachment L-Item D.4.       |                                                |
| Complaints/Grievances/Appeals (*) (+) | Report separately all enrollee complaints, grievances, and Medicaid appeals including the total number of enrollees served, total number of both complaints  
<p>|                                    |                                                                                                                                                                                                                   | DMA contract - Attachment L-               |                                                |</p>
<table>
<thead>
<tr>
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<tr>
<td>and grievances categorized by reason, reported separately; the number of both complaints and grievances referred to second level review or appeal, reported separately; and the number of complaints and grievances resolved at each level, total time of resolution and outcome, reported separately.</td>
<td># of complaints received reported by disability, source, type and resolution</td>
<td>Item C.2. (See Attachment N for procedures)</td>
<td></td>
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<tr>
<td>% of complaints received reported by disability, source, type and resolution (N: # of complaints received by reporting category D: total # of complaints received)</td>
<td></td>
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<td></td>
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<tr>
<td>Report all by %’s of N: measurement and D: total number of enrollees</td>
<td></td>
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<tr>
<td>Critical Incident Reports</td>
<td>Number and percentage of deaths and incidents that were reported on the past fiscal year’s LME Quarterly Incidents Reports (DMH Form QM13) that required LME intervention, categorized as follows: a. consumer deaths, b. restrictive interventions, c. consumer injuries, d. allegations of abuse, e. allegations of neglect or exploitation by a provider or caregiver, f. medication errors, g. consumer behavior, h. other incidents.</td>
<td>DMA contract - Attachment L- Item G.1.</td>
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<tr>
<td># of incident reports received by type of incident</td>
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<tr>
<td>% each type of incident occurred (N: # of incident reports received for type of incident D: # of incident reports received)</td>
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<tr>
<td># of incident reports received that required follow up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of incident reports received that required follow up (N: # of IR requiring follow up D: # of IR received)</td>
<td></td>
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<tr>
<td>Finance Reporting Requirements (provide financial reports as delineated in Attachment V)</td>
<td></td>
<td>DMA Contract - Attachment V</td>
<td></td>
</tr>
<tr>
<td>Freedom of Choice Statements</td>
<td>Proportion of records that contain a signed freedom of choice statement</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Report Name</td>
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<tr>
<td>Gap Analysis/Service Need Assessment</td>
<td></td>
<td>DMA contract - Attachment L-Item B.4. DMH contract - Section 5.1</td>
<td></td>
</tr>
<tr>
<td>Health and Safety (Incidents) Innovations</td>
<td>All incidents for the C Waiver</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Identification of Alcohol and Other Drug Services (+):</td>
<td>Reports the number and percentage of members with an alcohol and other drug (AOD) claim. AOD claims contain a diagnosis of AOD abuse or dependence and a specific AOD-related service during the measurement year in the following categories: any chemical dependency services: inpatient, day/night, ambulatory (separately and individually) (Report by age and sex)</td>
<td>DMA contract - Attachment L-Item D.5.</td>
<td></td>
</tr>
<tr>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
<td>HEDIS Defined-The percentage of adults diagnosed with AOD dependence who initiate treatment through one of the following: an inpatient AOD admission or an outpatient service for AOD abuse or dependence and any additional AOD services within 14 calendar days. Medicaid and all other enrollees, reported separately.</td>
<td>DMA contract - Attachment L-Item B.1.</td>
<td></td>
</tr>
<tr>
<td>Innovations Claims vs.Services Auth’d</td>
<td>The proportion of claims paid by the PIHP for Innovations waiver services that have been authorized in the service plan.</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>Integrated Care</td>
<td>For adults, reports the percentage of enrollees with high level behavioral health involvement 21-44, 45-64 and 65 years of age and older who had an ambulatory or preventative care visit during the measurement year. For children and adolescents, reports the percentage of continuously enrolled enrollees 3 to 6 years, 7-11 years and 12-20 years of age with high level behavioral health involvement who had a visit with a primary care practitioner. N: Those with one or more ambulatory or preventive care visits during the measurement year. D: Continuously enrolled individuals who have had at least one Medicaid mental health, substance abuse or developmental disability service during the</td>
<td>DMA contract - Attachment L-Item D.6.</td>
<td></td>
</tr>
<tr>
<td>Report Name</td>
<td>Report Description</td>
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<tr>
<td>ISP &amp; Specified Services (12 components to this)</td>
<td>Proportion of participants who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Mental Health Utilization- Inpatient Discharges and Average Length of Stay</td>
<td>Use of inpatient services (Medicaid and other enrollees, reported separately) reported by age, and gender (Mental Health Utilization - Inpatient Discharges and ALOS - summarize the utilization of inpatient MH services stratified by age and sex)</td>
<td>DMA contract - Attachment L- Item D.1.</td>
<td></td>
</tr>
<tr>
<td>Mental Health Utilization- Percentage of Members Receiving Inpatient, Day/Night Care, Ambulatory and Other Support Services</td>
<td>Reports the number and percentage of Medicaid enrollees and all other enrollees, reported separately, receiving MH services during measurement year in inpatient, day/night care and ambulatory services and provides an overview to extent it uses the different levels. Report which services are included in each category. Percentage of members receiving Inpatient, Day/Night Care, Ambulatory and other support services - HEDIS (Age groups, 0-12, 13-17, 18-20</td>
<td>DMA contract - Attachment L- Item D.2.</td>
<td></td>
</tr>
<tr>
<td>Network Capability</td>
<td># of providers by each type of service rendered (duplicated count)</td>
<td>DMA contract - Attachment L- Item E.1.</td>
<td></td>
</tr>
<tr>
<td>New Provider Enrollment Monitoring</td>
<td>DMA ensures that LME/MCOs follow the enrollment/monitoring process for newly enrolled providers.</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Ongoing Provider Enrollment Monitoring</td>
<td>DMA ensures that LME/MCOs follow the ongoing monitoring process for enrolled providers.</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Out of Network Services</td>
<td>N: Number of services provided out of network by type D: Total number of services provided</td>
<td>DMA contract - Attachment L- Item B.6.</td>
<td></td>
</tr>
<tr>
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<tr>
<td>Patient Satisfaction Survey</td>
<td>Number and percentage of requests for services that were denied by the LME-MCO (do a report by denial code)</td>
<td>DMA contract - Attachment L-Item C.3.</td>
<td></td>
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<tr>
<td></td>
<td>N: number of authorizations that were denied by LME-MCO</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>D: total number of authorizations requested</td>
<td></td>
<td></td>
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<tr>
<td>Payment (Authorization) Denials</td>
<td>DMA ensures that LME/MCOs follow the Plan of Care Approval and Implementation Processes</td>
<td></td>
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<tr>
<td>Plan of Care Approval</td>
<td>DMA ensures that LME/MCOs follow the Plan of Care Approval and Implementation Processes</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Provider Capacity</td>
<td>DMA reviews the PIHP Innovations provider network for adequate capacity and choice.</td>
<td>A</td>
<td></td>
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<tr>
<td>Provider Choice</td>
<td>Proportion of participants reporting they have a choice between providers</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Provider Compliance</td>
<td>Proportion of providers reviewed according to PIHP monitoring schedule to determine continuing compliance with licensing, certification, contract and waiver standards</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Provider Remediation</td>
<td>Proportion of providers for whom problems have been discovered and appropriate remediation has taken place</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Provider Satisfaction Survey</td>
<td></td>
<td>DMA contract - Attachment L-Item C.1.</td>
<td></td>
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<tr>
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<tr>
<td>Provider Standards</td>
<td>Proportion of providers that meet licensure, certification, and/or other standards prior to their furnishing waiver services</td>
<td></td>
<td></td>
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<tr>
<td>Provider Standards</td>
<td>Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan</td>
<td></td>
<td></td>
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<tr>
<td>Provider Standards</td>
<td>Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.</td>
<td></td>
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<tr>
<td>Quality Improvement Projects</td>
<td>2 quality improvement studies in year 1 of contract (1 clinical and 1 non-clinical), 1 additional quality improvement study in year 2. Plan developed to specifications outlined in Attachment N -yes or no</td>
<td>DMA Contract - Attachment M</td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity Diversity of Membership</td>
<td>Assesses the number and percentage of Medicaid members served versus enrolled at any time during the measurement year by race/ethnicity, Hispanic origin, and language. HEDIS Race/Ethnicity Diversity of membership and HEDIS Language Diversity of Membership</td>
<td>DMA contract - Attachment L-Item F.2.</td>
<td></td>
</tr>
<tr>
<td>Readmission Rates for Mental Health</td>
<td>The number and proportion of Medicaid enrollees readmitted to inpatient mental health facilities within 30 calendar days. (break down by all enrollees) N: Number of individuals with an MH diagnosis readmitted into an inpatient facility, detox facility, facility based crisis or PRTF with in 30 days of discharge from one of these facilities. D: Total number of individuals with an MH diagnosis discharged from an inpatient facility, detox, FBC or PRTF. (claims codes and dx codes provided in specifications)</td>
<td>DMA contract - Attachment L-Item A.1.</td>
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<tr>
<td>Readmission Rates for Substance Abuse-</td>
<td>The number and proportion of Medicaid enrollees readmitted to substance abuse treatment facilities within 30 calendar days. (break down by all enrollees) N: Number of individuals with an SA diagnosis readmitted into an inpatient facility, detox facility, facility based crisis or PRTF with in 30 days of discharge</td>
<td>DMA contract - Attachment L-Item A.2.</td>
<td></td>
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<tr>
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<td>from one of these facilities.</td>
<td>D: Total number of individuals with an SA diagnosis discharged from an inpatient</td>
<td></td>
<td></td>
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<tr>
<td>D: Total number of individuals with an SA</td>
<td>facility, detox, FBC or PRTF. (Claims codes and dx codes provided in specifications.)</td>
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<tr>
<td>Services Rec’d within 45 days</td>
<td>Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval.</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Slot/transfer tracking</td>
<td>DMA tracks waiver participation through reporting by the PIHP on new enrollees and consumers transferring in from other waivers</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Timely performance measure submission</td>
<td>DMA ensures that LME/MCOs submit information in a complete and timely manner.</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Unduplicated Count of Medicaid Members</td>
<td>Provides the age, sex, Medicaid eligibility category of enrollees served and enrolled by the plan and the average number of months Medicaid members are served by the plan and enrolled by the plan of the measurement yr HEDIS Unduplicated Count of Medicaid Members</td>
<td>DMA contract - Attachment L-Item F.1.</td>
<td></td>
</tr>
</tbody>
</table>