Based on feedback received from NC DHHS and AHEC regarding the NCQA site reviews that have already occurred, Alliance's practice transformation team has developed this document to assist organizations who are still preparing for their site review. The following document is organized into sections in accordance with the NCQA site review protocol.

General Guidance

1. **Be detailed and specific.** Make sure to include procedural workflows in your documents that outline not only what you will do, but exactly how you will do it. If using a policy and procedure template, make sure to provide step-by-step information. Your procedures should explain in detail your organization's day to day operations (include each task in each process, who is responsible for the task, and how it will be completed).

    Below is an example of a step-by-step procedure for assigning members to a care manager. This is an example only. Your organization must create your own procedure to align with your care management platform.

    Assigning members to a care manager

    1. The care manager supervisor will consider the following:

        a. Member choice.
        b. Member's acuity level.
        c. Location of the care manager and member.
        d. Care manager's existing caseload.
        e. Other services the member is receiving within the organization.

    2. The supervisor will then assign the member to the appropriate care manager, and enter the assignment in the platform *(include your organization's timeline for assignment)*.

    3. The care manager will receive notification of the assignment through the platform *(include required timeframe)*.

    4. The care manager will initiate contact with the member *(include required timeframe, and method of contact, and actions you will take if attempts are unsuccessful)*.

2. When submitting documentation, label each document with the corresponding section from the NCQA Site Review Protocol. For example: your policy and procedure for transitional care management should be labelled as 4.8; any additional documents submitted that go along with this policy should be labelled as "4.8_1 (document title)"; 4.8_2 (document title)", etc.

3. Give yourself credit for all that you do. Explain what you do and how you do it with step-by-step information. Something that may seem very basic to you may not be for the reviewers.

NCQA Section 2: Organizational Standing/Experience

2.2: Provider Relationships and Linkages

- Include specific information regarding agencies and community partners with whom you have or will have relationships. Remember that NCQA reviewers may not be familiar with behavioral health services in North Carolina, so make sure to provide a written narrative explaining the details of your relationship with each agency/community partner, including what the agency/community partner does and where your organization is in the contract process with each. Include the following information in your narrative:

  a. Who the agency is.
  b. What the agency does.
  c. Where they are located.
  d. The details of your relationship (ex: if they accept/send referrals, etc.).
  e. How your organization utilizes them as a resource.

Below is an example of how to describe the relationship that your organization will have with NCCARE360. This is an example only. Your organization must create this narrative to align with your policies and procedures.

"NCCARE360 is a statewide coordinated care network that is available to providers in all 100 counties across North Carolina. NCCARE360 acts as an electronic community-based organization and social service agency resource repository to identify local community-based resources. Our organization will be able to refer members to the community-based organizations and social service agencies available on NCCARE360, as well as track closed-loop referrals and report the outcome of that connection. Our organization will begin working with NCCARE360 effective December 1, 2022."

- In addition to your narratives, you may use the "Agency and Community Partners" form as a template to track your organization's relationships and resources (contact your assigned practice transformation specialist to request this document if you do not already have it). Note that if this form includes comprehensive information, it can be used as a supporting document for NCQA Sections 2.2, 3.2, and 4.8.

  - NCQA will want to know where you are in the development of all your relationships/contracts, so make sure to include that information (see the column "Contract status" on the attached form).

  - NCQA requires three formal contracts/MOAs/MOUs at the site review.

  - NCQA is looking for a relationship with a primary care provider (PCP), so make sure to include your consulting PCP in your list of relationships, or on this form if you choose to use it. Include a PCP or pediatrician that you have a relationship with whether it is a formal clinical consultant agreement.

- It is also recommended that your clinical consultants are included on this form (only one formal contract is required for clinical consultants for the site review but include information about your progress in contracting with all three required consultants).

2.3: Capacity and Sustainability

- In addition to an audited financial statement, providers will have to explain how they arrived at the projected number of members they will be serving in Tailored Care Management (explain the math).

- Submit the spreadsheet and narrative that your organization submitted for capacity building funds to NCQA, so they will be able to see the amounts delegated to health IT, staffing, or other infrastructure.

- Utilize a caseload projection model to project the number of members you will serve in Tailored Care Management based on one or more of the following:

  - Your organization's tailored plan eligible members (obtained from the Tailored Plans).
  - Your own claims data.
  - Using demographics from your practice management system (from your EHR).

  Remember that your organization's numbers will be higher than they are as a service provider because there are tailored plan members who are not connected to any agency that will be assigned to your organization. Consider how many members you feel your organization can accept for Tailored Care Management when projecting your total numbers.

NCQA Section 3: Staffing

3.3 Care Management Staff

- Include your organization's recruitment plan regarding how you will recruit and hire staff, to include dates of hire for positions, timeframes for recruitment and hiring, and any innovative recruitment strategies your organization will engage. Include how many of your existing staff will move to Tailored Care Management and how many you will need to hire. You may reference the "Recruitment and Retention Plan Template" for guidance (contact your assigned practice transformation specialist to request this document if you do not already have it).

3.2 Clinical Consultants

- For clinical consultants, NCQA is only requiring one formal contract at the site review, but make sure to submit information about the progress with engaging with others. If your organization is contracting with a clinically integrated network (CIN) and plans to utilize staff associated with that CIN, make sure to include details about this (the credentials of the consultant, what functions they will serve, time allotted to your organization, timeframe for implementation, etc.).

NCQA Section 4: Delivery of Tailored Care Management

- Include a written narrative of each of the daily functions of Tailored Care Management.
  The narrative needs to include your procedures for:

  a. Communication among provider types.
  b. Care coordination.
  c. 24-hour coverage.
  d. Annual physical exams.
  e. Continuous monitoring (including the care plan).
  f. Medication monitoring.
  g. System of care.
  h. Individual and family supports.
  i. Health promotion.

  Your organization is encouraged to utilize the Policy and Procedure templates provided by Alliance as a resource in developing these narratives and procedures, as those templates identify the requirements in both the RFA and the Provider Manual.

4.3 *Care Management Comprehensive Assessments and 4.4 Care Plans:*

- The care management comprehensive assessment (CMCA) does not need to be finalized, but your organization must present a plan (i.e., you can show your current comprehensive clinical assessment and the areas you will add to that, or you can show screen shots from your health IT system).

- If serving both the behavioral health (BH) and intellectual/developmental disability (IDD) population, your organization will need to create three different mock templates for both the CMCA and the Care Plan – one for BH, one for IDD, and one for co-occurring disorders (three mock templates for the CMCA and three mock templates for the care plan, each clearly labelled).

NCQA Section 5: Health Information Technology (HIT)

- Your organization will need to submit a HIT vendor contract or contract with a CIN. If this contract is not finalized yet, your organization will need to submit an explanation of why and your plan to contract with a vendor, including timelines, projected dates, a description of your efforts to obtain the contract, how you will utilize the platform, how/when you will train staff on the platform, etc.

- Your contract/plan should include your EHR, your care management platform, and your plan for admission-discharge-transfer (ADT) feeds.

NCQA Section 6: Quality Measurement and Improvement

- Include a description of a specific quality process that your organization has already implemented that will apply to Tailored Care Management (i.e., follow-up after hospitalization, access to care, etc.). Any quality improvement process that your organization will continue in Tailored Care Management must be clearly outlined (be specific if you have used PDSA cycles).

- Describe your quality team: purpose of the team, who is on the team, frequency of meetings, how the team determines goals/outcomes, how information is communicated to the rest of the organization, etc.

NCQA Section 7: Training

- Your organization must submit a training plan which should include:

  - Your plan for all care management staff to complete all required Tailored Care Management training, including an approximate timeline for completion (i.e., 3 months prior to go-live, prior to staff providing service, within 30 days of when the staff starts providing services, etc.). Please see sample training plan (https://www.alliancehealthplan.org/document-library/68934/) on our website.

  - Details regarding your organization's system for tracking and documenting all training (not only training specific to Tailored Care Management) received by your staff and procedures for following that system. Examples include training logs or certificates of completion. An explanation of how your organization tracks/will track when staff complete trainings, including who is responsible for tracking and where the tracking will be stored, should be included in your Policies and Procedures. The "Staff Training Tracking Log" is an example of a tracking method your organization may utilize (contact your assigned practice transformation specialist to request this document if you do not already have it).

  Your system for tracking staff training should include, at minimum:

  a. staff name.
  b. name of the training.
  c. the date(s) attended.
  d. total number of hours.
  e. name and credentials of the person who provided the training.
  f. subject/topic or content of training.
  g. training renewal date (if applicable).

  - Be sure to include attendance at learning collaboratives, provider meetings, Medicaid 101s, Medicaid TAG meetings, etc.

  - Job descriptions must include training requirements individualized for each staff's function.