FY 2022 Quality Management Program Evaluation

QMC Approved: 11/3/2022

Contents

Introduction 4
Section 1. QM Program and Structure 5
1.1 QM Department 5
1.2 Additional Internal Resources 5
1.2.1 Chief Medical Officer 5
1.2.2 Provider Network Development and Evaluation Department 6
1.2.3 Care Management Department 6
1.2.4 Utilization Management Department 6
1.2.5 Community Health and Well Being Department 6
1.2.6 Access and Information Department 7
1.2.7 Compliance and Risk Management Department 7
Section 2: Quality Committee and Subcommittees 7
2.1 Quality Management Committee (QMC) 7
2.1.2 Continuous Quality Improvement Committee (CQI) 8
2.1.1.1 Utilization Management – CQI Subcommittee 8
2.1.1.2 Provider Quality – CQI Subcommittee 9
2.1.1.3 Social Drivers of Health – CQI Subcommittee 10
2.1.1.4 Care Management – CQI Subcommittee 11
2.1.1.5 Member Experience – CQI Subcommittee 12
2.1.1.6 Delegation & Accreditation Oversight – CQI Subcommittee 13
2.1.1.7 Health Equity – CQI Subcommittee 13
2.1.1.8 Pharmacy & Therapeutics – CQI Subcommittee 14
Section 3: QM Program Goals and Objectives 15
Section 4: Major Organizational Quality and Performance Accomplishments 17
4.1 Began Serving Mecklenburg & Orange Counties 17
4.2 Tailored Plan (TP) Readiness 17
4.3 Additional CQI Subcommittees 17
4.4 External Quality Review 17
4.5 Innovations and Traumatic Brain Injury (TBI) Waiver Measures 17
4.6 Expanded Value-Based Contracts (VBCs) 17
Section 5: Quality Improvement Activities 17
5.1 Follow-Up after Mental Health Discharges (Uninsured) 17
5.1.1 Activity Goal 17
5.1.2 Activity Interventions and Barriers 18
5.1.3 Activity Measure 19

5.1.4 Activity Quantitative and Qualitative Analyses 19
5.1.5 Activity Recommendations 19
5.2 Follow-Up after Substance Use Discharges (Uninsured) 19
5.2.1 Activity Goal 19
5.2.2 Activity Interventions and Barriers 20
5.2.3 Activity Measures 21
5.2.4 Activity Quantitative and Qualitative Analyses 21
5.2.5 Activity Recommendations 21
5.3 Follow-Up after Substance Use Discharges (Medicaid) 22
5.3.1 Activity Goal 22
5.3.2 Activity Interventions and Barriers 22
5.3.3 Activity Measures 23
5.3.4 Activity Quantitative and Qualitative Analyses 23
5.3.5 Activity Recommendations 23
5.4 Diabetes Screening for People Using Antipsychotic Medications (SSD) 24
5.4.1 Activity Goal 24
5.4.2 Activity Interventions and Barriers 24
5.4.3 Activity Measures 25
5.4.4 Activity Quantitative and Qualitative Analyses 25
5.4.5 Activity Recommendations 25
5.5 Metabolic Monitoring for Youth on Antipsychotics (APM) 25
5.5.1 Activity Goal 25
5.5.2 Activity Interventions and Barriers 25
5.5.3 Activity Measures 26
5.5.4 Activity Quantitative and Qualitative Analyses 27
5.5.5 Activity Recommendations 27
5.6 Transition to Community Living (TCL) Primary Care Provider (PCP) Visits 27
5.6.1 Activity Goal 27
5.6.2 Activity Interventions and Barriers 27
5.6.3 Activity Measures 28
5.6.4 Activity Quantitative and Qualitative Analyses 29
5.6.5 Activity Recommendations 29
Section 6: Additional Quality Improvement and Performance Efforts 29
6.1 Performance Measures 29
6.1.1 Call Center Performance 30
6.1.2 Contract Super Measures 30
6.1.3 Medicaid Performance Measures 30

6.1.4 Innovations Waiver Measures 31
6.1.5 TBI Waiver Measures 32
6.2 Grievances and Complaints 34
6.2.1 Activity Goal 34
6.2.2 Activity Performance 35
6.2.3 Activity Analysis 35
6.2.4 Activity Next Steps 35
6.3 Adverse Incident Reports 35
6.3.1 Activity Goal 35
6.3.2 Activity Performance 35
6.3.3 Activity Analysis 36
6.4.4 Activity Next Steps 36
6.5 Member Authorization Appeals 36
6.5.1 Activity Goal 36
6.5.2 Activity Performance 36
6.5.3 Activity Analysis 36
6.5.4 Activity Next Steps 36
6.6 Provider Satisfaction Survey 37
6.6.1 Activity Goal 37
6.6.2 Activity Performance 37
6.6.3 Activity Next Steps 37
6.7 Perception of Care Survey 37
6.7.1 Activity Goal 37
6.7.2 Activity Performance 38
6.7.3 Activity Next Steps 38
6.8 Experience of Care and Health Outcomes (ECHO) Survey 38
6.8.1 Activity Goal 38
6.8.2 Activity Performance 38
6.8.3 Next Steps 39
Section 7: Value-Based Contracting (VBC) 39
Section 8: Practice Transformation 39
Conclusion and Recommendations 39
Appendix A: Measure Definitions 41

Introduction

Alliance is committed to providing quality and effective care to individuals in Wake, Durham, Cumberland and Johnston Counties. Alliance uses a data-driven continuous quality improvement approach to support internal efforts and the efforts of the Department of Health and Human Resources (DHHR) to improve member outcomes.

The purpose of this Quality Management Evaluation Report is to review Alliance Health's progress at implementing the quality management activities specified within the annual Quality Program Description and Annual Workplan for FY2022 (7/1/2021-6/30/2022). This report also identifies opportunities for improvement and informs future quality management strategies.

The Quality Management (QM) Program Evaluation which includes the following elements:

- Description of QM Program and Structure
- Description of Continuous Quality Improvement (CQI) Committee and Subcommittees
- QM Program Goals and Objectives
- Major Program Accomplishments
- Summary of Quality Improvement Activities including:
    - Goal of activity
    - Interventions/Actions taken
    - Measures trended over time
    - Quantitative and qualitative analyses including barrier analysis
    - Recommendations to continue or discontinue
- Additional Quality Improvement Efforts
- Conclusion that includes a summary of effectiveness addressing:
    - Adequacy of program resources
    - Quality Committee and Subcommittee structure
    - Practitioner participation and leadership involvement
    - Recommendations regarding structure or changes necessary to improve performance

Section 1. QM Program and Structure

The Alliance quality program involves all the agency's stakeholders. Leadership is provided by the Alliance Board of Directors and its Quality Management Committee (QMC). Within Alliance, the Continuous Quality Improvement Committee and its six subcommittees are responsible for quality. Provider and member representatives participate at the board, agency, and project level. Finally, all Alliance staff are responsible for continuous quality improvement.

1.1 QM Department

As of June 30, 2022, the Alliance QM Department consisted of the Senior Vice President of Quality Management who oversaw five teams:

- **Grievance, Incidents, and Appeals**: This team promotes quality assurance within Alliance and the Alliance provider network; develops reports for Alliance management, committees and the State; investigates and resolves incidents and complaints reported by members, providers, Alliance staff and others. In the last year this team has also taken on the responsibility of processing appeal requests from members. Staffing consists of a Grievance, Incidents, and Appeals Manager and five staff.

- **Quality Improvement:** This team oversees Quality Improvement Projects (QIPs) and other quality improvement related activities; performs quality reviews to identify opportunities for improvement; conducts in-depth analyses of internal processes and programs. Staffing includes the Quality Improvement Manager, and four staff to manage QIPs.

- **Quality Management Data**: This team was created to focus on the data needs of internal and external stakeholders working on quality projects. This team is responsible for providing guidance on utilizing data for quality tracking and improvement efforts, completion of external quality reporting, and the implementation and interpretation of surveys. Staffing includes the QM Data Manager, and three staff.

- **Accreditation:** This function oversees the pursuit and maintenance of national accreditation and links quality efforts across the organization to accreditation standards and monitors to ensure on-going compliance.

- **Data Science:** This team focuses on using advanced and predictive analytics to identify issues, target solutions, and efficiently improve the health outcomes of our members.

1.2 Additional Internal Resources

All employees at Alliance are responsible for the pursuit of continuous quality improvement. The departments and staff summarized below are central to Alliance's efforts at continuous quality improvement.

1.2.1 Chief Medical Officer

The Alliance Health Chief Medical Officer (CMO) serves as the designated healthcare practitioner overseeing the operations of the Quality Management Program. The CMO or designee is the Chair of the CQI Committee, providing guidance and oversight for all major quality efforts. The entire Medical Team provides clinical oversight, guidance and consultation for all Managed Care Organization (MCO) functions including: Utilization Management, Care Coordination, Call Center, Network Management and Quality Improvement.

1.2.2 Provider Network Development and Evaluation Department

The Provider Network Development and Evaluation Team is responsible for the promotion of high-quality and evidence-based services and supports. The team provides continuous review and evaluation of the provider network for quality of services, adherence to contract requirements, and standards of care and performance, while ensuring that a full array of providers are available to meet the needs of those in need of services. This team also works to:

- Develop and maintain the provider network with a sufficient number, mix and geographic distribution of providers to ensure availability of easy access, quality care and cost-effective services for consumers
- Host a variety of provider collaboratives aimed at sharing best practices within service-specific groups
- Support the Credentialing Committee to ensure that all providers and practitioners meet requirements to participate in the Alliance provider network

1.2.3 Care Management Department

The Care Management Team links individuals and families with special health care needs to services and supports in an effort to maximize potential outcomes, decrease the unnecessary use of emergency services and ensure quality care. This team:

- Manages Complex Case Management and Long-Term Services and Supports (LTSS) programs
- Supports inpatient and crisis providers with connections to treatment and other resources in the community
- Monitors member's wellbeing to ensure that care is delivered in a safe and effective manner that respects the member's rights

1.2.4 Utilization Management Department

The Utilization Management Team ensures that services are medically necessary and monitors consumer treatment to ensure that services are delivered based on consumer need and established clinical guidelines.

1.2.5 Community Health and Well Being Department

The Community Health and Well Being Team focuses on promoting quality partnerships and collaborative change, and redesigning systems of care to improve health outcomes and promote healthy communities. The team works to improve quality of life for all the people we serve by helping them understand their health care better and giving them tools and resources to actively engage in their care.

As part of Community Health and Well-being Team, the Community and Member Engagement Team works to ensure that the voices of individuals and families are heard and integrated at all levels at Alliance, seeking to empower them through education and exposure to resources.

This department is staffed entirely by people with lived experience. This team:

- Champions health literacy efforts aimed and ensuring that members and their families can understand and direct their treatment
- Supports the Consumer Family Advisory Councils (CFAC) in advising the Alliance administration and Board of Directors
- Leverages partnerships to increase access to permanent and temporary housing for the people we serve
- Leads stigma reduction and mental health first aid campaigns in our communities

1.2.6 Access and Information Department

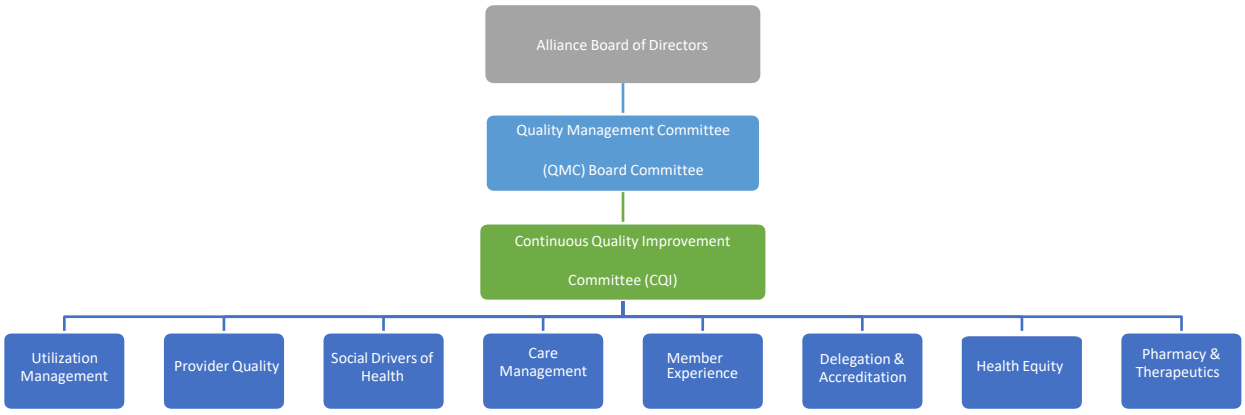
The Access and Information Team maintains the 24/7 Access and Information Line to ensure that individuals receive timely access to needed mental health (MH), intellectual and developmental disability (I/DD), and substance abuse services (SAS). The team provides information about services and resources available within the community and assistance to anyone requesting information about Alliance.

1.2.7 Compliance and Risk Management Department

The Compliance and Risk Management Team, at Alliance, assists the organization in making appropriate business decisions that comply with the law, working to prevent, detect and correct instances of legal and ethical violations and mitigate risk throughout the organization. The team provides compliance training to Alliance employees and members of the Provider Network, oversees policies and procedures and the code of ethics and conduct, conducts internal audits and investigations, and oversees program integrity activities such as fraud and abuse investigations.

Section 2: Quality Committee and Subcommittees

The Alliance Quality Committee structure is headed by the full Board of Directors, which has directed the Quality Management Committee to provide guidance for the quality program. A visual of the committee structure is below:



2.1 Quality Management Committee (QMC)

The Alliance Quality Management Committee (QMC) serves as the authority for approving the annual Quality Management Plan and conducts an evaluation of the Quality Management Program each fiscal year. QMC has the sole authority to open and close formal Quality Improvement Projects (QIPs) and receives regular status updates for all active QIPs. This group identifies actions that are needed to improve quality and ensures that follow-up occurs to realize the planned improvement. QMC reviews statistical data and provider monitoring reports to make recommendations to the Board of Directors and other Board Committees regarding policy decisions. The goal of the QMC is to ensure quality and effectiveness of services and to identify and address opportunities to improve Alliance operations and local service system with input from members, providers, family members, and other stakeholders.

Membership for this committee includes board members, two consumers or their family members, and two non-voting provider representatives.

2.1.2 Continuous Quality Improvement Committee (CQI)

Purpose	The CQI Committee is responsible for the implementation the Alliance Quality Program and Work Plan, monitoring of quality improvement goals and activities and identifying opportunities for improvement within the provider network and Alliance operations. The committee reviews organizational performance in order to prioritize solutions and make recommendations to the Quality Management Committee, of the Board, for additional review, feedback, recommendations and approval. In order to complete these tasks, six cross functional subcommittees exist to support these efforts. The subcommittees are described in tables below.
Responsibilities	• Implementing the Alliance Quality Plan • Monitoring of quality improvement goals and activities • Identifying opportunities for improvement within the provider network and Alliance operations • Monitoring performance regarding key quality indicators of Alliance internal and external functional areas including over/under utilization, member outcomes, network performance, etc.
Reports to	Quality Management Committee, of the Board
Committee Chair	• Chief Medical Officer (co-chair) • Senior Vice President of Quality Management (co-chair)
Committee Composition	Operations: • Chief Operating Officer • Senior VP- Community Health and Well Being • Senior Vice President – Population Health and Care Management Subcommittee Chairs: • Care Management Subcommittee • Utilization Management Subcommittee • Member Experience Subcommittee • Provider Quality Subcommittee • Social Determinates of Health Subcommittee • Delegation and Accreditation Oversight Subcommittee • Health Equity Subcommittee
Committee Meetings	The committee shall meet as often as its members deem necessary to perform the committee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.1 Utilization Management – CQI Subcommittee

Purpose	The purpose of the Utilization Management Subcommittee is to ensure that consumers have appropriate access to and utilization of behavioral health services. This subcommittee evaluates 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 subcommittee serves as a vehicle to communicate and coordinate quality improvement efforts to and with CQI.
Responsibilities	• Monitoring for over/under utilization of services • Identify utilization drivers and trends • Address inappropriate utilization patterns • Review and make recommendations to improve basic processes
Reports To	CQI
Subcommittee Chair	• Chief Medical Officer (co-chair) • Senior Director of Utilization Management (co-chair)
Subcommittee Composition	• Finance • Provider Networks • Care Management • Quality Management
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than fourtimes per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.2 Provider Quality – CQI Subcommittee

Purpose	The purpose of the Provider Quality Subcommittee is threefold: • To engage Alliance providers in developing, evaluating and approving guidelines for clinical practice across the network • To engage Alliance providers in the systematic monitoring and evaluation of provider performance measures, required by NCDHHS and included in Alliance provider contracts • To provide a forum for bi-directional communication between Clinical and Medical leadership in the provider network and Alliance It also provides a mechanism for provider input, feedback, and recommendations. The Provider Quality Subcommittee will draw upon published research,

	national guidelines, and local expertise to develop guidelines to support clinical decision-making by providers across the network. Furthermore, through identifying and monitoring performance measures, the committee will identify areas of opportunity to improve processes, identify interventions, and improve member outcomes.
Responsibilities	• Help develop, review, and approve clinical guidelines • Review data and other relevant information related to the provider network and make recommendations for improvement • Review and address industry and local trends and issues • Identify solutions to fill clinical and network needs and gaps • Identify and measure quality metrics that support evaluation of health and functional outcomes for members, access to mental health and substance use services, and effectiveness of mental health and substance services delivered by Alliance providers • Provide ongoing monitoring of identified performance measures to be compared against established benchmarks
Reports To	CQI
Subcommittee Chair	• Director of Network Evaluation (co-chair) • Chief Medical Officer or designee (co-chair)
Subcommittee Composition	• Ten Clinical subject matter experts from Mental Health (MH)/Substance Use Disorder (SUD) and Intellectual/Developmental Disability (I/DD) • Alliance pharmacist *Membership on this subcommittee, outside of the chairs, is entirely made up of providers representatives and network clinicians. Providers on this subcommittee represent a cross section of different service types, settings, and geographic locations within Alliance's catchment area.
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than fourtimes per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.3 Social Drivers of Health – CQI Subcommittee

Purpose	The purpose of the Social Drivers of Health Subcommittee is to ensure the environmental conditions impacting members are addressed, and to make recommendations about aligning Social Determinates of Health (SDOH) efforts with care management and network providers. This subcommittee reviewed SDOH assessments and interventions to align efforts across the system, so they can be most effective.

Responsibilities	• Assessing the social determinates of health needs of our members • Aligning resources and efforts within Alliance and across the provider network to help meet the Social Determinates of Health needs of our members • Determining impact of Social Determinates of Health interventions on the overall health and wellbeing of members
Reports To	CQI
Subcommittee Chair	• Senior Director of Clinical Innovation (Chair)
Subcommittee Composition	• Community Health and Wellbeing • Care Management • Quality Management • Medical Management
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than fourtimes per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.4 Care Management – CQI Subcommittee

Purpose	The purpose of the Care Management Subcommittee is to align care management resources to improve the efficacy of the care delivery network and optimize member outcomes. This subcommittee assists in defining and monitoring the quality of care management services being delivered.
Responsibilities	• Monitor impact and effectiveness of Care Management efforts and identify improvement opportunities • Create framework for evaluating outcomes and functions of internal and external Care Management efforts including Care Management Agencies (CMA) and Advance Medical Home + (AMH+). • Monitor the relationship between Care Management and service providers to ensure members receive the care they need in a timely and appropriate manner
Reports To	CQI
Subcommittee Chair	• Senior Vice President of Population Health and Care Management (Chair)
Subcommittee Composition	• Senior Vice President of Population Health and Care Management (Chair) • Senior Director of Care Management Operations • Director of Physical Healthcare Management • Provider Networks • Care Management • Medical Management • Pharmacy • Quality Management

Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.5 Member Experience – CQI Subcommittee

Purpose	The purpose of the Member Experience Subcommittee is to monitor data related to the member experience of care, identify trends, and suggest any necessary remediation steps, when necessary. Member satisfaction surveys, grievances, appeals, critical incidents, and other member experience data are all reviewed by this subcommittee.
Responsibilities	• Review grievances, critical incidents, appeals, member surveys, mystery shopper experiences, executive walkthrough findings, etc. • Make recommendations about efforts related to improving the experience of our members with Alliance and with network providers • Ensures that member experience is considered central to the definition of quality at Alliance • Direct QIPs that have been assigned to this subcommittee by the full CQI committee
Reports To	CQI
Subcommittee Chair	• Quality Management Specialist (Chair)
Subcommittee Composition	• Senior Director of Access • Provider Networks • Quality Management • Care Management • Community Health and Wellbeing • Medical Management • Member Representative • Provider Representative
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.6 Delegation & Accreditation Oversight – CQI Subcommittee

Purpose	The purpose of the Delegation and Accreditation Oversight Subcommittee is to ensure that accreditation and any delegated functions are completed successfully. This subcommittee provides a central body that monitors adherence to accreditation standards and ensures that any delegated functions receive appropriate oversight and monitoring.
Responsibilities	• Centralized monitoring of accreditation efforts • Ensure that any delegated functions are done according to requirements • Evaluate impact of delegated functions on providers and members
Reports To	CQI
Subcommittee Chair	• Chief Compliance Officer
Subcommittee Composition	• Corporate Compliance • Quality Management • Provider Networks • Access Call Center • Utilization Management
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.7 Health Equity – CQI Subcommittee

Purpose	The Health Equity Subcommittee is a centralized place to promote the elimination of health disparities, and the achievement of health equity for all members and recipients, by monitoring outcome gaps between populations, and ensuring that potential improvement efforts do not exacerbate disparities.
Responsibilities	The Health Equity Subcommittee will aide in aligning resources and efforts within Alliance and across the provider network to help meet the health equity needs of our members by: • Assessing the health equity needs of our members • Determining impact of interventions on the overall health and wellbeing of members • Directing QIPs that have been assigned to this subcommittee by the full CQI committee • Monitoring Provider Culturally Competent Plan
Reports To	CQI
Subcommittee Chair	• Quality Improvement Specialist, Quality Management (Chair)

Subcommittee Composition	• Quality Management • Community Health and Wellbeing • Organizational Effectiveness • Provider Networks • Medical Management • Provider Representative • Member Representative (1-2 Members)
Subcommittee Meeting	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.8 Pharmacy & Therapeutics – CQI Subcommittee

Purpose	The Pharmacy and Therapeutics (P&T) Subcommittee's mission is to uniformly, consistently, and equitably provide appropriate drug therapy to meet the clinical needs of Alliance Health Tailored Plan beneficiaries in an effective, efficient, and fiscally responsible manner.
Responsibilities	• Plan and implement pharmacy benefit management programs in partnership with the contracted Pharmacy Benefit Manager (PBM) that promote the safety, effectiveness, and affordability of medications • Develop Drug Utilization Review (DUR) reports and measures that are used to evaluate the effectiveness of pharmacy benefit utilization management programs • Monitor selected DUR reports and metrics to ensure that Alliance Health Plan members are receiving appropriate, safe, and medically necessary prescription, and develop a plan of action to correct deficiencies • Partner with participating network pharmacies willing to provide enhanced services to ensure access to medications for beneficiaries with unmet psychosocial needs • Approve communications with selected prescribers and pharmacists who have been targeted for educational intervention on optimal prescribing, dispensing, or pharmacy care practices • Review pharmacy benefit related grievances and appeals, and recommend actions to address both member and provider concerns • Consider the impact of periodic NC Medicaid Preferred Drug List (PDL) updates on members, collect feedback concerning PDL changes from providers, and make recommendations to the NC Medicaid P&T Committee • Suggest updates to clinical drug coverage policies to the NC Medicaid P&T Committee, in response to recent FDA approved labeling changes, new safety concerns, or current market conditions

Reports To	CQI
Subcommittee Chair	• Deputy Chief Medical Officer (co-chair)
Subcommittee Composition	Subcommittee members include, Alliance Health Plan Medical Management Team staff, and at least one practicing physician and one practicing pharmacist from Alliance's provider network. Members are appointed annually by the Deputy Chief Medical Officer who serves as the P&T Chairperson. The Alliance Pharmacy Director serves as the meeting organizer.
Subcommittee Meeting	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

Section 3: QM Program Goals and Objectives

The Quality Management Program plays a major role in ensuring Alliance is successful at meeting performance outcomes and contract requirements. The broad goals listed below are of particular focus to the QM staff and organization-wide QM activities:

- Ensure individual members receive services that are appropriate and timely
- Use evidence-based treatments that result in measurable clinical outcomes
- Ensure Alliance focuses on health and safety of members, protection of rights, and to monitor and continually improve the provider network
- Empower members and families to set their own priorities, take reasonable risks and participate in system management, and to shape the system through their choices of services and providers
- Build local partnerships with individual who depend on the system for services and supports, with community stakeholders, and with the providers of services
- 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.

Specifically, the priority performance goals for FY2022 are summarized below:

Quality Effort	Summary of Measure	Target

Follow-Up after Mental Health Discharges (Uninsured)	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.	40%
Follow-Up after Substance Use Discharges (Uninsured)	The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use disorder treatment that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.	40%
Follow-Up after Substance Use Discharges (Medicaid)	The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use disorder treatment that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.	40%
Diabetes Screening for People Using Antipsychotic Medications	The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	77%
Metabolic Monitoring for Youth on Antipsychotics	The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.	31%
Transition to Community Living Initiative (TCLI) Primary Care Visits	To increase the rate of confirmed primary care provider appointments with members in the TCLI housing transition and residency cohort.	80%
Expand CQI Subcommittee	To establish a Health Equity and a Pharmacy and Therapeutics committee to oversee quality and prepare for Tailored Plan.	By 1/1/2022
Healthcare Effectiveness Data and Information Set (HEDIS) Vendor	To engage in a contractual relationship with an NCQA-Certified HEDIS Vendor to allow access to reliable and validated data.	1/1/2022
Add New Counties	To add Mecklenburg and Orange County members, practitioners, and providers to Alliance while maintaining access and adequacy.	6/30/2022
Tailored Plan Preparation Efforts	To meet all stages of Tailored Plan readiness while maintaining the same standards throughout FY2022.	6/30/2022
National Committee for Quality Assurance (NCQA) Health Plan Accreditation	To successfully implement Tailored Plan meeting NCQA Health Plan Accreditation standards.	6/30/2022

Section 4: Major Organizational Quality and Performance Accomplishments

4.1 Began Serving Mecklenburg & Orange Counties

December 1, 2021, Alliance Health began serving members and recipients in Mecklenburg and Orange counties. This increased membership by approximately 50%. Leading up to this transition, Alliance increased our provider network, internal work force across organization, and increased member and provider education efforts. While this timeline was significantly shorter than initially anticipated, the transition occurred relatively smoothly for members and providers. Alliance has increased physical presence and county relationships in these counties as well, to ascertain and address gaps.

4.2 Tailored Plan (TP) Readiness

Alliance has successfully been awarded a Tailored Plan contract. Alliance has implemented a TP readiness project plan to successfully meet the post-contract deliverables contractually required. We are currently on target to meet these goals and go live as a Tailored Plan and support the Medicaid Direct population 12/1/2022.

4.3 Additional CQI Subcommittees

Alliance established two new CQI Subcommittees – Pharmacy & Therapeutics and Health Equity Council. These committees fill a gap in our quality reviews as we prepare to address whole person care including physical and pharmaceutical services for our members and recipients.

4.4 External Quality Review

All of Alliance's Quality Improvement Projects scored at the "high confidence" range during our annual External Quality Review (EQR). Alliance passed EQR with a score of 100%.

4.5 Innovations and Traumatic Brain Injury (TBI) Waiver Measures

Alliance continues to exceed all State required performance measures for the Innovations Waiver. Alliance also exceeded the performance measure for 6 out of 7 applicable performance measures for the TBI Waiver.

4.6 Expanded Value-Based Contracts (VBCs)

Alliance expanded the types and number of providers reimbursed under value-based contracts. We also added variety of value-based contracts offered to support additional quality initiatives in preparation for Tailored Plan.

Section 5: Quality Improvement Activities

Each of the Quality Improvement Activities below is a high-level summary of the full project which is detailed extensively in the full Quality Improvement Activity Report.

5.1 Follow-Up after Mental Health Discharges (Uninsured)

5.1.1 Activity Goal

Increase percentage of uninsured member discharges for individuals ages 3 through 64, who were admitted for mental health treatment in a community-based hospital, state psychiatric hospital, or facility-based crisis service that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge to at least 40%.

5.1.2 Activity Interventions and Barriers

Intervention	Barrier(s)
Provider Education ❖ Reorganization of the Provider Network Development (PND) Team to approach various areas of the Provider Network (PN) operation (PN Operations, PN Relations, and PN Development). ❖ An assessment of provider capacity communications by the Care Management Team is in the process of review by the Provider Networks Team. ❖ PND Team is exploring the interventions and action items which would effectively apply towards the expansion into Mecklenburg and Orange Counties. ❖ On May 2nd hospital liaisons transitioned to onsite duties which will assist with bridging communications and services with providers and with members.	❖ Provider's lack of awareness of performance towards measures. ❖ Inconsistency in accurate, timely, and actionable personal data documented at the point of individual intake and discharge.
Social Drivers of Health ❖ Care Management reorganization (with a focus on the Administrative Care Coordinators contacting members discharged, assisting with barriers, and improving timely member aftercare appointments) continues to serve as an effective campaign. ❖ With the deployment of various action items over the launch period of the QIP, a measure of effectiveness is in progress to determine the future approach towards the QIP deliverables. ❖ More information concerning the individuals that we serve in Mecklenburg and Orange Counties is expected soon.	❖ Telehealth challenges faced by members who do not have access to equipment that will allow follow-up care through telephonic or computer/internet accessibility. ❖ COVID-19 related open-access limitations and/or suspensions of providers services.
Value Based Incentives/Assertive Engagement ❖ Value-based incentives are reviewed in quarterly increments. The second measurement period is to confirm progress of the campaign and to determine monetary payments for performance was completed. ❖ Meetings between Duke and Freedom House held to further strengthen	❖ Lack of significant provider incentives to ensure appropriate member post-discharge follow-up. ❖ Lack of scheduling flexibilities or methods for referring individuals to alternate providers are used to prioritize individuals receiving timely follow-up.

Intervention	Barrier(s)
communications and to further streamline the Peer Bridger Program. ❖ One Care Cumberland claims process was reviewed to determine discrepancies with claims submissions. ❖ Communications concerning the extension of the Tailored Plan launch may affect the provider Scope of Work (SOW) updates and momentum of additional value-based initiatives.	

5.1.3 Activity Measure

Measures trended over time[1]

Goal	J	A	S	O	N	D	J	F	M	A	M	J
40%	34.6%	38.1%	37.2%	**41.0%**	37.6%	24.4%	*	*	*	*	*	*

*Data collection for this project includes a delay to account for claims lag, some months do not yet have final data. Red indicates goal not met.

5.1.4 Activity Quantitative and Qualitative Analyses

- Alliance has validated data for Q1 and Q2 at this time.
- During the month of December 2021, there was a marked decrease in performance. This is a 14.3 point decrease in performance. It is important to note that Alliance began serving Mecklenburg and Orange Counties in December 2021. Prior to this transition, these counties were served by an MCO with scores lower than Alliance historically.
- The number of members in the population increased from November (n=186) to December (n=225) 2021. This is due to the additional population associated with the merge of Mecklenburg and Orange Counties into our catchment area.
- Alliance exceeded the target of 40% in the month of October 2021.
- Alliance implemented new Care Management processes and additional provider value-based contracting in Q4 of FY2021. These efforts appear to have kicked off an upward trend through October 2022.

5.1.5 Activity Recommendations

Our recommendation is to continue this project and to monitor existing interventions for impact in the upcoming reported data and to refine the interventions as needed to ensure progress towards the goal. Alliance will continue to monitor for impact of Tailored Plan go-live and adjust interventions as appropriate.

5.2 Follow-Up after Substance Use Discharges (Uninsured)

5.2.1 Activity Goal

Increase the percentage of Medicaid member discharges for individuals ages 3 through 64, who were admitted for substance use disorder treatment in a community-based hospital, state psychiatric hospital,state Alcohol and Drug Abuse Treatment Center (ADATC), or detox/facility-based crisis service,

[1] Data from Super Measures Dashboard – July 2022

that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge to at least 40%.

5.2.2 Activity Interventions and Barriers

Intervention	Barrier(s)
Provider Education ❖ Reorganization of the PND Team to approach various areas of the PN operation (PN Operations, PN Relations, and PN Development). ❖ An assessment of provider capacity communications by the Care Management Team is in the process of review by the Provider Networks Team. ❖ The PND Team is exploring the interventions and action items which would effectively apply towards the expansion into Mecklenburg and Orange Counties. ❖ On May 2nd hospital liaisons transitioned to onsite duties which will assist with bridging communications and services with providers and with members.	❖ Provider's lack of awareness of performance towards measures. ❖ Inconsistency in accurate, timely, and actionable personal data documented at the point of individual intake and discharge.
Social Drivers of Health ❖ Care Management reorganization (with a focus on the Administrative Care Coordinators contacting members discharged, assisting with barriers, and improving timely member aftercare appointments) continues to serve as an effective campaign. ❖ With the deployment of various action items over the launch period of the QIP, a measure of effectiveness is in progress to determine the future approach towards the QIP deliverables. ❖ More information concerning the individuals that we serve in Mecklenburg and Orange Counties is expected soon.	❖ Telehealth challenges faced by members who do not have access to equipment that will allow follow-up care through telephonic or computer/internet accessibility. ❖ COVID-19 related open-access limitations and/or suspensions of providers services.
Value Based Incentives/Assertive Engagement ❖ Value-based incentives that are reviewed in quarterly increments second measurement period to (confirm progress of the campaign and	❖ Lack of significant provider incentives to ensure appropriate member post-discharge follow-up. ❖ Lack of scheduling flexibilities or methods for referring individuals to

Intervention	Barrier(s)
to determine monetary payments for performance) was completed. ❖ Meetings between Duke and Freedom House held to further strengthen communications and to further streamline the Peer Bridger Program. ❖ One Care Cumberland claims process was reviewed to determine discrepancies with claims submissions. ❖ Communications concerning the extension of the Tailored Plan launch may affect the provider SOW updates and momentum of additional value-based initiatives.	alternate providers are used to prioritize individuals receiving timely follow-up.

5.2.3 Activity Measures

Measures trended over time[2]

Goal	J	A	S	O	N	D	J	F	M	A	M	J
40%	38.8%	39.3%	33.6%	32.7%	27.1%	21.5%	*	*	*	*	*	*

*Data collection for this project includes a delay to account for claims lag, some months do not yet have final data. Red indicates goal not met.

5.2.4 Activity Quantitative and Qualitative Analyses

- Alliance has validated data for Q1 and Q2 at this time.
- During the month of December 2021, there was a marked decrease in performance. This is a 5.6 point decrease in performance. It is important to note that Alliance began serving Mecklenburg and Orange Counties in December 2021. Prior to this transition, these counties were served by an MCO with scores lower than Alliance historically.
- The number of members in the population increased from November (n=129) to December (n=144) 2021. This is due to the additional population associated with the merge of Mecklenburg and Orange Counties into our catchment area.
- Alliance has not met or exceeded the goal of 40% during the months in which we have validated data.
- Alliance implemented new Care Management processes and additional provider value-based contracting in Q4 of FY2021. These efforts appear to have kicked off an upward trend through August 2022.

5.2.5 Activity Recommendations

Our recommendation is to continue this project and to monitor existing interventions for impact in the upcoming reported data and to refine the interventions as needed to ensure progress towards the goal. Alliance will continue to monitor for impact of Tailored Plan go-live and adjust interventions as appropriate.

[2] Performance Standards Dashboard – July 2022

5.3 Follow-Up after Substance Use Discharges (Medicaid)

5.3.1 Activity Goal

Increase the percentage of Medicaid member discharges for individuals ages 3 through 64, who were admitted for substance use disorder treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service, that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge to at least 40%.

5.3.2 Activity Interventions and Barriers

Intervention	Barrier(s)
Provider Education ❖ Reorganization of the PND Team to approach various areas of the Provider Network (PN) operation (PN Operations, PN Relations, and PN Development). ❖ An assessment of provider capacity communications by the Care Management Team is in the process of review by the Provider Networks Team. ❖ The team is exploring the interventions and action items which would effectively apply towards the expansion into Mecklenburg and Orange Counties. ❖ On May 2nd hospital liaisons transitioned to onsite duties which will assist with bridging communications and services with providers and with members.	❖ Provider's lack of awareness of performance towards measures. ❖ Inconsistency in accurate, timely, and actionable personal data documented at the point of individual intake and discharge.
Social Drivers of Health ❖ Care Management reorganization (with a focus on the Administrative Care Coordinators contacting members discharged, assisting with barriers, and improving timely member aftercare appointments) continues to serve as an effective campaign. ❖ With the deployment of various action items over the launch period of the QIP, a measure of effectiveness is in progress to determine the future approach towards the QIP deliverables ❖ More information concerning the individuals that we serve in Mecklenburg and Orange Counties is expected soon.	❖ Telehealth challenges faced by members who do not have access to equipment that will allow follow-up care through telephonic or computer/internet accessibility. ❖ COVID-19 related open-access limitations and/or suspensions of providers services.

Intervention	Barrier(s)
Value Based Incentives/Assertive Engagement ❖ Value-based incentives that are reviewed in quarterly increments second measurement period to (confirm progress of the campaign and to determine monetary payments for performance) was completed. ❖ Meetings between Duke and Freedom House held to further strengthen communications and to further streamline the Peer Bridger Program. ❖ One Care Cumberland claims process was reviewed to determine discrepancies with claims submissions. ❖ Communications concerning the extension of the Tailored Plan launch may affect the Provider SOW updates and momentum of additional value-based initiatives.	❖ Lack of significant provider incentives to ensure appropriate member post-discharge follow-up. ❖ Lack of scheduling flexibilities or methods for referring individuals to alternate providers are used to prioritize individuals receiving timely follow-up.

5.3.3 Activity Measures

Measures trended over time[3]

Goal	J	A	S	O	N	D	J	F	M	A	M	J
40%	**50%**	**43.9%**	31.9%	36.1%	*	*	*	*	*	*	*	*

*Data collection for this project includes a delay to account for claims lag, some months do not yet have final data. Red indicates goal not met.

5.3.4 Activity Quantitative and Qualitative Analyses

- Alliance has validated data for Q1 and partial data for Q2.
- During the month of September 2021, there was a marked decrease in performance indicated by a decrease of 12 points. October saw an increase in eligible population compared to previous months. Previous quarter averaged 43 members/month. October reflects 61 members.
- Alliance exceeded the goal in July and August 2021.

5.3.5 Activity Recommendations

Our recommendation is to discontinue the formalized QIP but continue to track and trend these outcomes. Discontinuation is in efforts to prioritize Tailored Plan required Performance Improvement Projects (PIPs). The project will be reopened if data continues to support the need for a formalized PIP.

[3] Performance Standards Dashboard – July 2022

5.4 Diabetes Screening for People Using Antipsychotic Medications (SSD)

5.4.1 Activity Goal

Increase the percentage of adult members, 18–64 years of age with Schizophrenia or Bipolar Disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year to at least 77%.

5.4.2 Activity Interventions and Barriers

Intervention	Barrier(s)
Member and Provider Education ❖ The mPulse Mobile project is currently in the implementation phase. An analysis will be conducted in August to assess whether the messages resulted in a metabolic test being conducted. ❖ Clinical Recommendation-This project was initiated in January of 2021. Over the course of the project, the intervention showed steady increases in the percentage of Service Authorization Requests (SARs) that included the appropriate clinical recommendation for metabolic monitoring. The latest results indicated a significant decrease compared to the previous period. There is a continued effort to determine the root cause of this issue.	❖ Members and providers unaware of the need for testing.
Provider Data Sharing ❖ 29 provider HEDIS reports were developed and distributed to providers in the Practice Transformation Cohort in July. ❖ Analysis of the Provider Scorecard Project continues to show minimal percent change in closing the gap in care. Since last July, the percentage for closing the gap continues to range from **3-6** percent for SSD. ❖ Providers are also receiving baseline trend data to assess how well they are progressing towards the measurement goal. ❖ Provider Data Reports – Initial round of reports went through iteration process to increase actionability by providers. Focus is on recent data and members with existing and projected gaps in care.	❖ Providers unsure of which members need and/or have received testing.

Intervention	Barrier(s)
Point of Care Testing ❖ Practice transformation staff continue to work with providers regarding the Point of Care (POC) intervention. ❖ Practice transformation staff are working with providers to ensure all expired test strips used for the point of care monitoring devices are replaced/updated.	❖ Members have to go to a separate site for testing instead of being able to do all required functions at the behavioral health provider's office.

5.4.3 Activity Measures

Measures trended over time[4]

Goal	J	A	S	O	N	D	J	F	M	A	M	J
77%	72%	75%	75%	74%	74%	74%	75%	75%	75%	75%	*	*

* Data collection for this project includes a delay to account for claims lag, some months do not yet have final data. Red indicates goal not met.

5.4.4 Activity Quantitative and Qualitative Analyses

- Performance through March 2022 showed a trend of increase of about 2%.
- Discontinued participation from Hope Services. Agency indicated concerns about the high level of efforts in using the POC testing strips and the low level of reimbursements for them.
- 2 of 9 pilot providers have provided claims for the POC testing intervention.
- A few providers have indicated they are continuing to provide telehealth services to members, which limits the opportunity for POC testing.

5.4.5 Activity Recommendations

State benchmarking has not been provided for SSD at this time, so it is unclear if Alliance is currently meeting the benchmarks. Alliance is reprioritizing this QIP to focus resources on State-required Tailored Plan Performance Improvement Projects. It is recommended that the measure continue to be monitored to determine if Tailored Plan implementation improves rates as well.

5.5 Metabolic Monitoring for Youth on Antipsychotics (APM)

5.5.1 Activity Goal

Increase the percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year to at least 31%.

5.5.2 Activity Interventions and Barriers

Intervention	Barrier(s)
Member and Provider Education ❖ Continued exploration of assessing how to better bridge the gap in care for members within the APM cohort who are in	❖ Members and providers unaware of the need for testing.

[4] Performance Standards Dashboard – July 2022

Intervention	Barrier(s)
Department of Social Services (DSS) custody. ❖ The mPulse Mobile Project is currently in the implementation phase. An analysis will be conducted in August to assess whether the messages resulted in a metabolic test being conducted. ❖ Clinical Recommendation- This project was initiated in January of 2021. Over the course of the project, the intervention showed steady increases in the percentage of SARs that included the appropriate clinical recommendation for metabolic monitoring. The latest results indicated a slight decrease from the previous month.	
Provider Data Sharing ❖ 29 provider HEDIS reports were developed and distributed to providers in the Practice Transformation Cohort in July. ❖ Analysis of the Provider Scorecard Project continues to show minimal percent change in closing the gap in care. Since last July, the percentage for closing the gap continues to range from **1-2** percent for APM. ❖ Providers are also receiving baseline trend data to assess how well they are progressing towards the measurement goal. ❖ Provider Data Reports – Initial round of reports went through the iteration process to increase actionability by providers. Focus is on recent data and members with existing and projected gaps in care.	❖ Providers unsure of which members need and/or have received testing.
Point of Care Testing ❖ Practice transformation staff continue to work with providers regarding the POC intervention. ❖ Practice transformation staff are working with providers to ensure all expired test strips used for the point of care monitoring devices are replaced/updated.	❖ Barriers to going to a separate site for testing instead being able to do all required functions at the behavioral health provider's office.

5.5.3 Activity Measures

Measures trended over time[5]

Goal	J	A	S	O	N	D	J	F	M	A	M	J
32%	31%	33%	34%	34%	34%	33%	33%	33%	33%	33%	*	*

[5] Performance Standards Dashboard – July 2022

*Data collection for this project includes a delay to account for claims lag, some months do not yet have final data. Red indicates goal not met.

5.5.4 Activity Quantitative and Qualitative Analyses

- Performance has met the goal 11 out of 12 months this fiscal year. July 2021 was the only month where performance goal was not met – July missed the target by 1 percentage point.
- Discontinued participation from Hope Services. Agency indicated concerns about the high level of efforts in using the POC testing strips and the low level of reimbursements for them.
- 2 of 9 pilot providers have provided claims for the POC testing intervention.
- A few providers have indicated they are continuing to provide telehealth services to members, which limits the opportunity for POC testing.

5.5.5 Activity Recommendations

Our recommendation is to close this QIP as the targets have been met. While this QIP will be closed, it will continue to be monitored to ensure progress is not lost.

5.6 Transition to Community Living (TCL) Primary Care Provider (PCP) Visits

5.6.1 Activity Goal

Increase the percentage of confirmed PCP visits for individuals who received a housing slot and/or who have transitioned to housing within 90 days of the measurement period to 80%.

5.6.2 Activity Interventions and Barriers

Intervention	Barrier(s)
Member and Provider Bridge: ❖ Members who have transitioned from Mecklenburg catchment area represented nineteen percent of the Tailored Plan eligible members of the assessment. All were reported as not receiving a PCP visit in the measurement period. The measurement, with the exclusion of Mecklenburg County, was seventy seven percent. ❖ Member and provider outreach performed by the Transition to Community Living (TCL) nursing staff (within a period after monthly analysis), to raise awareness towards the need for and importance of a PCP visit, assist with any questions that they may have, as well as to bridge members with a provider. ❖ TCL nursing staff is in attendance of the member transition meeting to further assess member needs.	❖ Members who experience disparities where a PCP visit is not their primary focus (ex. temporary housing, food, etc.) ❖ Members who do not answer or return outreach calls ❖ Members who are not interested in a PCP visit ❖ Members who are not familiar with phone numbers from Alliance ❖ Members who prefer to use Emergency Department (ED) services as any physical health concerns surface ❖ Members who are hesitant to receive a PCP visit (ex. additional diagnosis, comfort with new physicians, etc.) ❖ Multiple Alliance teams performing communications with members ❖ Physical Health (PH) Provider availability in areas ❖ Member challenges to receive a PCP visit ❖ Covid -19 presence and protocols in relation to member hesitancies

Intervention	Barrier(s)
❖ Alliance staff will document and escalate member concerns, barriers, and engagement. For members who initially refuse PCP consideration, the staff will systematically schedule follow-up contacts to continue to engage and assist them.	❖ Members in the TCL process that were slotted for housing; but are not engaged in the housing process ❖ Members alternating plans of care ❖ Hesitancy due to the current state of insurance coverage ❖ Member potential inability to meet co-pay requirements for visits
Alliance Staff Awareness: ❖ Adjustments to the Member Assessment approach to further understand consumer PCP contact earlier in the TCL housing process. Implementation of adding PCP information on the Housing Slot Assessment performed by the In-Reach, Out-Reach, and Transition Coordinator staff. ❖ Team brainstorming towards the approach to review the potential hypothesis of the presence of barriers (due to dual coverage, no physical health coverage, service reporting and the ability to view/capture information).	❖ Integrated care awareness ❖ Standard work for identifying PCP visit needs ❖ Execution of tasks and role clarity of member bridging with PH Providers ❖ Communications, approach, and documentation of PCP information ❖ Behavioral Health (BH) Provider engagement with bridging members with PH Provider ❖ PCP updates for further member assessments
Provider Communications ❖ Creation of a staff PCP talking point document to assist with the standardization of the approach towards consumers and PCP linkage. ❖ Creation of a nurse outreach tracking tool to document member contact/ non-contact, and findings. ❖ Monthly communication of the PCP confirmation analysis and nurses' findings to staff to further brainstorm approach towards member.	❖ Bridge of gaps between BH and PH Providers ❖ Provider awareness of the importance of PCP visits ❖ Establishing expectations and guidelines towards holistic care before the launch of Tailored Plan. ❖ Provider data base launch to house TCL members' (in housing) information as well as members' doctor visit occurrences.

5.6.3 Activity Measures

Measures trended over time[6]

[6] Performance Standards Dashboard – July 2022

Goal	J	A	S	O	N	D	J	F	M	A	M	J
80%	NA	71%	83%	84%	78%	76%	62%	64%	61%	73%	78%	79%

* Red indicates goal not met.

5.6.4 Activity Quantitative and Qualitative Analyses

It is important to note that Alliance took on Mecklenburg and Orange Counties in December 2021. In January 2022, there was a distinct decline in performance which appears to be related to the addition of Mecklenburg and Orange County. It is anticipated that rates will start to increase again with the implementation of the TCL Complex Care Management Program and launch of Tailored Plan Care Management as there is a focus on physical health.

5.6.5 Activity Recommendations

It is our recommendation to continue this project into FY2023. It is anticipated that Tailored Plan launch will improve success rates of ensuring members are linked to PCPs.

Section 6: Additional Quality Improvement and Performance Efforts

6.1 Performance Measures[7]

The charts below list performances for all of the Alliance performance measures with State benchmarks. Any measure that does not meet the State benchmark will be highlighted in red and noted as out of compliance. Any measure out of compliance will have a footnote at the end of this section explaining the gap in performance and interventions being taken to address the performance gap. See Appendix A for measure definitions.

[7] Performance Standards Dashboard – July 2022

6.1.1 Call Center Performance

Metric	Goal	J	A	S	O	N	D	J	F	M	A	M	J
Call Abandonment Rate	<5%	1.6%	2.3%	1.6%	2.3%	1.9%	2.0%	1.9%	1.6%	1.2%	1.0%	1.4%	1.4%
Live Answer within 30 seconds	95%	97.6%	96.6%	97.6%	96.9%	97.3%	96.9%	97.2%	97.7%	98.1%	98.2%	98.1%	98.0%

6.1.2 Contract Super Measures[8]

Metric	Goal	J	A	S	O	N	D	J	F	M	A	M	J
Medicaid - Mental Health 7-Day Follow-up	40%	39.4%	48.0%	49.7%	43.3%	35.9%	*	*	*	*	*	*	*
Medicaid - Substance Use 7-Day Follow-up	40%	32.7%	50.0%	43.9%	31.9%	36.1%	*	*	*	*	*	*	*
Medicaid - Innovations Waiver Primary Care	90%	94.0%	93.8%	95.0%	95.0%	95.1%	*	*	*	*	*	*	*
Non-Medicaid - Mental Health 7-Day Follow-up	40%	39.4%	48.0%	49.7%	43.3%	35.9%	*	*	*	*	*	*	*
Non-Medicaid - Substance Use 7-Day Follow-up	40%	34.6%	38.1%	37.2%	41.0%	37.6%	24.4%	*	*	*	*	*	*

*Measure has not yet been reported.

6.1.3 Medicaid Performance Measures[9]

Metric	Goal	J	A	S	O	N	D	J	F	M	A	M	J
Care Coordination Assignment[10]	85%	96.2%	100.0%	90.9%	80.6%	90.0%	92.0%	92.3%	88.4%	80.4%	87.1%	87.5%	88.4%
Authorizations Processed within Timeframes	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Claims Proceed within 30 Days	90%	95.1%	95.3%	95.1%	95.7%	96.9%	95.7%	92.6%	90.7%	88.8%	94.8%	95.0%	96.5%
Resolution of Grievances within 30 Days	90%	90.0%	100.0%	100.0%	100.0%	94.1%	94.7%	92.9%	82.4%	96.6%	94.1%	94.1%	88.9%
Access to Care - Emergent	97%	99%			97%			98%			96%		
Access to Care - Urgent	82%	29%			38%			36%			34%		
Access to Care - Routine	75%	24%			30%			32%			28%		

[8] Performance Standards Dashboard – July 2022

[9] Performance Standards Dashboard – July 2022

[10] Percentage of readmits assigned to Care Coordination – This measure was not met in September (83%) and October (83%). Delays in care coordination were caused by an inpatient hospital's record system being down.

6.1.4 Innovations Waiver Measures[11]

Metric	Goal	FY21 Q3	FY21 Q4	FY22 Q1	FY22 Q2
Members receiving services within 45 days of individual support plan (ISP)[12].	85%	64.3%	81.8%	87.5%	75.0%
Percent of actions taken to protect the beneficiary.	85%	97.6%	92.3%	95.6%	90.0%
Incidents reported within timeframes[13]	85%	79.6%	86.7%	92.2%	85.2%
Percentage of deaths where required Local Management Entity (LME)/Prepaid Inpatient Health Plan (PIHP) follow-up interventions were completed as required.	85%	100.0%	100.0%	100.0%	100.0%
Medication errors resulting in medical treatment.	<15%	0.0%	0.0%	0.0%	0.0%
Beneficiaries who received appropriate medication.	85%	100.0%	100.0%	99.9%	100.0%
Incidents where required LME/PIHP follow-up interventions were completed.	85%	100.0%	100.0%	100.0%	100.0%
Percentage of incidents referred to the Department of Social Services (DSS) or Department of Health Service Regulation (DHSR).	85%	100.0%	100.0%	100.0%	100.0%
Percentage of restrictive interventions resulting in medical treatment.	<15%	0.0%	0.0%	0.0%	0.0%
Level of Care evaluations completed at least annually for enrolled beneficiaries.	85%	99.5%		100.0%	
Level of Care evaluations completed using approved processes and instrument.	85%	99.5%		100.0%	
New Level of Care evaluations completed using approved processes and instrument.	85%	100.0%		91.7%	
Individual Support Plans that address identified health and safety risk factors.	85%	100.0%		100.0%	
Person Center Plans (PCPs) that are completed in accordance with Division of Medical Assistance (DMA) requirements.	85%	97.2%		98.4%	
New enrollees who have a Level of Care (LOC) prior to receipt of services.	85%	100%			
New licensed providers that meet licensure, certification, and/or other standards.	85%	100.0%			

[11] Performance Standards Dashboard – July 2022

[12] Proportion of Innovations beneficiaries receiving services within 45 days – This measure was not met for four quarters (63%, 79%, 82%, 79%). Seven members experienced delays due to a lack of direct care staff. Seven members delayed or chose to pursue alternative services. One member did not meet the measure due to a retro ISP start date, however, they received services within 45 days of the indicator entry date.

[13] Percentage of level 2 and 3 incidents reported within require timeframes for Innovations beneficiaries – This measure was not met for Q3 (67%). The majority of late submissions were related to the same provider (same member). During investigation into an unrelated matter, it was discovered that the provider failed to submit incident reports for qualifying events over a several month span. Upon learning of this, the provider immediately addressed the issue, to include submission of incident reports for all identified events; however, these were all submitted outside of the required 72-hour timeframe. The provider also took additional corrective measures, to include termination of all involved staff, and retrained all current staff on incident reporting requirements. Concerns were identified and addressed by Alliance through both incident reporting and grievance processes. The provider agencies responsible for these late reports received a written notification and/or plan of correction in accordance with Alliance Health's actions for late submissions.

Metric	Goal	FY21 Q3	FY21 Q4	FY22 Q1	FY22 Q2
Providers reviewed according to PIHP monitoring schedule[14].	85%	100.0%			
Providers for whom appropriate remediation has taken place.	85%	100.0%			
Providers that successfully implemented an approved corrective action plan.	85%	100.0%			
Monitored providers wherein all staff completed all mandated training.	85%	90.9%			
ISPs in which the services and supports reflect participant assessed needs and life goals.	85%	100.0%			
Beneficiaries reporting that their ISP has the services that they need.	85%	99.6%			
Individuals for whom an annual plan and/or needed update took place.	85%	100.0%			
Beneficiaries who are receiving services as specified in the ISP[15].	85%	37.5%			
Records that contain a signed Freedom of Choice statement.	85%	99.2%			
Beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	85%	99.6%			
Beneficiaries reporting they have a choice between providers.	85%	99.6%			
Beneficiaries age 21 and older who had a primary care visit during year.	85%	95.6%			
Claims paid by the PIHP for Innovations Wavier services authorized in the service plan.	85%	96.9%			

6.1.5 TBI Waiver Measures[16]

Metric	Goal	FY21 Q3	FY21 Q4	FY22 Q1	FY22 Q2
Members receiving services within 45 days of ISP[17].	85%	100%	100%	60%	43%

[14] Proportion of providers reviewed according to PIHP monitoring schedule – For the time period 7/1/2019 to 6/30/2020, Alliance Health was scheduled to conduct routine monitoring for 29 Innovations providers. Alliance completed 23 of those having to halt monitoring on March 20, 2020 after the NC DHHS contacted all LME/MCOs asking them to "pause all state and Medicaid audits, settlements and other oversight functions that do not impact consumer health and safety" due to COVID-19. Due to that order, Alliance had to pause six previously scheduled/ongoing monitoring.

[15] Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan – 33 new waiver beneficiaries were reviewed for the time period 7/1/2019 to 6/30/2020, and 16 beneficiaries were found to have not received services in the type, scope and frequency listed in the ISP. 27 of the beneficiaries' ISPs started after 1/1/2020 and overall service delivery was likely impacted by COVID-19 precautions, either in refusal of staff, difficulty in recruiting and maintaining staff, or delays in transitions of care.

[16] Performance Standards Dashboard – July 2022

[17] Proportion of TBI beneficiaries receiving services within 45 days – This measure was not met for three quarters (75%, 63%, 0%). Seven members did not receive services within 45 days of ISP effective date. Three of the six did not meet the measure due to a retro ISP start date. The other four members had extenuating circumstances that our care coordination team was aware of and managing.

Metric	Goal	FY21 Q3	FY21 Q4	FY22 Q1	FY22 Q2
Percent of actions taken to protect the beneficiary.	85%	100%	100%	N/A	100%
Percentage of incidents referred to DSS or DHSR, as required.	85%	N/A	N/A	N/A	100%
Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	85%	N/A	N/A	N/A	100%
Medication errors resulting in medical treatment.	<15%	N/A	N/A	N/A	N/A
Beneficiaries who received appropriate medication.	85%	100%	100%	100%	100%
Incidents reported within timeframes.	85%	50%	100%	N/A	100%
Incidents where required LME/PIHP follow-up interventions were completed.	85%	N/A	N/A	N/A	100%
Percentage of restrictive interventions resulting in medical treatment.	<15%	N/A	N/A	N/A	N/A
Percentage of restrictive interventions used after all other possibilities.	85%	N/A	N/A	N/A	N/A
Percentage of restrictive interventions used by trained staff.	85%	N/A	N/A	N/A	N/A
Percentage of restrictive interventions documented according to State policy.	85%	N/A	N/A	N/A	N/A
Level of Care evaluations completed at least annually for enrolled beneficiaries.	85%	100%		100%	
Level of Care evaluations completed using approved processes and instrument.	85%	100%		100%	
New Level of Care evaluations completed using approved processes and instrument.	85%	100%		100%	
Individual Support Plans that address identified health and safety risk factors.	85%	100%		100%	
PCPs that are completed in accordance with DMA requirements.	85%	100%		100%	
New enrollees who have a LOC prior to receipt of services	85%	100%			
New licensed providers that meet licensure, certification, and/or other standards.	85%	100%			
Providers reviewed according to PIHP monitoring schedule.	85%	100%			
Providers for whom appropriate remediation has taken place.	85%	100%			
Providers that successfully implemented an approved corrective action plan.	85%	N/A			
Monitored providers wherein all staff completed all mandated training.	85%	100%			

Metric	Goal	FY21 Q3	FY21 Q4	FY22 Q1	FY22 Q2
ISPs in which the services and supports reflect participant assessed needs and life goals.	85%	100%			
Beneficiaries reporting that their ISP has the services that they need.	85%	100%			
Proportion of PCPs that are completed in accordance with State Medicaid Agency's requirements[18].	85%	94%			
Beneficiaries who are receiving services as specified in the ISP[19].	85%	49%			
Records that contain a signed Freedom of Choice statement.	85%	100%			
Beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	85%	100%			
Beneficiaries reporting they have a choice between providers.	85%	100%			
Beneficiaries age 21 and older who had a primary care visit during year.	85%	98%			
Claims paid by the PIHP for TBI Wavier services authorized in the service plan.	85%	99%			

6.2 Grievances and Complaints

Any individual receiving services, legally responsible person and/or network provider authorized in writing to act on behalf of an individual receiving services, is encouraged to contact Alliance if they feel that services being provided are unsatisfactory or if the individual's emotional or physical well-being is being endangered by such services. Alliance staff will assist any individual receiving services, legally responsible person and/or network provider authorized in writing to act on behalf of an individual in filing a grievance as needed.

6.2.1 Activity Goal

Alliance assists individuals that feel the care they received was unsatisfactory to resolve the cause of the complaint whenever possible by working with members, providers, and other state agencies.

[18] Proportion of PCPs that are completed in accordance with State Medicaid Agency's requirements – This measure was not met (79%) because six of twenty-nine beneficiaries either did not have a hand-written care coordinator signature or did not have an annual risk assessment documented in the record per waiver guidelines. Care Coordination made corrections to ensure a physical or electronic signature that meets the documentation standards is entered on each ISP for those identified. Care Coordination moved away from the use of the HRST assessment which can only be produced after the individual is entered into the HRST system (which may occur after ISP development) to the Functional Assessment of Support Needs developed by Alliance and DMH staff to inform ISPs.

[19] Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan – This item was not met due to just 13 of 27 members (48%) having received services in type, scope, amount, and frequency as specified. For members on the TBI waiver, Residential Supports were provided at the expected frequency. The members not utilizing supports in the type, scope, amount, and frequency as specified received supports in a private setting. 12 of the 14 were reported to have difficulty finding and maintaining staff and 5 of those were reported to have at least periodic refusal of services. The end of the waiver year also coincided with the COVID-19 pandemic during which 6 of the 14 reduced service utilization due to health precautions. Care Coordinators continue to monitor service provision and support providers to identify and resolve barriers to service provision. Care Coordinators offer provider choice to individuals and families if an authorized provider is unable to provide the services as outlined in the ISP.

6.2.2 Activity Performance

The following table shows the aggregate grievance total and rate per 1,000 members for the past two years:

Grievance Category	FY2020	FY2021	FY2022	Change per 1,000	Goal Grievances/1,000 Members	Met
Quality of Care	142/0.65	231/1.05	158/1.76	↑	10/1,000	Met
Access	88/0.4	63/0.29	213/0.76	↑	10/1,000	Met
Attitude/Service	20/0.09	17/0.08	147/0.53	↑	10/1,000	Met
Billing/Financial	51/0.22	30/0.14	141/0.51	↑	10/1,000	Met
Quality of Practitioner Office Site	0/0	0/0	0/0	N/A	10/1,000	Met

6.2.3 Activity Analysis

During FY2022, Alliance received an increase in the number of grievances received in each category. However, it is important to note that during this time, Alliance had significant population changes. In July 2021, Alliance's population shifted as Standard Plans went live in North Carolina. Our population served was reduced. In December, our population shifted once again through the addition of Mecklenburg and Orange Counties. It was expected that the number of grievances would increase during that transition period while our total population decreased from FY2021. This resulted in the overall number of grievances per 1,000 members increasing. While the numbers did increase, Alliance was still well under the target of no more than 10 grievances per 1,000 members.

6.2.4 Activity Next Steps

- Continue to address the concerns of each complainant to ensure excellent care is delivered to our members
- Minimize appeals of grievance resolutions with clear communication
- Monitor for on-going changes in patterns of how and when members are filing grievances due to the pandemic.

6.3 Adverse Incident Reports

Alliance tracks the submission of level 2 and 3 critical incidents reported by providers.

6.3.1 Activity Goal

Ensure that all critical incidents are appropriately addressed to ensure member safety.

6.3.2 Activity Performance[20]

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Level 2 Critical Incident Reports	173	172	197	185	183	299	256	297	372	385	315	323
Level 3 Critical Incident Reports	21	26	25	35	31	50	44	41	44	55	52	45

Source: Alliance Monitoring Reports

[20] Level 2 and Level 3 incident reports received through Incident Report Improvement System (IRIS).

6.3.3 Activity Analysis

The volume of incident submissions remained consistent with rates from the previous year until November 2021. Mecklenburg and Orange Counties joined Alliance in December 2021. As expected, there was an increase in the total number of incidents reported. However, the volume reported appears to coincide with the population increase.

6.4.4 Activity Next Steps

- Continue to work with providers, members and other state agencies to ensure that all critical incidents are addressed appropriately to ensure member safety
- Continue to monitor changes in patterns related to Tailored Plan implementation and evolving membership.

6.5 Member Authorization Appeals

Alliance tracks appeal rates to ensure that members receive appropriate care and Alliance's utilization functions are performed well.

6.5.1 Activity Goal

Ensure that appeals are appropriately addressed to ensure that members receive the care they need.

6.5.2 Activity Performance

The following Table shows the aggregate appeals data total and rate per 1,000 members for the past two years:

Appeal Category	FY2020	FY2021	FY2021	Change per 1,000	Goal Grievances/1,000 Members	Met
Quality of Care	0/0	0/0	0/0	No change	10/1,000	Met
Access	139/6.32	39/0.16	77/0.28	↑ 0.12	10/1,000	Met
Attitude/Service	0/0	0/0	0/0	No change	10/1,000	Met
Billing/Financial	0/0	0/0	0/0	No change	10/1,000	Met
Quality of Practitioner Office Site	0/0	0/0	0/0	No change	10/1,000	Met

6.5.3 Activity Analysis

Alliance had low appeal rates and low rates of authorizations being overturned upon appeal. This demonstrates that the Alliance utilization management function is responding to service requests in a manner consistent with clinical coverage policies. Much of the reduction in appeals is due to the impact of the COVID pandemic flexibilities issued by the North Carolina Department of Health and Human Services (NC DHHS) which negated the need for appeals by removing prior authorization requirements. This continued until the end of the COVID flexibilities put in place by NC DHHS until the end of the state of emergency.

6.5.4 Activity Next Steps

- Continue to process appeals and provide feedback to the Utilization Management Department as appropriate.
- Continue to monitor changes in patterns related to the discontinuation of COVID flexibilities.
- Monitor for changes in patterns related to Tailored Plan implementation as Alliance assumes responsibility for physical health and pharmacy benefits.

6.6 Provider Satisfaction Survey[21]

The 2021 DHHS Provider Satisfaction Survey was conducted by the Carolina Centers for Medical Excellence (CCME) under contract with DHHS. A brief summary of the survey results are included below, for full results visit our website: www.alliancehealthplan.org

6.6.1 Activity Goal

Alliance works with DHHS to administer the Provider Satisfaction Surveys to gather information about LME/MCO functioning from the perspective of participating network providers and practitioners.

6.6.2 Activity Performance

- Overall satisfaction with LME/MCO saw a two-percentage point increase from 2020 to 2021.
- For the past 5 years, Alliance scored significantly above State average for referring consumers whose needs match the agency
- Alliance performed significantly lower than the State average in the area of "credentialing/recredentialing process occurs in a timely manner".
- Improvements from 2020-2021:
    - Agency satisfaction with appeals process for denial, reduction, or suspension of service(s)
    - LME/MCO requests for corrective action plans and other supporting materials are fair and reasonable. It is important to note this was a focal point for FY2022 and resulted in a marked improvement.
    - The LME/MCO staff conduct fair and thorough investigations.
- Clinical Coverage Policies remains the most requested training topic – since 2016

6.6.3 Activity Next Steps

- Credentialing/recredentialing will be provided at the State level. Alliance will monitor contracting processes to ensure timely enrollment.
- Continue provider education and practice transformation supports.
- Expand Provider Helpdesk capacity

6.7 Perception of Care Survey

The North Carolina Mental Health and Substance Abuse Consumer Perception of Care Survey is conducted annually by the NC DHHS. The survey assesses individual and family perceptions of the quality of care, provider service and LME/MCO performance. A brief summary of the survey results are included below, for full results of the visit our website: www.alliancehealthplan.org

Alliance's responsibilities included: identifying providers of MH and Substance Abuse (SA) services to English and Spanish-speaking individuals; calculating the number adults, youth and children seen by each provider; distributing survey forms to providers; and following up with providers to assure that surveys were completed and returned to DHHS.

6.7.1 Activity Goal

Alliance works with providers to administer the Perception of Care Surveys to gather information about network performance from the perspective of an individual receiving care.

[21] 2021 Provider Satisfaction Survey Results

6.7.2 Activity Performance

Alliance supported the distribution and administration of the Perception of Care Survey for FY2021. The *2021 Mental Health and Substance Use Services Client Perceptions of Care* was published July 2022. As of date of this report, the Alliance-specific data has not been received.

6.7.3 Activity Next Steps

All member satisfaction survey results are reported to the Member Experience CQI Subcommittee where they are evaluated for follow-up and a plan is developed to address prioritized items. The evaluation includes data from all surveys, as well as performance data.

6.8 Experience of Care and Health Outcomes (ECHO) Survey

Carolinas Center for Medical Excellence (CCME), was contracted to conduct a satisfaction survey of the members participating in the 1915(b)(c) Medicaid Waiver program. This survey utilized the Consumer Assessment of Healthcare Providers and Systems (CAHPS) adult and child versions of the Experience of Care and Health Outcomes (ECHO®) Survey for Managed Behavioral Healthcare Organizations. The purpose of the survey was to assess member perceptions of the LME/MCOs in North Carolina. A brief summary of the survey results are included below, for full results of the visit our website: www.alliancehealthplan.org

6.8.1 Activity Goal

Alliance works with CCME to administer the ECHO Survey in order to gather information about Alliance and network performance from the perspective of an individual receiving care.

6.8.2 Activity Performance

Adult Survey Findings[22]:

- At or above State average:
  - Getting treatment and information
  - Perceived improvement
  - Information about treatment options
- Below State average:
  - Getting treatment quickly
  - How well Clinicians communicate
- Improvements from 2020 to 2021:
  - Delays in treatment while waiting for plan approval were not a problem
  - Care Coordinator usually or always responds to calls in a timely manner
  - Talked (informed) about including family and friends in treatment
  - Usually or always involved as much as you (member) wanted in treatment
  - Told about different treatments that are available

Child Survey Findings[23]:

- At or above State average:
  - Overall satisfaction
  - Getting treatment quickly
  - Getting treatment and Information from the Plan
- Below State average:
  - How well Clinicians communicate
  - Perceived improvement

[22] 2021 Adult Medicaid ECHO Report
[23] 2021 Child Medicaid ECHO Report

- Improvements from 2020 to 2021:
    - Getting help from customer service was not a problem
    - Rating of counseling or treatment
    - Much better or a little better able to accomplish things compared to 1 year ago (member)
    - Usually or always got help by telephone

6.8.3 Next Steps

The Member Experience Committee reviews all survey data, grievances/complaints, appeals, and other markers of member satisfaction to develop prioritized targets for interventions.

Section 7: Value-Based Contracting (VBC)

Alliance launched several value-based payment programs targeting improvement on the 7-day follow-up measures. Alliance entered a value-based contract with outpatient providers to:

- Implement VBC with Cumberland One and expand to other counties in FY2023.
- Support a Peer Bridger program aimed to improve follow-up from University of North Carolina's (UNC) Non-Hospital Detoxification program.
- Support a Peer Bridger program focusing on improving both MH and SUD 7-day follow-up performance for individuals leaving Duke inpatient units.
- Incentivize four providers of State-funded outpatient and enhanced services with incentive payments for improvement in State and Medicaid Funded SUD 7-day follow-up rate, and State-funded MH follow-up rates.

Alliance continues to collect data on the efficacy of these programs to improve member outcomes and adjust as needed. These programs have proven to be successful in engaging providers. This program is being expanded to include other kinds of providers to target additional process and outcome measures.

Section 8: Practice Transformation

Alliance launched the Practice Transformation Program to support Care Management Agencies (CMAs) and Advanced Medical Homes + (AMH+) through Tailored Plan readiness. This program supports CMAs/AMH+ in developing internal processes and procedures around Tailored Care Management, understanding and improving HEDIS outcome measures, quality improvement programming, and the CMA certification process through partnering with leadership to complete self-assessments and gap analyses.

Alliance continues to collect data on the efficacy of this program and adjusts as needed. Additional data is required before a full evaluation of these programs can be offered. The larger evaluation is expected next year.

Conclusion and Recommendations

In Alliance Health's current state and based on the assessment above, the QM program, CQI and its subcommittees are not sufficient for Tailored Plan implementation. Over the next fiscal year Alliance will continue to experience significant changes. On December 1st, 2022, Alliance will go live as a Tailored Plan and add coverage for physical health, pharmacy, and a host of other benefits beyond the existing behavioral health

benefits that are currently covered. At that same time, Alliance will also add a Medicaid Direct contract to cover behavioral health services for a specific population of Medicaid members. This will increase the number of covered lives.

While practitioner involvement and leadership in the QM Program has been adequate over the previous year, Alliance recognizes the need to increase physical health and pharmacy knowledge within its QM Program. Alliance has increased personnel over FY2022 and will be including a more diverse group of leadership on CQI and its subcommittees to ensure whole person health is represented.

While the Quality Management Department at Alliance is a strong team with a wealth of knowledge and experience, there are distinct gaps in physical health and pharmaceutical knowledge. QM Department structure and staffing will be assessed to ensure sufficient knowledge and skills are represented to support whole-person care.

The following specific recommendations are being made for the following year:

- Finalize implementation of certified HEDIS vendor and incorporate those metrics into organizational functions (i.e. Population Health, Value-Based Contracting, internal, etc)
- Increase physical health and pharmaceutical expertise within QM Department and across CQI Committee/Sub-Committees
- Implement quality workplan to include Tailored Plan, State-funded, and Medicaid Direct contract requirements
- Implement Performance Improvement Projects (PIPs) as specified by the Department
- Assess and update charters and membership of CQI and Subcommittees to increase physical health and pharmacy representation
- Prepare to meet all of the Tailored Plan quality requirements for performance and reporting by building upon our existing quality infrastructure.
- Expand workforce across the organization to meet the volume-based demands of serving additional members and covering new benefits.
- Update State reporting to reflect updated State-mandated templates and reporting schedule.

Appendix A: Measure Definitions

	Metric	Definition
Call Center	Call Abandonment Rate	Abandonment occurs when the caller dials directly into the organization's Member Services Call Center or selects the Member Services option, is placed in the call queue and hangs up the phone, disconnecting from the call center before being answered.
	Answer within 30 seconds	The number of calls answered by a live voice within 30 seconds.
Contract Super Measures	Medicaid - Mental Health 7-Day Follow-up	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health treatment in a community-based hospital, state psychiatric hospital, or facility-based crisis service that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.
	Medicaid - Substance Use 7-Day Follow-up	The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use disorder treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility based crisis service that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.
	Medicaid - Innovations Waiver Primary Care	The percentage of continuously enrolled Medicaid enrollees under the 1915(c) Innovations Waiver (ages 3 and older) who received at least one service under the Innovations Waiver during the measurement period who also received a primary care or preventive health service.
	Non-Medicaid - Mental Health 7-Day Follow-up	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.
	Non-Medicaid - Substance Use 7-Day Follow-up	The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use disorder treatment that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.
	TCLI - Housing	This measure provides the number and percentage of the LME/MCO's annual allotted TCLI housing slots for whom eligible individuals transition to supportive housing.
Medicaid Performance Measures	Care Coordination Assignment	Of all readmits (MH or SA) during the month, indicate the number that were assigned to a Care Coordinator upon readmission.
	Authorizations Processed within Timeframes	Number of standard authorization requests that were processed within 14 calendar days. Number of expedited and inpatient authorization requests that were processed within 3 calendar days.
	Claims Proceed within 30 Days	Number of clean claims that were received during the reporting month that were paid or denied within 30 days of receipt. This number is a subset of the # Paid + # Denied. It should not have to be updated, as the report due date is >30 days after the end of the month being reported.
	Resolution of Grievances within 30 Days	Number of complaints being reported in this report period, that were either resolved in 30 days or referred to other entities for investigation within 30 days. Reference 10A NCAC 27G.0607
	Access to Care - Emergent	Number of calls requesting MH/IDD/SU services determined to need emergent care for which care was provided within 2 hours 15 minutes of request.
	Access to Care - Urgent	Number calls requesting MH/IDD/SU services determined to need urgent care for which a service was provided within 2 calendar days of request.

	Metric	Definition
	Access to Care - Routine	Number calls requesting MH/IDD/SU services determined to need routine care for which a service was provided within 14 calendar days of request.
	Adherence to antipsychotic medications for individuals with Schizophrenia.	The percentage of members 18 years of age and older during the measurement year with Schizophrenia or Schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.
	Diabetes screening for people with Schizophrenia or Bipolar Disorder who are using antipsychotic medications.	The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
	Metabolic monitoring for children and adolescents on antipsychotics.	The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.
Innovations Waiver Measures	Members receiving services within 45 days of ISP.	Proportion of new waiver beneficiaries who are receiving services according to their ISP within 45 days of ISP approval.
	Percent of actions taken to protect the beneficiary.	Number and percent of actions taken to protect the beneficiary, where indicated (include: consumer injury, consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.
	Incidents reported within timeframes.	Percentage of Level 2 and 3 incidents reported within required timeframes.
	Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	Number and percentage of deaths where required LME/PIHP follow-up interventions were completed as required.
	Medication errors resulting in medical treatment.	Percentage of medication errors resulting in medical treatment.
	Beneficiaries who received appropriate medication.	Percentage of beneficiaries who received appropriate medication.
	Incidents where required LME/PIHP follow-up interventions were completed.	Number and percentage of Level 2 or 3 incidents where required LME/PIHP follow-up interventions were completed, as required.
	Percentage of incidents referred to the DSS or DHSR.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.
	Percentage of restrictive interventions resulting in medical treatment.	Percentage of restrictive interventions resulting in medical treatment.
	Level of Care evaluations completed at least annually for enrolled beneficiaries.	Proportion of Level of Care evaluations completed at least annually for enrolled beneficiaries.
	Level of Care evaluations completed using approved processes and instrument.	Proportion of Level of Care evaluations completed using approved processes and instrument.
	New Level of Care evaluations completed using approved processes and instrument.	Proportion of New Level of Care evaluations completed using approved processes and instrument.
	Individual Support Plans that address identified health and safety risk factors.	Proportion of Individual Support Plans that address identified health and safety risk factors.

	Metric	Definition
	PCPs that are completed in accordance with DMA requirements.	Proportion of PCPs that are completed in accordance with DMA requirements.
	New enrollees who have a LOC prior to receipt of services.	Number and percent of new waiver enrollees who have a LOC prior to receipt of services.
	New licensed providers that meet licensure, certification, and/or other standards.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.
	Providers reviewed according to PIHP monitoring schedule.	Proportion of providers reviewed according to PIHP monitoring schedule to determine continuing compliance with licensing, certification, contract and waiver standards.
	Providers for whom appropriate remediation has taken place.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place.
	Providers that successfully implemented an approved corrective action plan.	Proportion of monitored non-licensed/non-certified providers that successfully implemented an approved corrective action plan.
	Monitored providers wherein all staff completed all mandated training.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.
	ISPs in which the services and supports reflect participant assessed needs and life goals.	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals.
	Beneficiaries reporting that their ISP has the services that they need.	Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need.
	Individuals for whom an annual plan and/or needed update took place.	Proportion of individuals for whom an annual plan and/or needed update took place.
	Beneficiaries who are receiving services as specified in the ISP.	Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan.
	Records that contain a signed Freedom of Choice statement.	Proportion of records that contain a signed Freedom of Choice statement.
	Beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.
	Beneficiaries reporting they have a choice between providers.	Proportion of beneficiaries reporting they have a choice between providers.
	Beneficiaries age 21 and older who had a primary care visit during year.	The percentage of waiver beneficiaries age 21 and older who had a primary care or preventative care visit during the waiver year.
	Claims paid by the PIHP for Innovations wavier services authorized in the service plan.	The proportion of claims paid by the PIHP for Innovations Wavier services that have been authorized in the service plan.
TBI Waiver	Beneficiaries receiving services in the type, scope, amount, frequency in ISP.	Proportion of new waiver beneficiaries who are receiving services according to their ISP within 45 days of ISP approval.

	Metric	Definition
	Actions taken to protect the beneficiary, where indicated.	Number and percent of actions taken to protect the beneficiary, where indicated (Deaths will be excluded here).
	Incidents referred to DSS or DHHS, as required.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.
	Deaths where required LME/PIHP follow-up interventions were completed.	Number and percentage of deaths where required LME/PIHP follow-up interventions were completed, as required.
	Medication errors resulting in medical treatment.	Percentage of medication errors resulting in medical treatment.
	Beneficiaries who received appropriate medication.	Percentage of beneficiaries who received appropriate medication.
	Incidents reported within required timeframes.	Percentage of Level 2 and 3 incidents reported within required timeframes.
	Incidents where required LME/PIHP follow-up interventions were completed.	Percentage of Level 2 or 3 incidents where required LME/PIHP follow-up interventions were completed, as required.
	Restrictive interventions resulting in medical treatment.	Percentage of restrictive interventions resulting in medical treatment.
	Restrictive interventions used in an emergency after exhausting all other possibilities.	Percent of restrictive interventions used in an emergency after exhausting all other possibilities.
	Restrictive interventions used by a trained staff member.	Percent of restrictive interventions used by a trained staff member.
	Restrictive interventions that are documented according to State policy.	Percent of restrictive interventions that are documented according to State policy.
	Level of Care evaluations completed at least annually for enrolled beneficiaries.	Proportion of Level of Care evaluations completed at least annually for enrolled beneficiaries.
	Level of Care evaluations completed using approved processes and instrument.	Proportion of Level of Care evaluations completed using approved processes and instrument.
	New licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.
	Individual Support Plans that address identified health and safety risk factors.	Proportion of Individual Support Plans that address identified health and safety risk factors.
	Individuals for whom an annual plan and/or needed update took place.	Proportion of individuals for whom an annual plan and/or needed update took place.