FY 2021 Quality Management Program Evaluation

Contents

1. 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 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 annul Quality Program Description and Annual Workplan for FY 2021 (7/1/2020-6/30/2021). This report also identifies opportunities for improvement and informs future quality management strategies.

The QM Program Evaluation includes the following elements:

- Description of QM Program and Structure
- Description of 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

2. QM Program and Structure

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

QM Department

As of June 30, 2021, the Alliance QM Department consisted of the Senior Vice President of Quality Management who oversaw four 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,

geomapping, 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.

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.

Chief Medical Officer

The Alliance Health Chief Medical Officer (CMO) serves as the designated behavioral healthcare practitioner overseeing the operations of the quality management program. The CMO is a co-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 MCO functions including Utilization Management, Care Coordination, Call Center, Network Management and Quality Improvement.

Provider Network Development and Evaluation

Responsible for the promotion of high-quality and evidence-based services and supports. It 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.

- Develops and maintains 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
- Supports the Credentialing committee to ensure that all providers and practitioners meet requirements to participate in the Alliance provider network

Care Management

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.

- Manages Complex Case Management and Long-Term Services and Supports programs
- Support 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

Utilization Management

Ensures that services are medically necessary and monitors consumer treatment to ensure that services are delivered based on consumer need and established clinical guidelines.

Community Health and Well Being

Focused on promoting quality partnerships and collaborative change and redesigning systems of care to improve health outcomes and promote healthy communities. We work 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 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. The department is staffed entirely by people with lived experience.

- Champions Health Literacy efforts aimed and ensuring that members and their families can understand and direct their treatment.
- Support the Consumer Family Advisory Councils (CFAC) in advising the Alliance administration and Board of Directors
- Leverage partnerships to increase access to permanent and temporary housing for the people we serve.
- Lead stigma reduction and Mental Health First Aid campaigns in our communities.

Access and Information

The Center maintains the 24/7 Access and Information Line to ensure that individuals receive timely access to needed mental health, intellectual and developmental disability, and substance abuse services. It provides information about services and resources available within the community and assistance to anyone requesting information about Alliance.

Office of Corporate Compliance

Helps Alliance make appropriate business decisions that comply with the law, working to prevent, detect and correct instances of legal and ethical violations. 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.

3. Quality Committee and Subcommittees

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

Global Quality Management Committee (QMC)

The Alliance Global 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 (QIP) 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 representatives from Alliance's Consumer and Family Advisory Council (CFAC), and two non-voting provider representatives.

Continuous Quality Improvement Committee (CQI)

The CQI Committee is the venue for the review and assessment of all performance data and quality activities for Alliance. The CQI Committee meets to review clinical and provider network performance data and review quality improvement initiatives. The CQI Committee is responsible for the implementation the Alliance Quality Management 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 Global Quality Management Committee of the Board for additional review, feedback, recommendations and approval. This committee is chaired by the Chief Medical Officer and Senior Vice President of Quality Management.

In order to complete these tasks, six cross functional subcommittees exist to support these efforts. The subcommittees and their efforts are summarized in the following sections.

Utilization Management – CQI Subcommittee

This committee 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 committee serves as a vehicle to communicate and coordinate quality improvement efforts to and with CQI. It is co-chaired by the Senior Director of Utilization Management and the Chief Medical Officer.

Provider Quality – CQI Subcommittee

The purpose of the Provider Quality Committee is threefold: a) to engage Alliance providers in developing, evaluating and approving guidelines for clinical practice across the network, b) to engage Alliance providers in the systematic monitoring and evaluation of provider performance measures required by NC Medicaid and the Division of Mental Health (DMH) and included in Alliance provider contracts, and c) to provide a forum for bidirectional communication between Clinical and Medical directors with Alliance. The Provider Quality Committee 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 This committee is co-chaired by the Chief Medical Officer and the Director of Network Evaluation. Membership on this committee, outside of the chairs, is entirely made up of providers. Providers on this committee represent a cross section of different service types, settings, and geographic locations within Alliance's catchment area.

Social Drivers of Health – CQI Subcommittee

The purpose of this committee is to ensure the environmental conditions impacting members are addressed and to make recommendations about aligning SDOH efforts with care management and network providers. This committee reviewed SDOH assessments and interventions to align efforts across the system so they can be most effective. This committee is chaired by Senior Director of Clinical Innovations.

Care Management – CQI Subcommittee

The purpose of this committee is to align care management resources to improve the efficacy of the care delivery network and optimize member outcomes. This committee assists in defining and monitoring the quality of care management services being delivered. This committee is chaired by the Senior Director of Care Management.

Member Experience – CQI Subcommittee

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 committee. This committee is chaired by the Senior Director of Access.

Delegation & Accreditation – CQI Subcommittee

This committee provides a central body that monitors adherence to accreditation standards and ensures that any delegated functions receive appropriate oversight and monitoring. This committee is chaired by the Chief Compliance Officer.

4. 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:

- To ensure individual members receive services that are appropriate and timely;
- To use evidence-based treatments that result in measurable clinical outcomes;
- To ensure Alliance focuses on health and safety of members, protection of rights, and to monitor and continually improve the provider network;
- To 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;
- To build local partnerships with individual who depend on the system for services and supports, with community stakeholders, and with the providers of services; and
- To demonstrate an interactive, mutually supportive, and collaborative partnership between the state agencies and Alliance in the implementation of public policy at the local level and realization of the state's goals of healthcare change.

Specifically, the priority performance goals for FY2021 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.	80.1%
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	34.6%

Obtain NCQA MHBO Accreditation	Alliance will secure a Managed Behavioral Healthcare Organization accreditation from the National Committee for Quality Assurance	By 6/30/21
TCLI In-Reach Timeliness	Improve the percentage of individuals that receive regular contact by in-reach specialist as a part of the TCLI Settlement.	TBD

5. Major Organizational Quality and Performance Accomplishments

NCQA Accreditation

During FY2021, Alliance was awarded a Managed Behavioral Healthcare Organization (MBHO) accreditation with a Long-Term Services and Supports (LTSS) distinction from the National Committee for Quality Assurance. This is a step towards our requirements as a future tailored plan.

External Quality Review

All of Alliance's Quality Improvement Projects scored at the "high confidence" range during our annual External Quality Review.

Implementation of Appeals Platform

Implemented new appeals platform within larger Care Management platform being deployed across the organization. This has improved internal monitoring of the appeals function

Innovations and 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 measure for the TBI Waiver.

Increase Outreach for Transition to Community Living Members

Streamlined internal processes and developed data sharing which reduced administrative burden and allowed staff to spend more time focused on member outreach.

Expanded Value-Based Contracts

Expanded the types and number of providers reimbursed under value-based contracts.

Increased Social Drivers of Health Interventions

Implemented the statewide NCCARE360 platform to refer and track outcomes for members with identified needs to community resources. Implemented transportation program through ModivCare that provides up to 4 roundtrip rides, include travel to pharmacies, for individuals who are discharged from hospital settings. Expanded therapeutic housing options to include bridge housing, which is a 3-5 month peer-led supported housing program for people who are moving to independent living settings from homelessness

Enhanced Opioid Treatment Availability

Expanded opioid treatment availability by adding OTP providers in Cumberland and Durham counties and OBOT providers in all but Johnston County

6. 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.

a. Follow-Up after Mental Health Discharges (Uninsured)

a. Goal of activity

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%.

b. Interventions and Barriers

Intervention	Barrier(s)
Provider Education – Inpatient and Outpatient provider education campaigns to ensure all parties are working together effectively to link members to aftercare.	- Providers 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 – Addressed logistical barriers to aftercare by establish telehealth services from homeless shelters and building transportation services to aftercare appointments into routine workflows to ensure that all members are offered transportation.	- 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 – Expanded the number of outpatient providers attempting to engage members before and after discharge to link them to care after discharge. – Implemented outcome-based incentives for assertive engagement providers.	- 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

c. Measures trended over time

Goal	J	A	S	O	N	D	J	F	M	A	M	J
40%	32%	30%	24%	22%	27%	30%	32%	*	*	*	*	*

*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.

d. Quantitative and Qualitative Analyses

- During the month of January 2021, a total of 191 uninsured members met the inclusion criteria; of these, only 32% (n=61), received a follow up visit within the 1-7 day timeframe.
- This is a two percent increase over the previous month, a five percent increase over baseline, and is below the project goal of 40%.
- This is not a statistically significant improvement over the baseline (p=0.3035).
- To improve provider understanding of their performance seeing members within 1-7 days after discharge, provider report cards for the eight highest volume providers based on received claims were developed and discussed with providers in individual meetings. These report cards were first created in November and are updated and shared with providers on a monthly basis. This improved understanding of performance may have contributed to the small increase in the measure in the following months.
- Assertive engagement was added to four provider contracts in early November to more actively engage with discharged members and allow flexibility in services that count toward the measure. Providers have been recruiting and training staff to offer this service, which may have contributed to the small performance increase in the following months.

e. 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.

b. Follow-Up after Substance Use Discharges (Uninsured)

a. Goal of activity

- 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%.

b. Interventions and Barriers

Intervention	Barrier(s)
Provider Education – Inpatient and Outpatient provider education campaigns to ensure all parties are working together effectively to link members to aftercare.	- Providers 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 – Addressed logistical barriers to aftercare by establish telehealth services from homeless shelters and building transportation services to aftercare appointments into routine workflows to ensure that all members are offered transportation.	- 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 – Expanded the number of outpatient providers attempting to engage members before and after discharge to link them to care after discharge. – Implemented outcome-based incentives for assertive engagement providers.	- 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

c. Measures trended over time

Goal	J	A	S	O	N	D	J	F	M	A	M	J
40%	29%	41%	40%	35%	32%	29%	34%	*	*	*	*	*

*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.

d. Quantitative and Qualitative Analyses

- During the month of January 2021, a total of 127 uninsured members met the inclusion criteria; of these, only 34% (n=43), received a follow up visit within the 1-7 day timeframe.
- This is a five percent increase over the previous month, a three percent decrease over baseline, and is below the project goal of 40%.
- This is not a statistically significant decrease over the baseline (p=0.6921).
- To improve provider understanding of their performance seeing members within 1-7 days after discharge, provider report cards for the eight highest volume providers based on received claims were developed and discussed with providers in individual meetings. These report cards were first created in November and are updated and shared with providers on a monthly basis. This improved understanding of performance may have contributed to the small increase in the measure between November and January.
- Assertive engagement was added to four provider contracts in early November to more actively engage with discharged members and allow flexibility in services that count toward the measure. Providers have been recruiting and training staff to offer this service, which may have contributed to the small performance increase between November and January.

e. 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.

c. Follow-Up after Substance Use Discharges (Medicaid)

a. Goal of Activity

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%.

b. Interventions and Barriers

Intervention	Barrier(s)
Provider Education – Inpatient and Outpatient provider education campaigns to ensure all parties are working together effectively to link members to aftercare.	- Providers 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 – Addressed logistical barriers to aftercare by establish telehealth services from homeless shelters and building transportation services to aftercare appointments into routine workflows to ensure that all members are offered transportation.	- 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 – Expanded the number of outpatient providers attempting to engage members before and after discharge to link them to care after discharge. – Implemented outcome-based incentives for assertive engagement providers.	- 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

c. Measures trended over time

Goal	J	A	S	O	N	D	J	F	M	A	M	J
40%	41%	47%	38%	39%	41%	51%	27%	*	*	*	*	*

*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.

d. Quantitative and Qualitative Analyses

- During the month of January 2021, 42 Medicaid members met the inclusion criteria; of these, 29% (n=12), received a follow-up visit within the 1-7 day timeframe.
- This is a 27 percent decrease over the previous month, a three percent increase over baseline, and is below the project goal of 40%.
- This is not a statistically significant improvement over the baseline (p=0.8011).
- Medicaid SUD has a smaller population than the other 7 Day Follow-up measures, which accounts for some of the variation in performance between months; a smaller population means each member's action or inaction has a notable impact on the overall measure.
- To improve provider understanding of their performance seeing members within 1-7 days after discharge, provider report cards for the eight highest volume providers based on received claims were developed and discussed with providers in individual meetings. These report cards were first created in November and are updated and shared with providers on a monthly basis. This improved understanding of performance may have contributed to the increase in performance between November and December, but does not explain the performance dip in January.
- Alliance and provider staff met in mid-December to discuss ways to improve successful member engagement in the peer bridger program. It has been difficult to engage with members prior to discharge due to current COVID-19 restrictions on unit access. In the month of January, only six members were referred to the program, and three were successfully engaged within 1-7 days of discharge. Referrals to the program have continued to decrease, which may account for some of the performance decrease in January.

e. 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.

d. Diabetes Screening for People Using Antipsychotic Medications

a. Goal of activity

- 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 82%.

b. Interventions and Barriers

Intervention	Barrier(s)
Member and Provider Education - Education to increase provider's awareness - Direct to member texting campaign to provide education about screenings. - Included clinical guideline recommendation in responses to service authorization requests	Members and Providers unaware of the need for testing
Provider Data Sharing - Provider reports were developed and are being distributed to providers as a part of our larger Practice Transformation efforts.	Providers unsure of which members need and/or have received testing
Point of Care Testing - Alliance funded equipment so that behavioral health providers could complete metabolic monitoring on individuals during their behavioral health visits	Barriers to going to a separate site for testing instead being able to do all required functions at the behavioral health provider's office.

c. Measures trended over time

Goal	J	A	S	O	N	D	J	F	M	A	M	J
82%	72%	72%	71%	71%	70%	71%	69%	69%	70%	71%	72%	71%

*Red indicates goal not met.

d. Quantitative and Qualitative Analyses

- Performance has not improved, but has maintained despite significant barriers to receiving care for members related to the financial, social, and health impacts of the on-going pandemic.
- Practice Transformation staff has been working closely with the pilot providers for the Point of Care testing intervention. While not all providers have incorporated this intervention into their office work flow, a few have, recently indicated metabolic testing has occurred at the point of care. One agency reported they had completed at least 20 POC tests as part of the intervention. With the delay of claims data being 2-3 months, evidence of this activity will take a few months to be verified. Currently, April data showed no providers had submitted claims data as part of the POC intervention for the SSD measure.
- Data reports were developed and distributed to providers in the Practice Transformation Cohort. In the month of March there were 515 SSD members with a gap in care, 14 (3%) of those were closed in April. This intervention appears to be effective at communicating the gap to providers.
- Since the inception of the clinical guideline recommendation intervention there has been a steady increase in the number of clinical recommendations in authorization feedback. Each monthly update is shared with the UM supervisor in order to address any needed feedback for staff regarding the intervention.

e. 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.

e. Metabolic Monitoring for Youth on Antipsychotics

a. Goal of activity

- Increase the percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year to at least 38%.

b. Interventions and Barriers

Intervention	Barrier(s)
Member and Provider Education - Education to increase provider's awareness - Direct to member texting campaign to provide education about screenings. - Included clinical guideline recommendation in responses to service authorization requests	Members and Providers unaware of the need for testing
Provider Data Sharing - Provider reports were developed and are being distributed to providers as a part of our larger Practice Transformation efforts.	Providers unsure of which members need and/or have received testing
Point of Care Testing - Alliance funded equipment so that behavioral health providers could complete metabolic monitoring on individuals during their behavioral health visits	Barriers to going to a separate site for testing instead being able to do all required functions at the behavioral health provider's office.

c. Measures trended over time

Goal	J	A	S	O	N	D	J	F	M	A	M	J
38%	28%	28%	28%	28%	28%	29%	28%	29%	30%	31%	31%	30%

*Red indicates goal not met.

d. Quantitative and Qualitative Analyses

- Performance has not improved, but has maintained despite significant barriers to receiving care for members related to the financial, social, and health impacts of the on-going pandemic.
- Practice Transformation staff has been working closely with the pilot providers for the Point of Care testing intervention. While not all providers have incorporated this intervention into their office work flow, a few have, recently indicated metabolic testing has occurred at the point of care. One agency reported they had completed at least 20 POC tests as part of the intervention. With the delay of claims data being 2-3 months, evidence of this activity will take a few months to be verified. Currently, April data showed no providers had submitted claims data as part of the POC intervention for the SSD measure.
- Data reports were developed and distributed to providers in the Practice Transformation Cohort. In the month of March there were 515 SSD members with a gap in care, 14 (3%) of those were closed in April. This intervention appears to be effective at communicating the gap to providers.
- Since the inception of the clinical guideline recommendation intervention there has been a steady increase in the number of clinical recommendations in authorization feedback. Each monthly update is shared with the UM supervisor in order to address any needed feedback for staff regarding the intervention.

e. 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.

f. TCL In-Reach Timeliness

a. Goal of activity

- Increase rate of members who receive an in-reach contact within 90 days. 95% of all individuals in the In-Reach phase of the Transition to Community Living Imitative (TCL) will receive a contact by an Alliance In-Reach staff, at minimum every 90 days.

b. Interventions and Barriers

Intervention	Barrier(s)
Internal Tracking – Created an internal warning system that alerts TCL staff and supervisors when a contact is coming due.	Not having a data report that can be used to sort by contact day, assigned In-Reach Specialist Unable to identify those at risk for exceeding 90-day threshold
Increase consistency of member assignment	Members in In-Reach assigned to people that are no longer Alliance employees, or otherwise incorrectly assigned.
Streamlining Process – Focused the process internally to have a single source of truth and to limit duplicate data entry that was creating confusion and leading to errors.	Increasing proportion of members at risk for not receiving a timely contact (most recent contact 80-90 days)

c. Measures trended over time

Goal	J	A	S	O	N	D	J	F	M	A	M	J
95%	N/A	93%	93%	92%	95%	100%	100%	100%	100%	100%	100%	N/A

*This project began in August and was successfully closed after hitting the benchmark in May.

d. Quantitative and Qualitative Analyses

During the final re-measurement period, (May 2021) a total of 1025 distinct members were identified as part of the In-Reach phase of TCL; 100% (n=1023) of the members in the cohort received a timely contact. Of the cohort members, 60% (n=614) had received a contact in less than 45 days from their previous contact, while 39% (n=409) received a contact between 45-90 days since their previous contact, and >1% (n=2) had not received a contact in over 90 days, since their previous contact. This measure has met the goal for this period. Additional analysis included ensuring accuracy of member assignments to the correct organization. The project was completed and supported accuracy in caseload distribution.

e. Recommendations

This project successfully met the performance target and has been closed.

7. Additional Quality Improvement and Performance Efforts

a. Performance Measures

The chart below lists performance 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.

Call Center Performance

Metric	Goal	J	A	S	O	N	D	J	F	M	A	M	J
Call Abandonment Rate	<5%	1%	1%	1%	2%	1%	1%	1%	1%	1%	2%	3%	3%
Live Answer within 30 seconds	95%	98%	98%	98%	98%	98%	98%	98%	98%	98%	97%	96%	95%

Contract Super Measures

Metric	Goal	J	A	S	O	N	D	J	F	M	A	M	J
Medicaid - Mental Health 7-Day Follow Up	40%	52%	39%	42%	53%	37%	44%	41%	52%	46%	*	*	*

Medicaid - Substance Use 7-Day Follow Up	40%	41%	47%	38%	39%	41%	53%	27%	37%	33%	*	*	*
Medicaid - Innovations Waiver Primary Care	90%	94%	95%	94%	94%	94%	94%	93%	*	*	*	*	*
Non-Medicaid - Mental Health 7-Day Follow Up	40%	32%	30%	24%	22%	27%	30%	32%	30%	32%	*	*	*
Non-Medicaid - Substance Use 7-Day Follow Up	40%	29%	41%	40%	35%	32%	29%	34%	33%	38%	*	*	*

*Measure has not yet been reported.

Medicaid Performance Measures

Metric	Goal	J	A	S	O	N	D	J	F	M	A	M	J
Care Coordination Assignment[1]	85%	89%	87%	83%	83%	100%	90%	87%	98%	94%	93%	92%	92%
Authorizations Processed within Timeframes	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Claims Proceed within 30 Days	90%	96%	96%	97%	98%	98%	98%	96%	97%	98%	98%	99%	99%
Resolution of Grievances within 30 Days	90%	100%	100%	100%	100%	100%	100%	94%	100%	100%	100%	90%	100%
Access to Care - Emergent	97%	98%			100%			100%			100%		
Access to Care - Urgent	82%	38%			42%			37%			40%		
Access to Care - Routine	75%	38%			41%			40%			36%		

Innovations Waiver Measures

Metric	Goal	FY20 Q3	FY20 Q4	FY21 Q1	FY21 Q2
Members receiving services within 45 days of ISP[2]	85%	63%	79%	82%	79%
Percent of Actions Taken to Protect the Beneficiary	85%	100%	98%	100%	100%
Incidents reported within timeframes[3]	85%	67%	88%	87%	89%
Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	85%	100%	100%	100%	100%
Medication errors resulting in medical treatment.	<15%	0%	0%	0%	0%
Beneficiaries who received appropriate medication	85%	100%	100%	100%	100%

[1] 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.

[2] 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.

[3] 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.

Incidents where required LME/PIHP follow-up interventions were completed	85%	100%	100%	100%	100%
Percentage of incidents referred to the DSS or DHSR	85%	100%	93%	100%	100%
Percentage of restrictive interventions resulting in medical treatment.	<15%	0%	0%	0%	0%
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%		93%	
Individual Support Plans that address identified health and safety risk factors	85%	97%		100%	
PCPs that are completed in accordance with DMA requirements.	85%	97%		97%	
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%	N/A			
Providers reviewed according to PIHP monitoring schedule[4]	85%	79%			
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%			
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%			
Individuals for whom an annual plan and/or needed update took place	85%	100%			
Beneficiaries who are receiving services as specified in the ISP[5]	85%	52%			

[4] 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.

[5] 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.

Records that contain a signed freedom of choice statement	85%	98%
Beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	85%	99%
Beneficiaries reporting they have a choice between providers	85%	99%
Beneficiaries age 21 and older who had a primary care visit during year	85%	88%
Claims paid by the PIHP for Innovations wavier services authorized in the service plan	85%	98%

TBI Waiver Measures

Metric	Goal	FY20 Q3	FY20 Q4	FY21 Q1	FY21 Q2
Members receiving services within 45 days of ISP[6]	85%	75.%	100%	63%	0%
Percent of Actions Taken to Protect the Beneficiary	85%	N/A	100%	100%	N/A
Percentage of incidents referred to DSS or DHSR as required	85%	N/A	N/A	N/A	N/A
Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	85%	N/A	N/A	N/A	N/A
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%	N/A	100%	100%	N/A
Incidents where required LME/PIHP follow-up interventions were completed	85%	N/A	100%	N/A	N/A
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%	

[6] 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.

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%	89%	
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%	
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[7]	85%	79%	
Beneficiaries who are receiving services as specified in the ISP[8]	85%	48%	
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%	

[7] 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.

[8] 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.

Beneficiaries reporting they have a choice between providers	85%	100%
Beneficiaries age 21 and older who had a primary care visit during year	85%	89%
Claims paid by the PIHP for TBI wavier services authorized in the service plan	85%	100%

b. 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.

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.

Performance

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

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

Source: Alliance Monitoring Reports and Member Experience Report FY2021

Analysis

During FY2021, Alliance received a similar range of grievances and concerns when compared to the second half FY2020, once the volume of grievances stabilized as providers and members grew accustomed to services during to pandemic. There was a slight increase in the number of grievances related to quality of care concerns and many these grievances are related to on going concerns about service delivery in during a pandemic. The increase in utilization of the grievance function is a good sign that members are able to advocate for their needs and see Alliance as a helpful partner in resolving their issues.

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.

c. Adverse Incident Reports

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

Goal

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

Performance

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Level 2 Critical Incident Reports	167	192	200	220	158	163	189	156	177	205	203	227
Level 3 Critical Incident Reports	21	23	26	24	18	25	27	18	31	29	29	31

Source: Alliance Monitoring Reports

Analysis

The volume of incident submissions remained consistent with rates from the previous year. This level of reporting has been stabilized after the reduction in services during the initial months of the COVID-19 pandemic as providers and members adjusted to services post-pandemic.

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 COVID-19 pandemic.

d. Member Authorization Appeals

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

Goal

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

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	Change per 1,000	Goal Grievances/1,000 Members	Met
Quality of Care	0/0	0/0	No change	10/1,000	Met
Access	139/6.32	39/0.16	⬇ 5.88	10/1,000	Met
Attitude/Service	0/0	0/0	No change	10/1,000	Met
Billing/Financial	0/0	0/0	No change	10/1,000	Met
Quality of Practitioner Office Site	0/0	0/0	No change	10/1,000	Met

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 which negated the need for appeals by removing prior authorization requirements.

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 COVID-19 pandemic and associated flexibilities.

e. Provider Satisfaction Survey

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 of the visit our website: https://www.alliancebhc.org/providers/quality-management/

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.

Performance

- Same as the state average for overall satisfaction
- For the past 4 years, Alliance scored significantly above state average for Referring Consumers Whose Needs Match Agency
- Improvements from 2019 to 2020:
    - Support and communication from LME-MCO staff
    - Appeals process and denial explanation
    - Useful website
- Clinical Coverage Policies remains the most requested training topic – since 2016

Next Steps

- Requests for corrective action plans and other supporting materials are fair and reasonable
- Review credentialing process to ensure timeliness and appropriate notice

f. 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: https://www.alliancebhc.org/providers/quality-management/

Alliance's responsibilities included: identifying providers of MH and 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.

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.

Performance

Adult Survey Findings:

- Domains with scores at or above state average:
    - General Satisfaction
    - Access
    - Quality and Appropriateness
    - Social Connectedness
- Domains with scores lower than state average:
    - Treatment Planning
    - Outcomes
    - Functioning

Youth Survey Findings:

- Domains with scores at or above State average:
  - Access
  - Outcomes
- Domains with scores lower than state average:
  - General Satisfaction
  - Treatment Planning
  - Cultural Appropriateness

Family Survey Findings:

- Domains with scores at or above state average:
  - General Satisfaction
  - Access
  - Treatment Planning
  - Cultural Appropriateness
  - Outcomes
  - Functioning
- Domains with scores lower than state average:
  - Social Connectedness

Next Steps

- Treatment Planning – Adult and Youth lower than state average
- Social Connectedness for Family decreased in 2020 and was lower than state average; possibly related to COVID-19

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.

g. 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 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: https://www.alliancebhc.org/providers/quality-management/

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.

Performance

Adult Survey Findings:

- At or above state average:
  - Overall Satisfaction
  - Perceived Improvement
- Below state average:
  - Getting Treatment Quickly
  - How Well Clinicians Communicate
  - Information about Treatment Options

    - Getting Treatment and Information from the Plan (low denominator)
- Improvements from 2019 to 2020:
    - Clinicians usually or always listened carefully (statistically significant)
    - Felt they could refuse medicine or treatment
    - Given wanted information to manage condition
    - Helped by counseling or treatment

Child Survey Findings:

- At or above state average:
    - Getting Treatment Quickly
    - Getting treatment and Information from the Plan
- Below state average:
    - Overall Satisfaction
    - How Well Clinicians Communicate
    - Perceived Improvement
- Improvements from 2019 to 2020:
    - When child needed counseling or treatment, they received it when wanted
    - Got counseling needed via phone
    - Seen within 15 minutes of appointment

Next Steps

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

Survey	Survey Target	Most Recent Performance Level	Target Performance Level
ECHO - Child	Families desire more information about treatment options.	67%	70%
ECHO - Child	Families want to see improvements in their child's behavioral health and adolescents want to perceive their behavioral health is improving.	63%	65%
ECHO - Child	Families want quicker access to urgent care for their child or adolescent.	62%	65%
ECHO -Adult	Adults seek more information about treatment options from the Plan.	56%	60%
ECHO -Adult	Members want to be included in their treatment and decision making.	56%	60%
ECHO -Adult	Members perceive improvements in their behavioral health.	65%	68%
ECHO -Adult	Families want quicker access to urgent care.	58%	60%

8. Value-Based Contracting

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

- Support a Peer Bridger program aimed to improve follow-up from UNC's 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 adjusts as needed. Additional data is required before a full evaluation of these programs can be offered. That larger evaluation is expected next year.

9. Conclusion and Recommendations

In Alliance Health's current state and based on the assessment above, the QM program, CQI and its subcommittees are sufficient to be effective in meeting identified goals. Practitioner involvement and leadership in the QM program has been adequate over the previous year, as well. While this statement is true for the previous fiscal year, it may not be accurate for our future state due to Medicaid Transformation in North Carolina.

Over the next year Alliance will continue to experience significant changes. On July 1st 2021, Medicaid Transformation in North Carolina went live with Standard Plans taking over the management of most Medicaid member's benefits. For Alliance, covered lives dropped significantly to include only those members with the highest levels of behavioral health needs. In the coming months, two additional counties will join our organization and will increase the number of high need members by 50%. Finally, at the end of this fiscal year 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. All of these changes will dramatically expand our provider network and change our membership. Our challenge will be to remain focused on ensuring excellent care for our members while expanding the quality structures that have made our current performance possible.

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

- Launch of the Health Equity and Pharmacy and Therapeutics subcommittees of the Continuous Quality Improvement Committee.
- Implement a certified HEDIS vendor and begin incorporating those metrics into organizational function
- Monitor the performance of new counties closely to quickly identify and resolve any issues related to expansion
- 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.

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 as described below.
	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 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

	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
	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 Measures	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.
	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.