All Provider Meeting
March 21, 2018
1:00pm – 3:00pm
4600 Emperor Boulevard, Durham, NC
Rooms 104-105
Welcome and Introductions (Cathy Estes Downs)
Alliance Provider Advisory Council (APAC) - Ali Swiller - new Co-Chair
Alliance Updates
Clozapine: Improving Access to Treatment - (Vera Reinstein)
7 Day Challenge and Care Coordination update - (Courtney Cantrell)
Legislative Updates (Brian Perkins/Sara Wilson)
IDD Updates (Jarret Stone)
Accreditation and NCI Reminders
Credentialing Updates
LIP Solo General Liability Insurance requirement
QM Updates - (Wes Knepper)
(QM-11 Reporting, Backup Staffing and NC-TOPPS submissions)
Hope Services - Partial Hospitalization program information - Sara Leonard

Powerpoint will be posted on the Alliance Website by March 23, 2018
https://www.allianc ebhc.org/providers/provider-resources/all-provider-meetings/
Clozapine: Improving Access to Treatment

• Most effective and underutilized antipsychotic
• CRH 100+ patients / challenge on discharge (7 day challenge)
• Treatment barriers
  – literature
  – community?
• Solutions to barriers to treatment: Alliance provider survey handout
• Return survey to Vera Reinstein:
  – vreinstein@alliancebhc.org or efax to 919-651-8678
  – call in on secure voicemail 919-651-8640
  – Survey
    • see handout today
    • on Alliance website: for providers/provider resources/pharmacy updates
MH/SUD Care Coordination
Philosophy and the 7 Day Challenge
Care Philosophy

• Care focuses on **engaging** members, **removing barriers to quality treatment**, and **handing care off to providers** with support from CC team through information- and care plan-sharing.

• Care coordination is focused on promoting and enhancing the relationship between individuals and providers through collaboration.
Organizational Structure: Care Team

- Tiered system of care coordination with licensed CC acting as managers of cases, assigning tasks to admin CCs with specialization.
- Care is team-based, team members work at top of their licenses.
MH/SUD Care Coordination Functions

- Facilitate treatment engagement.
- Ensure proper level of care.
- Assess and address unmet clinical needs (medical and psychiatric).
- Address health, safety, or service delivery issues.
- Evaluate and address significant barriers to treatment progress and/or engagement
- Problem-solve unmet coordination of care needs
- Engage Child and Family Teams

*Ensure enhanced providers are offering the required case management functions from NC CMA Clinical Policy 8A, 8A-1 and 8A-2*
## Standardized Interventions

- Standardized workflows, assessments, and Interventions based on **behavioral health**, **physical health**, **social determinants**, and **long-term support needs** with **recovery** and **self-determination** focus.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Interventions</th>
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</table>
| Member has caregiver issues that may interfere with reaching or maintaining healthcare goals. | Member will not have any caregiver issues that interfere with reaching or maintaining their healthcare goals | - Emphasize the importance of the caregiver maintaining their self-care, health, and social support system.  
- Support member to apply for an caregiver resources and community resources.  
- Review/discuss with the member their current family/caregiver support changes |
Population Stratification

- **Proactively** identify members’ needs for care coordination and **match level of need to care coordination touch and intervention.**
Outcomes

- CC outcomes are measured related to efficiency and effectiveness of CC, and proactive monitoring of these measures occurs at all levels of supervision.

**Efficiency**
- Care Coordination caseloads
- Number of interventions accomplished
- Time elapsed while in care coordination

**Effectiveness**
- Decreased inpatient re/admissions
- Decreased ED admissions
- Increased engagement (lower treatment dropout)
7 Day Challenge
The Requirements

• Follow-up within 7 days for individuals discharging from
  – Psychiatric inpatient (including 3-way beds)
  – SUD inpatient
  – ADATC/state facilities
  – FBC/ADU
MHSUD Care Coordination Role

• Hospital Liaisons (where applicable)
  – Prioritize individuals at risk for not attending follow-up
  – Assess and establish plan for overcoming barriers to follow-up
  – Ensure quality discharge plan and other documentation passed on to receiving provider*

• Administrative Care Coordinator
  – Monitors visits to follow-up appointments

• Community Care Coordinator
  – Continues with interventions to facilitate engagement/follow-up
  – Hands off care plan to provider once individual is engaged

*Subject to individual signing a release of information
Enrollees Potentially Eligible for MH/SUD Care Coordination

Special Healthcare Needs Population

At-Risk Crisis Enrollees

Other Populations Defined by Alliance (e.g., children at risk for therapeutic foster care placement through advanced analytics pilot)

Please note: Care Coordinator consultation is always available to Alliance I/DD care coordinators for cases with a behavioral health component. Additionally, not everyone in these categories will have an unmet need or barrier to quality care that needs to be addressed by care coordination. Care coordination supervisors assess referrals for appropriateness within the priorities presented in subsequent slides.
Medicaid Eligibility for Care Coordination

At-Risk for Crisis Population-

Missed Appointments: Adults or Children who are At-Risk for emergency or inpatient treatment and do not appear for scheduled appointments.

First Service as Crisis: Adults or Children for whom a crisis service is their first interaction with the MH/SUD/IDD system.

Discharge: Adults or Children discharged from a psychiatric inpatient facility/hospital, ADATC, Psychiatric Residential Treatment Facility (children), Facility-Based Crisis Center, or a general hospital unit following admission for MH, SUD or IDD conditions. For individuals in the Transitions to Community Living Initiative, care coordination following a state hospital or inpatient psychiatric facility discharge continues for at least 90 days post-discharge.
Medicaid Eligibility Cont’d

Special Healthcare Populations-

Adults and Children
• Substance Use: Substance use dependence and an ASAM of III.7 or higher
• Dual Diagnosis (MH/SUD): Diagnoses falling in both categories (not limited to substance dependence) and either a LOCUS/CALOCUS of V or higher and ASAM of III.5 or higher
• Dual Diagnosis (IDD/MH): Diagnoses falling in both categories and a LOCUS/CALOCUS of IV or higher
• Dual Diagnosis (IDD/SUD): Diagnoses falling in both categories and an ASAM of III.3 or higher

*Not everyone in these categories will have an unmet need or barrier to quality care that needs to be addressed by care coordination.
Medicaid Eligibility Cont’d

Special Healthcare Populations-

Adults
Mental Health: LOCUS score VI or higher and a diagnosis listed in section 6.11.3(c) of the DMA/Alliance contract

Transitions to Community Living
Individuals transitioning to the community receive care coordination for at least 90 days following transition. After the initial 90 days, care coordination should continue if needs are still unmet and the individual meets other Special Healthcare Needs Criteria.

*Not everyone in these categories will have an unmet need or barrier to quality care that needs to be addressed by care coordination.
Medicaid Eligibility Cont’d

Special Healthcare Populations-

Children
Mental Health: CALOCUS score VI or higher and a diagnosis listed in section 6.11.3(b)(1) of the DMA/Alliance contract

Discharge from Facility: In addition to the criteria for the At-Risk population, upon notification of discharge, children may be eligible for care coordination to help with transition from the following settings: Youth Development Center/Youth Detention Center operated by DJJ or DOC and therapeutic group homes.

Children with Complex Needs

*Not everyone in these categories will have an unmet need or barrier to quality care that needs to be addressed by care coordination.
Children with complex presentation of IDD and MH/SUD: Alliance uses advanced analytics to identify Medicaid eligible children “ages 5 and under age 21” with a developmental disability and mental health disorder who are likely to be at risk of not being able to remain in a community setting.

Care coordination for a subset of these individuals is primarily conducted by specialized IDD/MHSUD teams. Refinement of the means of identification of these children is currently occurring with state input.
Non-Medicaid Eligibility

Department of Health and Human Services defines specific uninsured or under-insured (non-Medicaid) populations to be considered eligible for care coordination up to available resources.

Alliance has prioritized within the eligible categories for the non-Medicaid population residing in the Alliance catchment area. Not everyone eligible for care coordination will receive full care coordination from Alliance because providers are expected to provide case management services for many of the enhanced services (per enhanced service definitions).
Non-Medicaid Eligibility - Cont’d

Adults and Children

- 24-hour treatment facility discharges, including inpatient psychiatric units/ADATC and FBC/ADU or people at critical treatment junctures who are being provided state-funded service

- Individuals with Level 3 incident reports

- Individuals with three or more crisis services in the last 12 months

- Top 20% in cost (uninsured) in each disability area

Serving Durham, Wake, Cumberland and Johnston Counties
Children

Children who receive non-Medicaid funded services from the LME/MCO AND

- Are currently in residential care
- Have been discharged in the past 30 days (d/c) from detention center (NCDPS/DJJ) AND LME/MCO received notice of discharge or concern about unmet service needs
- Have a history of four or more lifetime hospitalizations
Children
Children who receive non-Medicaid funded services from the LME/MCO AND
In past 12 months:

- In DSS custody with two or more disrupted therapeutic residential placements (due to BH)
- Three or more prior mobile crisis calls (i.e., current call is the 4th)
- Two prior outpatient providers (i.e., current request for service is the third)
Non-Medicaid Eligibility- Cont’d

Adults

• Individuals in transition or otherwise eligible for the Transitions to Community Living Initiative, including those transitioning between services while in TCLI in order to ensure strong linkage to services.
• Outpatient Commitment--Only if eligible for LME/MCO services.
• Jail discharges (liaisons handle these at their capacity)
• Prison release into the community.
Referral Process

To make a referral to Care Coordination, please call Alliance's Access and Information Center at 1-800-510-9135.
# MH/SUD Care Coordination Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>County</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nave Sands</td>
<td>Director of MH/SUD Care Coordination</td>
<td>Durham</td>
<td><a href="mailto:nsands@alliancebhc.org">nsands@alliancebhc.org</a>, 919-651-8417</td>
</tr>
<tr>
<td>Towanda Witherspoon</td>
<td>Durham- MH/SUD Care Coordination Supervisor</td>
<td>Durham</td>
<td><a href="mailto:twitherspoon@alliancebhc.org">twitherspoon@alliancebhc.org</a>, 919-651-8853</td>
</tr>
<tr>
<td>Kimberli Johnson</td>
<td>Durham- MH/SUD Care Coordination Supervisor</td>
<td>Durham</td>
<td><a href="mailto:kjohnson@alliancebhc.org">kjohnson@alliancebhc.org</a>, 919-651-8816</td>
</tr>
<tr>
<td>Emily Kerley</td>
<td>Wake- MH/SUD Care Coordination Supervisor</td>
<td>Wake</td>
<td><a href="mailto:mjaeger@alliancebhc.org">mjaeger@alliancebhc.org</a>, 919-651-8734</td>
</tr>
<tr>
<td>Crystal O'Briant</td>
<td>Wake MH/SUD Care Coordination Supervisor</td>
<td>Wake</td>
<td>Co’<a href="mailto:briant@alliancebhc.org">briant@alliancebhc.org</a>, 919-651-8785</td>
</tr>
<tr>
<td>Karen Gall</td>
<td>Wake- MH/SUD Care Coordination Supervisor</td>
<td>Wake</td>
<td><a href="mailto:kgall@alliancebhc.org">kgall@alliancebhc.org</a>, 919-651-8747</td>
</tr>
<tr>
<td>Jessica King</td>
<td>Wake- MH/SUD Care Coordination Supervisor</td>
<td>Wake</td>
<td><a href="mailto:jking@alliancebhc.org">jking@alliancebhc.org</a>, 919-651-8759</td>
</tr>
<tr>
<td>Carlotta Ray</td>
<td>Cumberland- MH/SUD Care Coordination Supervisor</td>
<td>Cumberland</td>
<td><a href="mailto:cray@alliancebhc.org">cray@alliancebhc.org</a>, 910-491-4790</td>
</tr>
<tr>
<td>Johnathan Giles</td>
<td>Cumberland- MH/SUD Care Coordination Supervisor</td>
<td>Cumberland</td>
<td><a href="mailto:jgiles@alliancebhc.org">jgiles@alliancebhc.org</a>, 910-491-4805</td>
</tr>
<tr>
<td>Lindsay Allen</td>
<td>Johnston- MH/SUD Care Coordination Supervisor</td>
<td>Johnston</td>
<td><a href="mailto:lallen@alliancebhc.org">lallen@alliancebhc.org</a>, 919-989-5546</td>
</tr>
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</table>

Serving Durham, Wake, Cumberland and Johnston Counties
Resources

Alliance Behavioral Healthcare
Locate a Provider,
Upcoming Training, and Updates
www.alliancebhc.org

Department of Health and Human Services
https://www.ncdhhs.gov/

Division of Medical Assistance
https://dma.ncdhhs.gov/
# Administrative Care Coordinator Assignment

<table>
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<tr>
<th>Admin</th>
<th>Provider</th>
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<tr>
<td>Griffin, Bruce</td>
<td>A, B, C providers that are not on this list that start with these letters.</td>
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<tr>
<td>Pellish, Noel</td>
<td>B&amp;D</td>
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<tr>
<td>Griffin, Bruce</td>
<td>BCPS (DWI center)</td>
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<td>Griffin, Bruce</td>
<td>Cape Fear Valley BHC</td>
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<td>Griffin, Bruce</td>
<td>Carolina Outreach (Cumberland)</td>
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<tr>
<td>Jones, Felicia</td>
<td>Carolina Outreach (Durham)</td>
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<tr>
<td>Payne, Melissa</td>
<td>Carolina Outreach (Johnston); Carolina Outreach (Wake)</td>
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<tr>
<td>Griffin, Bruce</td>
<td>Carolina Psychiatry</td>
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<td>Griffin, Bruce</td>
<td>Carolina Treatment Center</td>
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<td>Carter Clinic</td>
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<td>Coastal Carolina Neuropsychiatric Center</td>
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<td>D, E, F, G providers that are not on this list that start with these letters.</td>
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<td>Freedom House, ,</td>
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<tr>
<td>Griffin, Bruce</td>
<td>Haire Enterprises</td>
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## Administrative Care Coordinator Assignment

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<td>Griffin, Bruce</td>
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<td>Jones, Felicia</td>
<td>Healing with CAARE</td>
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<td>Soler Margaret</td>
<td>Hope Services</td>
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<td>Griffin, Bruce</td>
<td>Integrated Behavioral Healthcare</td>
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<tr>
<td>Payne, Melissa</td>
<td>Johnston County Public Health</td>
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<tr>
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<tr>
<td>Griffin, Bruce</td>
<td>KV Consultants</td>
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<td>Soler Margaret</td>
<td>Monarch</td>
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<td>Pathways to Life</td>
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<td>Southlight</td>
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<td>Jones, Felicia</td>
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<tr>
<td>Soler Margaret</td>
<td>Youth Villages</td>
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All Provider Meeting
NC Medicaid Transformation Update

March 21, 2018
Where Things Stand

• Federal approval needed for NC’s Medicaid Transformation plan

• State legislative approval needed for NC to implement key components of this plan
Federal Approval Needed

- A primary tool for enacting such modification is 1115 Demonstration Waivers – “the 1115 Waiver”
  - Broad authority for states to change how Medicaid services are delivered
  - Must be budget neutral for the federal government
  - Granted for 5-year terms and can be renewed
CMS Review of NC’s Waiver

• DHHS has had weekly meetings with CMS subject matter experts since September

• DHHS continues to target July 1, 2019 as the start date for managed care
  • But, the longer CMS takes to approve the waiver the more likely it is this start date could be pushed back
Legislative Approval Required

NC General Assembly must pass legislation for DHHS to implement key parts of Medicaid Transformation plan

• Integration of behavioral health into Medicaid health plans (prepaid health plans (PHPs))

• Creation of Behavioral Health and I/DD Tailored Plans focus on specialized needs of individuals with behavioral health disorders, I/DD, and TBI
Alliance’s Legislative Priorities

• Consistent with the State’s plan, we continue to request that the GA pass legislation enabling LME-MCOs to establish and operate BH I/DD Tailored Plans

• We also continue to request that DHHS create a plan for implementing these Tailored Plans that utilizes LME-MCO experience and community relationships to best integrate care for the individuals we have a proven history serving
Legislative State of Play

• GA’s official legislative “short session” begins in May

• In January and February the GA held some special legislative sessions

• During these special sessions, we worked with Senate and House health policy leaders to craft legislation to achieve integration and establish the Tailored Plans

• Legislators were “close” to reaching an agreement but did not do so prior to concluding the special sessions
DHHS Transformation Milestones

August 2017
• Proposed Program Design

November 2017
• Amended 1115 Waiver Application
• Tailored Plans
• Supplemental Payments
• Managed Care Operational and Actuarial
• RFIs
DHHS Transformation Milestones

February 2018
  • Network Adequacy

March 2018
  • Enrollment Broker RFP
  • Benefits & Clinical Coverage Policies
  • Beneficiaries in Medicaid Managed Care
  • Care Management & Advanced Medical Home
I/DD Updates

All Provider Meeting
March 21, 2018
I/DD Updates

• Super measure – Connection with Primary Care
• ICF/IID Mid-Level Project
• Remote Monitoring Home
• Children with Complex Needs Update
• TBI Waiver
Accreditation-Monitoring Reminder

Effective July 3, 2017- LME-MCO Communication Bulletin #J254

Agencies that are Nationally Accredited will no longer be monitored on a two-year cycle.

For providers accredited two years or more, only the official notification (e.g. letter, memorandum, certificate, etc.) from the accrediting body will need to be provided to the LME-MCO within 30 days of receipt.

For providers that receive only a provisional or one-year accreditation, they must submit all findings of the accrediting body to the LME-MCO within 30 days of receipt. Upon review of the findings, the LME-MCO will make a determination if there is a need for targeted monitoring.
Accreditation Submission

Alliance will have an online portal in the near future to submit the required accreditation documentation. Please monitor Provider News regarding implementation guidelines.

For providers that receive their accreditation documentation prior to the implementation of the portal please continue to email the documents to:
PNDProviderReports@alliancebhc.org
“Providers currently using NCI will need to select another curriculum as an alternative to NCI to train their staff in the use of prevention and restrictive intervention techniques. A provider could choose from the list of other curricula approved by DMH/DD/SAS or develop their own curriculum and submit it to DMH/DD/SAS for approval.

DMH/DD/SAS will review curriculums within 45 business days. Curriculums will be processed as expeditiously as possible; however, as the volume of curriculums increases, the timeline for review and approval may need to be adjusted.”
NCI Important Information

“December 31, 2018 - NCI Instructor certifications will expire on or before this date based on their last certification. The Transition period ends. All providers shall have selected and implemented a new curriculum as an alternative to NCI.

Please send any questions regarding the process for transitioning to a new curriculum: DMH.NCI@dhhs.nc.gov.”
Nurse Practitioner (NP) credentialing requirements

LME-MCO Communication Bulletin #J253- DMA Clinical Coverage Policy 8C

“Nurse Practitioners not certified as PMHNP may be eligible to provide psychiatric services to Medicaid beneficiaries if they meet all the requirements listed below, as demonstrated to the credentialing body of the LME-MCO

a. Documentation that they have three (3) full-time years of psychiatric care and prescribing experience under licensed psychiatric supervision including psychiatric assessments and psychotropic medication prescribing; and

b. A signed supervision agreement with a North Carolina Licensed Psychiatrist that covers prescribing activities; and

c. Continuing education requirements, going forward, which include 20 hours each year focused on psychiatric physiology, diagnosis, and psychopharmacology. (21 NCAC 36.0807)
Nurse Practitioner (NP) credentialing requirements

• The LME-MCO credentialing body and the Medical Director are responsible for assessing the qualifications of Nurse Practitioners not yet certified as Psychiatric Mental Health Nurse Practitioners and for monitoring the supervision and continuing education requirements.

• Waiver of the requirement for three years of supervised psychiatric experience for a NP not yet certified as a PMHNP must be based on access needs of the LME-MCO, documented in the records of the credentialing body, approved by the LME-MCO Medical Director, and reassessed on an annual basis. Other details in items b. and c. above apply.”
Credentialing Reminders

**Site changes** - all site changes require a minimum of a 30 day notification using the Notice of Change form. All new sites will need to be enrolled in NCTracks prior to being entered in Alpha. The effective date will be the date indicated on the Notice of Change (the actual date of the move) or the NCTracks effective date - whichever comes last. Previous sites will be end dated on the date the provider is no longer providing services from that site. Please ensure your enrollment of any new site in NCTracks has an effective date that will not cause a gap as it may result in a gap in contract end and start dates which will result in payment denials. Please note any services billed from a site that the provider has indicated they have moved from may result in a recoupment and a compliance referral.
Credentialing Reminders

Licensed Practitioners and Provider Agencies- please ensure that you stay current with your NCTracks enrollment. If your Medicaid Health Plan is terminated in NCTracks your enrollment with Alliance is suspended until you are reinstated in NCTracks. Effective dates once a suspension is lifted for current providers will mirror the NCTracks effective dates. If you are paid by Alliance for services when your NCTracks enrollment is terminated or if there is a gap in the reinstatement period you are at risk for recoupment for that time period.

Re-Credentialing-Please note that at the time of re-credentialing a billing review will be done for each Licensed Practitioner(LP). If there is no billing for the previous 12 months the provider will be decredentialled. The LP would be eligible to re-apply to the Network.
Attention **LIP Solo Providers**

**General Liability Insurance Requirement**

To be in accordance with Alliance’s contract with the State all contracted LIP solo entities will be required to purchase and maintain Comprehensive General Liability Insurance which includes Bodily Injury and Property Damage Liability Insurance protecting the provider.

*Currently contracted LIP Solo Providers will be required to email by April 15, 2018 a copy of the above policy with an effective date of no later than July 1, 2018 to ProviderNetwork@AllianceBHC.org. Contracts will not be renewed for providers that do not submit this required insurance information.*

Any new LIP Solo providers initially credentialed and/or contracted with an effective date after October 25, 2017 will be required to have this coverage to meet credentialing and contracting requirements. In addition, LIP Solo’s that are currently going thru the re-credentialing process will be required to submit the above policy as part of the recredentialing process.
Failure to Provide Back-Up Staff

• If a provider agency or Employer of Record (EOR) staff is unable to provide a service, and the provider agency or EOR is unable to provide a back-up staff, the provider agency or EOR is required to report this to the LME-MCO.

• The Innovations Incident Report for Failure to Provide Back-Up Staffing (fillable PDF) should be used to document these occurrences. This can be located on the Alliance website (under Providers – Publications, Forms & Documents). Effective 1/1/18, reports submitted in other formats will be returned for resubmission on the correct form.

• The report (fillable PDF) should be submitted to the LME-MCO on a bi-weekly basis. Reports can be sent via secure email to backupstaffing@alliancebhc.org.
Backup Staffing & Service Breaks

• Service breaks are defined as holidays, family vacations, weather conditions, illnesses, and scheduling conflicts.

• Service breaks do not require back-up staffing reporting to the LME-MCO.

• Service breaks should be documented internally and routinely reviewed with the consumer’s assigned Care Coordinator.

• If a consumer is consistently using a reduced amount of service, then the plan should be amended.
QM-11 Waiver

• Alliance has submitted, on behalf of our provider network, a waiver of the QM-11 report submission.
• Nothing changes unless you choose to opt out of the waiver.
• If you opt out, you will need to submit the QM-11 report quarterly.
Upcoming Survey Results

• Alliance’s analysis of the ECHO and Provider Satisfaction Survey results should be available soon

• We will look forward to your feedback about how Alliance interpret the results and improves performance
Partial Hospitalization

Hope Services, LLC
What is PHP?

– Partial Hospitalization is designed to offer face-to-face therapeutic interventions to provide support and guidance in preventing, overcoming, or managing identified needs on the PCP.

– Aimed at improving and stabilizing the client’s level of functioning in all domains, increasing coping abilities or skills, or sustaining the achieved level of functioning to prevent acute hospitalizations or be able to shorten their stay.

– Partial Hospitalization provides daily medical monitoring and oversight.
Appropriate referrals

- Clients stepping down from acute hospitalizations who need continued daily medication oversight in order to be successful in the community setting due to need to closely monitor medication compliance and/or side effects.

- Clients at risk of hospitalization in which hospitalization could be prevented if daily medication oversight, treatment and safety planning are present.
Service Type and Setting

- PHP is provided per service definition at a minimum of 4 hours per day, 5 days per week, and 12 months a year, excluding designated holidays.
- Hours are typically 11-3pm with some accommodations between 11-5pm.
- PHP is provided in our licensed Ray of Hope facility that offers a structured, therapeutic program under the direction of a physician.
- Consumers have daily contact with Nurse Practitioner under the supervision of our Medical Director/Child and Adolescent Psychiatrist.
Curriculum

• Ray of Hope provides PHP utilizing a developed, age appropriate, CBT based curriculum that includes:
  – Structured, CBT based therapeutic activities designed to support a client remaining in the community
  – Individual, family or group interventions
  – Assist the individual client with coping and functioning through a variety of pre planned age appropriate activities
  – PHP can be received with other services when appropriate under EPSDT
Programming of PHP

• The group composition of PHP consumers, however each PHP consumer’s plan is individualized.
• PHP consumers will see our Licensed Nurse Practitioner and Licensed professional daily and any additional interventions indicated will be staffed daily through clinical oversight, exceeding the PHP definition’s requirements.
• Case management outside the group setting as well as ongoing clinical assessment of progress and regression will be included within PHP programing.
Description of Daily Rounds

- Daily rounds NP of all PHP consumers shall occur on site daily. Rounds shall include the following:
  - Staffing
    - Identify all new patients admitting to PHP
    - Review critical incidents
    - Review of family contact
    - Review of medication changes and side effects
    - Review pending discharges and treatment recommendations
  - Rounds on each consumer to assess for HPI (history of present illness) to include mental status exam, assessment of current symptoms, med compliance, and med side effects.
  - Laboratory and other diagnostic test as necessary
  - Write new orders as indicated
  - Follow up with Licensed Professional regarding any emergent/urgent treatment issues
  - Follow up with Medical Director to review new orders and emergent/urgent treatment issues-track through EMR
Other Required Elements of the Program

• CCA by the licensed clinician within 3 business days of admission; the inpatient assessment can be used for youth transitioning from an inpatient setting.
• Substance use disorder assessment when indicated; the inpatient assessment can be used for youth transitioning from an inpatient setting.
• A minimum of 1 weekly Individual or family therapy sessions per week by a licensed clinician.
• Daily group therapy as indicated in the PCP.
• Daily recreation therapy and psycho-educational groups.
• Substance abuse education and therapy are provided as indicated by diagnosis.
• Daily Contact with family for progress reporting and assessment or a minimum of three times weekly.
• CFT/ and or Family Session and Treatment Review held within 3 business days of admission, and prior to discharge. Provider of ongoing services is included in CFT and or Family Session prior to discharge.
Required Elements continued

- Crisis intervention as needed and First Responder Responsibility
- Collaboration with outpatient psychiatrist or physician for youth already being managed by a community provider.
- Coordination of care and service linkage including primary care provider and community behavioral health provider.
- Coordination of care with primary care provider is required for youth who develop medically significant side effects from prescribed psychotropic medications, e.g., potential weight gain, metabolic screening for youth prescribed atypical antipsychotics
Discharge Planning

- Discharge planning starts at admission and continues through weekly CFT and treatment plan reviews.
- During treatment, Discharge Plan is a team approach and includes:
  - Anticipated discharge date
  - Discharge placement (home or another care facility)
  - Next level of care
  - Updates as treatment progresses
- At time of discharge, Discharge Plan will be given to parent/guardian and includes:
  - First appointment within 7 days of discharge
    - Date, Time, Provider name, address and phone number
  - Supply of medication or prescription
  - Linkages with community services:
    - School
    - Primary Care Provider, other Health Professionals
    - Suggestions for community resources
  - Updated Comprehensive Crisis Plan
  - Evidence of youth and parent/guardian participation
- A plan to communicate clinical information to the Primary Care Physician, prescribing physician and Provider of post-discharge care
Discharge Criteria

Client’s level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

a. beneficiary has achieved goals, discharged to a lower level of care is indicated; or

b. beneficiary is not making progress, or is regressing and all realistic treatment options with this modality have been exhausted.
Utilization Management

Prior authorization is required. Expected length of stay is 7-14 days.

- Documentation required for initial authorization is a CCA, service order, PCP and Comprehensive Crisis Plan
- For youth transitioning from a hospital or ED, the psychiatric assessment/discharge summary can be submitted in lieu of the CCA.
- Due to the short-term nature of this program the PCP can have 2 tx. goals related to stabilization and discharge planning
- Documentation required for reauthorization requests: Discharge Plan identifying the recommended next level of care and the CCA (authorization request, if not provided at admission).
Referral Process

• Please contact our Intake Department for all referrals:

• 919-714-7500 ext. 1101

• Families may visit our Open Access Clinic anytime Monday - Friday between 9 am-3 pm:
  3000 Highwoods Blvd. Suite 310
  Raleigh, NC 27604