FY 2020 Quality Management Program Description

Approval

The Alliance FY 2020 Quality Program Description was reviewed and approved by the Alliance Board of Director's Global Quality Management Committee.

Signature: Pam Silberman Date: 9-5-19

Pam Silberman
Chair, Alliance Global Quality Management Committee

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1. Introduction

a. Description of Alliance

Alliance Health is a public-sector managed care organization administering behavioral health services for the North Carolina counties of Cumberland, Durham, Johnston and Wake. Alliance authorizes Medicaid and state funds for members in the Alliance Region who need services for mental health, intellectual/developmental disabilities and substance use/addiction.

Alliance is a multi-county area authority/Local Management Entity (LME) established and operating in accordance with Chapter 122C of the North Carolina General Statutes. Alliance is a political subdivision of the State of North Carolina and an agency of local government. Additionally, Alliance operates as a regional Prepaid Inpatient Health Plan (PIHP) on a capitated risk basis for behavioral health services as described in 42 CFR Part 438.

Alliance is responsible for authorizing, managing, coordinating, facilitating and monitoring the provision of State, Federal and Medicaid-funded MH/IDD/SUD services in Cumberland, Durham, Johnston and Wake Counties. The LME/MCO model developed by the State utilizes a funding strategy that includes single management of all public funding resources through a local public system manager. Under this model, Alliance receives funding from multiple Federal, State and County sources. The financing provides for coordination and blending of funding resources, collaboration with out-of-system resources, appropriate and accountable distribution of resources, and allocation of the most resources to the people with the greatest disabilities. Re-engineering the system away from unnecessary high-cost and institutional use to a community-based system requires that a single entity has the authority to manage the full continuum of care.

Alliance receives funding on a capitated per-member, per-month (PMPM) basis, which covers both treatment services and administrative costs, for the entire Medicaid Network population in the four Alliance counties. Alliance also receives a limited allocation from the Department for State-funded MH/IDD/SA services, and some competitive grant funding.

The North Carolina MH/DD/SAS Health Plan is a prepaid inpatient health plan (PIHP) funded by Medicaid and approved by the Centers for Medicare and Medicaid (CMS). The Health Plan combines two types of waivers: a 1915(b) waiver generally known as a Managed Care/Freedom of Choice Waiver, and two 1915(c) waivers generally known as a Home and Community-Based Waiver.

The NC Innovations Waiver is a 1915(c) Home and Community Based Services (HCBS) Waiver (formerly the Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities). This is a waiver of institutional care. Funds that are typically used to serve a person with intellectual and/or developmental disabilities in an Intermediate Care Facility through this waiver may be used to support the participant *outside* of the ICF setting.

The TBI Waiver is another 1915 (c) waiver that provides an array of home and community based services, through a three-year Medicaid waiver pilot, in Alliance's four-county region. The waiver is designed to provide an alternative to nursing facility care or specialty rehabilitation hospital care for eligible individuals with a traumatic brain injury.

Alliance manages a variety of County-funded programs, including but not limited to crisis and assessment centers and outpatient walk-in clinics.

In July of 2019 Alliance officially change its name to Alliance Health to more accurately reflect the full person care approach.

b. Alliance's Mission

To improve the health and well-being of the people we serve by ensuring highly effective, community-based support and care.

c. Alliance's Vision

To be a leader in transforming the delivery of whole person care in the public sector.

d. Alliance's Values

Accountability and Integrity: We keep the commitments we make to our stakeholders and to each other. We ensure high-quality services at a sustainable cost.

Collaboration: We actively seek meaningful and diverse partnerships to improve services and systems for the people we serve. We value communication and cooperation between team members and departments to ensure that people receive needed services and supports.

Compassion: Our work is driven by dedication to the people we serve and an understanding of the importance of community in each of our lives.

Dignity and Respect: We value differences and seek diverse input. We strive to be inclusive and honor the culture and history of our communities and the people we serve.

Innovation: We challenge the way it's always been done. We learn from experience to shape a better future.

e. Alliance Members

Alliance's coverage area includes a total population of 1,911,842. By far the largest county by population is Wake, exceeding the population of the other three counties combined. Wake and Durham are the most densely populated counties, reflecting their more urbanized settings. Johnston is the least densely populated county.

Population by County in Alliance Catchment Area				
County	Population	Square Miles	Persons per Square Mile	Medicaid Enrollees
Cumberland	329,653	652	506	69,497
Durham	310,847	286	1,087	44,359
Johnston	200,102	791	253	31,445
Wake	1,071,240	835	1,283	100,519
Alliance Total	1,911,842	2,564	746	245,820

FY 2019 Q3 DMHDDAS Quarterly Performance Measures Report

The service area includes both urban and rural areas but the majority of the population lives in urban areas. Because of the proximity to relatively dense population areas such as Raleigh, Durham and Fayetteville, all Alliance counties are classified as 'metropolitan/urban' counties according to United States Office of Management and Budget criteria.

The four counties that make up Alliance Behavioral Health Care are racially and ethnically diverse. Across the Alliance area, the primary ethnic group is Caucasian followed by Black and Hispanic/Latino. There is some variability across region, however. Johnston has a higher percentage of white population, with Black and Hispanic/Latino populations roughly the same percentage. Compared to the state average, Alliance has a higher percentage of Hispanic/Latino population with Durham and Johnston having the highest percentage in the Alliance area.

Race and Ethnicity by County in Alliance's Catchment Area					
	Cumberland	Durham	Johnston	Wake	North Carolina
White alone	51.8%	53.5%	79.6%	68.4%	70.8%
Black or African American alone	38.6%	37.8%	16.5%	21.1%	22.2%
American Indian and Alaska Native alone	1.8%	0.9%	0.9%	0.8%	1.6%
Asian alone	2.8%	5.2%	0.9%	7.2%	3.1%
Native Hawaiian and Other Pacific Islander alone	0.4%	0.1%	0.1%	0.1%	0.1%
Two or More Races	4.6%	2.5%	2.0%	2.5%	2.2%
Hispanic or Latino *	11.0%	13.7%	13.7%	10.2%	9.5%
White alone, not Hispanic or Latino	43.5%	42.5%	67.9%	60.2%	63.1%

Source: 2010 Census Data V2017
*Hispanics may be of any race, so also are included in applicable race categories

Alliance's catchment area is experiencing higher than average population growth and is challenged to meet the needs of a diverse population with important needs such as those who do not speak English, homeless individuals with mental illness and substance use disorders, and members of the military, veterans and their families.

f. Alliance Providers

Alliance depends on a strong and diverse network of agencies and group practices, licensed independent practitioners and hospitals to provide the range of high-quality services and supports required by the densely-populated Alliance region. Alliance has credentialed providers and most organization types available in every county, as well as prescribers and licensed practitioners.

Services available in the network include a broad array of Medicaid and State-funded care, and providers served 46,242 Medicaid consumers and 17,024 with State funds in FY 2019.

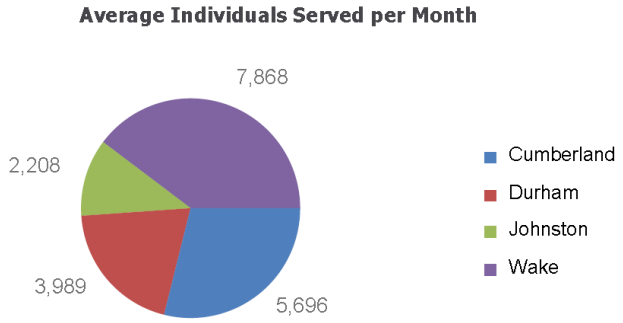
The following chart provides a summary of service expenditures for FY 2019:

Medicaid Funding

From Paid Claims Data (Date of Service)

Average Individuals Served per Month	Average Monthly Payments	Average Penetration rate
19,760	$29.8M	8.47%

Service Groups	Paid Amount
Innovations	$96,067,498
ICF/MR	$86,847,258
Outpatient	$44,219,827
Inpatient	$26,972,892
IIHS	$26,283,604
BH LT Residential	$20,864,097
Other Services	$18,385,771
PRTF	$14,272,030
ACTT	$12,348,349
1915 (b)(3) Services	$10,724,248
Case Management	$268,934

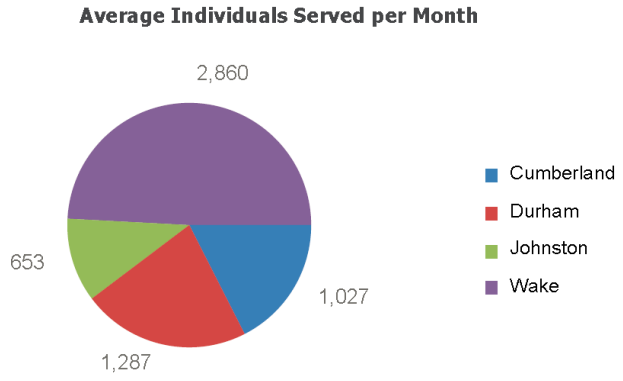


Non-Medicaid Funding

From Paid Claims Data (Date of Service)

Average Individuals Served per Month	Average Monthly Payments	Average Penetration rate
5,827	$3.8M	3.44%

Service Groups	Paid Amount
Outpatient	$14,232,003
Inpatient	$11,047,961
BH LT Residential	$7,491,242
Community Support	$6,905,919
Crisis Services	$3,104,879
ACTT	$2,294,590
MST	$399,044
Psych Rehab	$259,386
IIHS	$232,485
Other Services	$186,988



Contracts between Alliance and MH/IDD/SA providers create reciprocal partnerships designed to ensure an integrated system of quality services and supports is available to Cumberland, Durham, Johnston and Wake County residents. All contracts between Alliance and providers contain requirements that promote person and family-centered treatment, sound clinical and business practices, and delivery of high quality services within Alliance's System of Care.

Alliance uses performance indicators, outcome measures and other factors to determine selection and retention of providers in its network; however, consumer access to care will remain the primary determining factor.

The continual self-assessment of services, operations, and implementation of Quality Improvement Plans to improve outcomes to consumers is a value and expectation that Alliance extends to its providers. Providers are required to be in compliance with all quality assurance and improvement standards outlined in North Carolina Administrative Code as well as in the Alliance Contract. These items include:

- The establishment of a formal continuous Quality Improvement Committee to evaluate services, plan for improvements, assess progress made towards goals, and implement quality improvement projects and follow through with recommendations from the projects. This does not apply to LIPs.
- The assessment of need as well as the determination of areas for improvement should be based on accurate, timely, and valid data. The provider's improvement system, as well as systems used to assess services, will be evaluated by Alliance at the provider's qualifying review.
- The submissions of accurate and timely data, as requested, including claims for services delivered, no later than the deadline set by Alliance. Assessment of program fidelity, effectiveness, and efficacy shall be derived from data and any data requested. Providers shall be prepared to submit any and all data, reports, and data analysis upon request.
- Meeting performance standards set by Alliance and by the NC Health and Human Services for behavioral health services.

2. Purpose of the Alliance Quality Program

Quality Management plays a major role in ensuring Alliance has well-established and evaluated processes for the timely identification, response, reporting, and follow-up to consumer incidents and stakeholder complaints about service access and quality.

Alliance must meet a variety of Quality Management requirements. These are set by Alliance's contracts with the state of North Carolina; by the federal government's Medicaid waiver process; and by the URAC accreditation requirements.

Alliance also must ensure that its employees and providers are fully compliant with critical incident and death reporting laws, regulations, and policies, as well as event reporting requirements of national accreditation organizations. QM, along with the Medical Director and/or designees, shall review, investigate, and analyze trends in critical incidents, deaths, and take preventive action to minimize their occurrence with the goals of improving the behavioral healthcare system, behavioral healthcare access, and consumer and provider outcomes.

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

3. Purpose of the Quality Management Plan

The Quality Management Plan outlines the quality management structure and activities throughout the organization. The plan describes the process by which the organization monitors, evaluates and improves organizational performance, to ensure quality and efficient outcomes for enrollees served. It also describes how administrative and clinical functions are integrated into the overall scope and purpose of the Quality Management Department.

The Quality Management Program Description is updated and reviewed annually thereafter. Progress toward performance improvement goals are evaluated yearly.

4. Goals and Objectives of the QM Program

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

- To ensure individual consumers 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, protection of rights, accountability, and to monitor and continually improve the provider network;
- To empower consumers and families to set their own priorities, take reasonable risks, participate in system management, and to shape the system through their choices of services and providers;
- To build local partnerships with individuals who depend on the system for services and supports, with community stakeholders, and with the providers of service; and
- To demonstrate an interactive, mutually supportive, and collaborative partnership between the State agencies and Alliance n the implementation of public policy at the local level and realization of the State's goals of healthcare change.

5. Principles and Strategies of the QM Program

Alliance's Quality Management program is based on the principles of Continuous Quality Improvement.

a. Continuous Quality Improvement

Alliance's quality program begins with Quality Assurance (QA), which is a major activity of Alliance's QM Department. QA involves ongoing activities that ensure compliance with rules, regulations, and requirements. Examples of the QA activities conducted by Alliance include internal audits or reviews, performance measurement, provider monitoring, and consumer satisfaction surveys.

QA allows Alliance to identify opportunities for Quality Improvement (QI), which involves continuously monitoring, analyzing, and improving of systems and procedures throughout the agency, i.e., "Continuous Quality Improvement" or CQI.

Alliance has implemented a Plan/Do/Study/Act model for CQI:

- Plan: how you plan to accomplish your goals
- Do: implement procedures for reaching goals
- Study: use data to determine effectiveness
- Act: modify procedures as needed to reach goals more effectively

A goal of the CQI process is ensuring quality care for members. This is achieved by:

- Evaluating evidence-based practices
- Ensuring equal/easy access to services
- Maintaining client rights
- Obtaining consumer feedback
- Aligning agency policies and procedures with Federal, State, contract and accreditation expectations

Another goal of the CQI process is contributing to Alliance's viability as an ongoing organization by using data and outcomes measures to gauge clinical and administrative success.

b. Accreditation

Alliance also demonstrates its commitment to Continuous Quality Improvement via accreditation by URAC, a national accreditation organization. The URAC accreditation process is an evaluative, rigorous, transparent and comprehensive process in which a health care organization undergoes an examination of its systems, processes, and performance by an impartial external organization (accrediting body) to ensure that it is conducting business in a manner that meets predetermined criteria and is consistent with national standards.

Alliance has achieved URAC accreditation in four areas: Utilization Management, Call Center, Health Network, and Credentialing.

The Health Utilization Management is the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan. URAC's Health Utilization Management Accreditation ensures that all types of organizations conducting utilization review follow a process that is clinically sound and respects consumers' and providers' rights while giving payers reasonable guidelines to follow.

The Health Call Center provides triage and health information services to the public via telephone, website, or other electronic means. URAC's Health Call Center Accreditation ensures that registered nurses, physicians, or other validly licensed individuals perform the clinical aspects of triage and other health information services in a manner that is timely, confidential, and includes medically appropriate care and treatment advice.

The Health Network is made up of contracted physicians and other health care providers.
URAC's Health Network Accreditation standards include key quality benchmarks for network management, provider credentialing, quality management and improvement, and consumer protection.

The Credentialing Department reviews new and current providers to assure that providers meet all required standards of licensure, legal standing and performance. Alliance has initiated a recredentialing process to assure that all current providers are reviewed at least every three years.

6. Oversight of QM Program Activities

Oversight of Alliance's quality management activities and the Continuous Quality Improvement process is the responsibility of the Alliance Board of Directors, the Board's Global Quality Committee, and the Alliance CQI Committee and its various subcommittees.

a. Board of Directors

Alliance is governed by a Board of Directors which is responsible for overseeing the operations of Alliance and its efforts to provide effective services for children and adults with psychiatric, intellectual/developmental disabilities, or substance use/addiction needs. The Alliance Board consists of community stakeholders that are appointed by their respective County Commissioners. Service providers cannot serve as Board members.

b. Global QM Committee

The Global QMC is the standing committee that is granted authority for Quality Management by the MCO. The QMC reports to the Alliance Board of Directors. The Alliance Board of Directors Chairperson appoints the Quality Management Committee, which consists of seven voting members — a combination of Board members and Consumer and Family Advisory Committee (CFAC) members. Other non-voting members include at least one MCO employee and two provider representatives.

The MCO employees typically assigned include the Director of the Quality Management (QM) Department, who has the responsibility for overall operation of the Quality Management Program; the MCO Medical Director, who has ultimate responsibility of oversight of quality management; and other staff as designated. The Global QMC meets at least six times each fiscal year and provides ongoing reporting to the Alliance Board. The Global QMC approves the MCO's annual Quality Improvement Projects, monitors progress in meeting Quality Improvement goals, and provides guidance to staff on QM priorities and projects. Furthermore, the Committee evaluates the effectiveness of the QM Program and reviews and the QM Plan annually.

c. Alliance Committees

Quality activities at Alliance are overseen internally by the Continuous Quality Improvement Committee and its subcommittees, which focus on program/provider improvement, appropriateness and effectiveness of care and services, integration of healthcare efforts, high-risk and high-cost factors, and utilization of evidence-based practices in the care continuum. Decisions are determined by this committee based on input and feedback from committees, staff and stakeholders.

The CQI subcommittees are:

- Provider Quality
- Utilization Management
- Member Experience
- Care Management
- Social Drivers of Health
- Delegation and Accreditation

Each CQI committee has created a charter defining its purpose, responsibilities, relationships and membership. Responsibilities include developing data and reports on the committee's areas of responsibility; identifying risks and opportunities; reporting these risks/opportunities to the CQI Committee; and updating the CQI Committee on progress towards resolving the identified issues.

The credentialing committee, while not a subcommittee of CQI, submits quarterly reports to the CQI leadership committee as a way to ensure the credentialing function is integrated into the larger quality management framework of Alliance.

d. External Reviews

In addition to internal review by the Alliance Board and the CQI Committee, Alliance's Quality Management program is routinely assessed by external review organizations:

*DHHS Intradepartmental Monitoring Team***:** The North Carolina Department of Health and Human Services' Intradepartmental Monitoring Team (DHHS IMT) is responsible for oversight of Alliance on behalf of the state of North Carolina. The DHHS IMT consists of staff members from the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse (DMH). The DHHS IMT conducts an annual review of Alliance in conjunction with consulting firm Mercer. The annual review includes of a desk review of key documents and an on-site review of the administrative, financial, clinical and quality operations.

External Quality Review (EQR): Under federal law, Alliance must undergo annual external quality review. DHHS contracts with an external quality review organization (EQRO) to conduct the annual review. Alliance completed its first EQR in November 2014. Alliance will undergo its next EQR in 2020.

*URAC***:** Alliance is accredited by URAC in the areas of Health Network, Utilization Management, Health Call Center and Credentialing. URAC required reaccreditation reviews every three years and conducts compliance checks more frequently. During FY 2020, Alliance will undergo reaccreditation by URAC for all modules.

7. QM Department

The Alliance QM Department consists of a QM Director, who oversees three teams: Quality Improvement; Grievances, Incidents, and Appeals; and the Quality Data team.

The QM Director reports directly to the Chief Operating Officer. Alliance's Medical Director provides collaboration and guidance. The medical team meets bi-weekly with QM staff to review quality-related issues.

QM Director: The QM Director manages a Quality Management Department and works closely with all internal departments, sites, boards of directors, CFACs and other external entities as required. The QM Director is involved with overseeing internal and external quality improvement activities throughout the Alliance area. The QM Director develops and designs measurement tools for meeting contractual performance criteria and accreditation requirements. The QM Director oversees organizational and provider assessments, measurements, and research when applicable and/or necessary. The QM Director develops and implements policies and procedures to ensure compliance with regulatory requirements related to quality improvement, outcome monitoring, and evaluation of services and programs.

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. Staffing consists of a Grievance and Incidents Manager and four Quality Assurance Analysts.

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 Review Manager, two Quality Review Coordinator II positions and one Quality Review Coordinator I positions.

Quality Management Data: This team was created during FY18 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, two Power Analysts, and a Data Consultant.

8. Data and Reporting Systems

AlphaMCS: The AlphaMCS system's features include Patient Management; Service Provider Management; Claims Processing; Quality Management; Provider Agency Portal; Reporting; Care Coordination; and EDI. The AlphaMCS system is fully web accessible. The QM Department also is actively involved with the development of new AlphaMCS features and reports. QM staff participates in a weekly AlphaMCS user group teleconference; beta tests new features and reports; and produces AlphaMCS reports for QM and other departments.

Jiva – Jiva is the cutting-edge Alliance care management tool. Jiva works with our other data analytics platforms to help us identify individuals in need of care coordination prior to a crisis event, and to more effectively prioritize populations of people who are at high risk for poor health outcomes. Data in Jiva automatically recommends care plans based on common problems encountered by these populations and generates goals and interventions to help care coordinators engage individuals in appropriate treatment.

State: QM Department staff has access to important online reporting systems run by NC DHHS. These include the NC Treatment Outcomes and Program Performance System (NC-TOPPS), which collects quality data from providers; and the Incident Response Improvement System (IRIS), which is used by providers to report Level II and Level III incidents.

Internal: The QM Department also uses internal database and reporting systems developed by Alliance's IT Department. These include the BI Report System, which provides access to routine reports. QM staff works directly with the IT Department to design, develop and test new BI reports. During FY 2019, Alliance expanded its internal reporting capabilities via contracts with CMT and MicroStrategy. CMT provides reports combining Alliance's encounter data with pharmaceutical and primary care data for Alliance's consumers. MicroStrategy provides advanced analytic tools allowing a broad range of reporting.

9. QM Program Relationships

Continuous Quality Improvement must be ongoing and pervasive. The Alliance QM Program is the responsibility of all staff, and the QM Department has ongoing relationships with all Alliance departments and stakeholders. All Alliance stakeholders – from each staff member, to whole departments, to consumers and providers, to the Alliance Board - contribute to the CQI process.

a. Alliance Staff

Alliance staff work with our community partners to drive improvement efforts across our service delivery network. The QM Department routinely informs staff of quality-related development via updates at all-staff meetings, posting on Alliance SharePoint sites, and updated policies and procedures.

b. Departments

Administration: Alliance's Administration Department is led by the Alliance Chief Executive Officer and his staff. The QM Department assists the CEO with routine reports; ad hoc reports requested by the state and external stakeholders; and special presentations to the Alliance Board of Directors and

county commissioners. The QM Department is represented on Alliance's Executive Leadership Team by the Chief Operating Officer.

Organizational Effectiveness: The Organizational Effectiveness department includes the Strategic Project Management Office, Communications, and Organizational Learning and Development. The QM department has regular meetings with these groups in order to collaborate on enterprise strategic initiatives from the strategic plan.

Medical Affairs Department: The Medical Affairs Department is headed by the Alliance Medical Director and includes Alliance's Peer Advisors. The QM Department meets regularly with the Medical Affairs team to review quality improvement activities. The Medical Affairs team and QM Department have worked together to implement IRR testing of Call Center and UM staff.

The Medical Director and QM staff meet regularly to review quality activities.

Networks Development and Evaluation Department: QM staff assist Provider Networks by developing reports and data sets for Provider Networks staff, reviewing provider contracts, identifying quality issues with providers undergoing recredentialing, and conducting program evaluation studies.

Utilization Management Department: Alliance's UM Department reviews and approves Service Authorization Requests (SARs) from providers for Medicaid and non-Medicaid services. At the request of UM Department leadership, the QM Department's Quality Review Team reviews UM activities and documentation. The QI team also participates in the development and administration of Inter-Rater Reliability testing of UM staff to determine the accuracy and consistency of reviews. The QM Director and other QM staff are members of the UM Committee.

Care Coordination: Alliance provides Care Coordination services to all Innovations enrollees and to high-risk MH/SA consumers with a history of crisis care or other high-cost treatment. This team leverages Jiva, our care management platform, to ensure that members receive the care they need and that their non-clinical needs are met as well.

Access Department: Overseen by the Alliance Chief Clinical Officer, the Alliance Access Department is the first point of contact for consumers seeking services. The QM Department receives routine reports from the Access Department on average speed to answer, abandonment rate and service levels, and includes these reports in Alliance's monthly reporting to the state. The QI team also consults with Access on Inter-Rater Reliability testing of Access staff to determine the accuracy and consistency of communications with consumers and conducts oversight of the delegated contractor for roll-over calls.

Business Operations: The Finance Department manages Alliance's financial activities and claims processing. Finance Department staff assist the QM Department with the development of reports for quality reviews. The Chief Financial Officer is a member of the CQI Committee.

Community Health and Well Being: The Community Health and Well Being Department works with federal/state/local agencies, providers and consumer advocacy groups to improve the delivery of care. QM Department staff assist Community Relations by developing reports required by block grant programs, participating in CQI activities and evaluation with crisis services providers and jail programs, and participating on county-wide Crisis Collaboration provider groups.

Information Technology: The Information Technology Department works with Alliance's IT vendor AlphaMCS to test new features, develops internal database systems, creates reports, supports the Alliance data network, and maintains Alliance's computers. The IT Department also trains Alliance's Business Analysts. The QM Department's Business Analyst is in routine contact with the IT Department to evaluate new database features and reports. The QM Director discusses IT developments as a member of the IT Committee.

Compliance: The Office of Compliance encourages ethical and sound ways to do business in compliance with federal and state law, contractual requirements, policies and accreditation standards. Compliance provides training and manages Alliance's policies and procedures, conducts internal audits, monitoring and investigations to prevent, detect and remediate non-compliance. The Office of Compliance Program Integrity Unit conducts fraud and abuse prevention and detection activities and reports suspected credible allegations of fraud to DMA PI. The QM Department provides Compliance with the results of any analyses finding evidence of non-compliance or fraud and abuse by providers or Alliance staff. The QM Department also informs Compliance of trends in complaints, grievances and incidents involving providers.

c. Individuals Receiving Services

Individuals Receiving Services are represented at Alliance via the Consumer and Family Advisory Committee, or CFAC, which is made up of Individuals Receiving Services and family members who receive mental health, intellectual/developmental disabilities and substance use/addiction services. CFAC is a self-governing committee that serves as an advisor to Alliance administration and the Board of Directors.

Members of the Alliance CFAC collaborated in the choosing of providers to assume the services previously provided by Wake County and participated in Alliance's Board Budget Retreat. They carried their concerns to local legislators about the needs of our communities and served as respected voices at the State CFAC level.

Quality Management Department staff routinely update all CFAC members on Alliance's quality improvement activities. CFAC has representatives as voting members on the Board's Global Quality Management Committee.

d. Providers

The Alliance Provider Advisory Council (APAC) includes representatives from each county within the Alliance catchment area and all age and disability areas. The APAC provides input to Alliance on development and implementation of its Local Business Plan, identification of needs and gaps, and other areas in which provider input is critical. The APAC also coordinates provider feedback from local Provider Advisory Councils in each county.

Quality Management Department staff routinely updates APC on Alliance's quality improvement activities that impact providers. Three providers serve as non-voting members of the Board's Global Quality Management Committee. In addition, the QM Department enrolls providers to participate on advisory committees for quality improvement programs that can benefit from provider input.

The Committee on Provider Quality, a sub-committee of CQI, is composed of a diverse representation of the provider network and serves as a conduit for enhancing provider-led quality initiatives within the network.

The QM Department also informs providers of its activities via presentations at All-Provider meetings, notices in provider communications, and postings on the Alliance web site. QM staff also provides technical assistance for providers on NC-TOPPS and IRIS submissions, and the creation of quality management plans.

10. QM Program Activities

The Alliance QM Program involves a wide range of quality-related activities that are focused on all aspects of Alliance's activities.

a. Quality Improvement Projects

QIPs are formal, long-term initiatives that focus on one or more clinical or non-clinical area(s) with the aim of improving health outcomes and beneficiary satisfaction. Alliance is required to conduct QIPs both under its contracts with DMA and DMH, and also as part of URAC accreditation. Federal regulations also set requirements for QIPs:

- URAC: Alliance must conduct two QIPs for each module for which Alliance accredited: Core, Call Center, Health Utilization Management, and Health Network. A QIP can focus on more than one module. One QIP must focus on consumer safety.

- State Contracts: Alliance must conduct at least 3 QIPs, of which at least one must be clinical and at least one non-clinical. QIPs shall focus on reducing the need for inpatient at community hospitals, and reducing the use of crisis and Emergency Department services.

- Federal regulations: QIPs can be clinical or non-clinical, must impact health or functional status, and reflect high-volume or high-risk populations. Examples include access to care, grievances, appeals and children with special health care needs.

QIPs are typically more resource-intensive and longer-term than other quality improvement activities. Under URAC requirements, the QIP must show sustained improvement for one year after project goals are met.

QIPS are identified by tracking routine performance reports, conducting special quality reviews, reviewing reports from Alliance's CQI subcommittees, and surveying Alliance staff, providers and Individuals Receiving Services and/or families.

A QIP is launched with consultation from the CQI Committee and the Global QM committee when a problem and potential solution have been identified through ongoing data analysis. Data is initially collected to establish a statistical baseline, interventions are implemented, and post-intervention data are collected.

Each QIP is managed by a QM Department staff member who serves as Project Lead. Decisions are made by a dedicated Project Advisory Team consisting of subject matter experts. The team includes a member of Alliance's Medical Affairs department if the QIP addresses clinical issues.

b. Performance Improvement Projects
Performance Improvement Projects are short-term activities addressing a problem identified through ongoing data analysis. The PIP may involve additional data analysis to understand root causes. PIPs are typically less resource-intensive, shorter-term, or more targeted than QIPs. Like QIPs, a PIP may involve multiple interventions.

c. Clinical Practice Guidelines:
Alliance uses clinical guidelines that have been reviewed by the Alliance Clinical Advisory Committee and approved for use by the medical director as part of the medical necessity determination process.

The QM Department assesses provider compliance with the clinical practice guidelines adopted by Alliance. This process involves: identifying two or more milestone elements in a clinical practice guideline; determining provider compliance via data analysis or record reviews; informing providers of any compliance issues via training and other communications; and identifying outlier providers for focused training.

d. Quality Reviews
A Quality Review involves a review of a process or documentation against best practice standards. Quality Reviews are identified through ongoing data analysis, as a contract requirement, or upon request by a department. QM staff will create a review tool based on standards, and rate performance as met/not met/partially met against standards. Staff will then create recommendations or an action plans, and re-evaluate with additional quality review.

e. Studies
A study focuses on a concern identified through ongoing data analysis. QM staff may conduct in-depth data analysis to gain a better understanding of the problems and root causes. Studies typically are less resource-intensive, short-term and targeted. A study may evolve into PIP or QIP.

f. Ongoing Analysis of Data
QM staff develop a report to closely monitor performance data associated with a contract performance measure, HEDIS measures or program requirement. Alliance currently conduct ongoing analyses of crisis data, management reports, utilization, STR, MCO operations, financial, performance of network, and System of Care data.

g. Surveys
QM staff develop and disseminate surveys to gather and incorporate feedback. Respondents include consumers, providers, Area Board members and stakeholders. QM staff also review the findings of surveys conducted by the state and other external parties. These include the annual Perception of Care survey and Provider Satisfaction Survey conducted by the state, and the Provider ECHO Survey conducted as part of the federal EQR process. The QM Department works with the relevant departments and committees to develop, implement and track improvements identified in the survey results.

h. Provider Network

Alliance is required under its state contract to conduct an annual evaluation of its provider network. The evaluation must identify any gaps in coverage or choice for consumers. Alliance's Provider Network Department then creates an annual development plan based on the evaluation's findings.

QM staff support the evaluation process via analysis of provider locations and consumer access, and the creation of "geomaps" illustrate gaps in coverage.

Also at the request of the Provider Network Department, QM staff conducts numerous evaluations of provider programs to further assess the effectiveness of Alliance's provider network.

11. Grievances

A grievance is an expression of dissatisfaction about any matter other than decisions regarding requests for Medicaid services. Alliance's goal is to use a fair, impartial and consistent process for receiving, investigating, resolving and managing grievances filed by consumers or their legal guardians/representatives concerning Alliance staff or Network Providers.

Examples of a grievance may include but are not limited to grievances about quality of care, failure of the provider or Alliance to follow Client Rights Rules; failure of providers to provide services in the consumer's PCP or ISP including emergency services noted in the crisis plan and interpersonal issues such as being treated rudely. Consumers, or a network provider authorized in writing to act on behalf of a consumer, may file a grievance.

The QM Department's Grievance and Incident Team is responsible for processing grievances submitted from within and outside Alliance. Grievances first are designated as Medicaid-related or non-Medicaid-related depending on consumer eligibility.

Medicaid: QM staff will notify, in writing by U.S. mail, the complainant within five (5) working days of receiving the grievance to acknowledge receipt of the grievance and communicate whether the grievance will be initially addressed informally or by conducting an investigation. Alliance's initial response to a grievance shall be to attempt to resolve the issue through informal dialogue and to reach agreement between the parties.

Alliance will seek to resolve grievances expeditiously and provide written notice by U.S. mail to all affected parties no later than ninety (90) calendar days of the date Alliance received the grievance. Alliance may extend the timeframe by up to fourteen (14) calendar days if the client requests extension or there is a need for additional information and the delay is in the best interest of the client.

Non-Medicaid: QM staff will notify in writing by U. S. mail the complainant within five (5) working days of receiving the grievance regarding whether the grievance will be initially addressed informally or by conducting an investigation. Alliance's initial response to a grievance shall be to attempt to resolve the issue through informal dialogue and to reach agreement between the parties. Alliance will seek to resolve grievances expeditiously and provide written notice by U.S. mail to all affected parties no later than fifteen (15) calendar days of the date Alliance received the grievance. If the grievance is not resolved within fifteen (15) working days, then QM staff will send a letter to the complainant updating progress on the grievance resolution and the anticipated resolution date.

12. Incidents

Providers must implement procedures that ensure the review, investigation, and follow up for each incident that occurs through the Providers' internal quality management process. This includes:

- A review of all incidents on an ongoing basis to monitor for trends and patterns.
- Strategies aimed at the reduction/elimination of trends/patterns.
- Documentation of the efforts toward improvement as well as an evaluation of ongoing progress.
- Internal root cause analyses on any deaths that occur.
- Mandatory reporting requirements are followed.
- Entering Level II and III incidents into the State's Incident Response Improvement System (IRIS).

An incident is an event at a facility or in a service/support that is likely to lead to adverse effects upon a consumer. Incidents are classified into several categories according to the severity of the incident. All Category A and B Providers serving consumers in the Alliance catchment area are required to report Level II or Level III incidents to Alliance within seventy-two (72) hours of the incident. The report also must be reported in the state's web-based Incident Response Improvement System (IRIS). All crisis providers are required to report incidents that occur during the provision of crisis services.

The QM Department's Grievance and Incidents Team is responsible for tracking incident reporting by network providers. The goal is a uniform and consistent approach for the monitoring of and response to incidents which are not consistent with the routine operations of a facility or service or the routine care of a client enrolled in the Alliance network.

Upon receipt, QM staff reviews all incidents for completeness, appropriateness of interventions and achievement of short and long term follow up both for the individual consumer, as well as the Provider's service system. If questions/concerns are noted when reviewing the incident report, QM staff will work with the provider to resolve these.

If concerns are raised related to consumer's care, services, or the provider's response to an incident, an onsite review of the Provider may be arranged. If deficiencies are found during the review process, the provider will be required to submit and implement a plan of correction. QM staff will provide technical assistance as needed and appropriate to assist the Provider to address the areas of deficiency and implement the plan.

13. Provider Monitoring

Alliance is required under its state contract to routinely monitor its providers to assure compliance with state and federal regulations, and patient rights requirements The QM Department works closely with Provider Monitoring. Most importantly, the QM Department is responsible for recommending a special provider monitoring when QM has found a series of grievances or incidents that raise issues of provider performance or consumer safety.

14. Over/Under Utilization

Service over/under utilization may indicate poor quality and potentially inefficient care. To ensure the appropriate provision of services, Alliance implements a program that monitors a broad range of data to determine variations in the use of service across providers and levels of care. The UM Committee, a CQI subcommittee, and Clinical operations leadership are responsible for detecting over and under-utilization and analyze claims (encounter) data and authorization data on a monthly basis to determine

utilization patterns. Data analysis will identify the potential need for further review. Data reviewed includes:

- Average Length of stay in inpatient and residential facilities
- Provider treating multiple family members individually
- Consumers receiving multiple services
- High cost/high utilized service trends
- Use of evidenced based services
- Inpatient Readmissions
- High volume of authorized units compared to billing
- Higher than average costs per treatment episodes

In the event that data analyses identify questionable patterns, Alliance may contact Providers to review their medical records in order to identify the reasons particular practice patterns are different from the norm. Although this could be a function of the Provider's case mix severity, it could also indicate potential problems that need to be resolved.

Clinical Operations leadership may refer to the UR Manager for a record review or may refer cases to the Compliance Department for a further review. Responses to validated utilization issues include, training and technical assistance, increased monitoring or referral to the Special Investigations unit if the over-utilization appears to be driven by wasteful practice of fraudulent billing. Alliance also may initiate internal action plans to ensure more appropriate service management by the clinical operations department if utilization issues are related to poor oversight and care coordination.

15. Training

Alliance provides timely and reasonable training and technical assistance to providers on a regular basis in the areas of State mandates and initiatives, or as a result of monitoring activities related to services for which the provider has a contract with Alliance. A wide variety of links to web-based resources of potential interest to the Provider Network can be found on the Alliance website at: https://www.alliancehealthplan.org/videoswebinars/

Training of both internal and external stakeholders is an essential part of Alliance's quality program. In particular, the QM Department plays a significant role in developing training to inform stakeholders and staff of quality processes in general, and processes actively subject to quality improvement activities.