FY 2019 Quality Management
Program Evaluation

Approval

The Alliance FY 2019 Quality Program Evaluation 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

Revised August 8, 2019
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1. Purpose

Alliance is committed to providing quality and effective care to individuals in Wake, Durham, Cumberland and Johnston Counties.

The purpose of this Quality Management Evaluation Report is to review Alliance Health’s progress at implementing the quality management activities required under its contract with the North Carolina Department of Health and Human Services (DHHS) and as a URAC-accredited organization.

This report also will identify areas needing improvement and establish future quality management program strategies.

2. Alliance Quality Program

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. Within Alliance, the Continuous Quality Improvement (CQI) Committee and its seven 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.

<table>
<thead>
<tr>
<th>FY 2019 Goal</th>
<th>Alliance will augment its internal data sharing and reporting to ensure that staff across all departments actively manage performance on quality metrics.</th>
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</thead>
</table>
| FY 2019 Performance | Highlights of Alliance’s Quality Program include:  
- A Care Management Software (Jiva) Platform was implemented for Care Coordination in October 2018. Configuration of the UM and appeals modules are currently in process. The tool standardizes efforts, promotes increased quality and efficiency, and offers enhanced tracking of cases, activities, and outcomes.  
- Implementation of Alliance Complete Care, a transition to a multi-disciplinary team approach to care management building on the success of the Complex Integrated Care Team.  
- Implementation of an advance analytics model to identify risk factors for members and assist with assignment to care teams to address most effectively address the member’s needs.  
- Implementation of additional value based service contracts for Enhanced Therapeutic Foster Care and Family Centered Treatment.  
- Implemented a standardized SDOH screening tool within Jiva  
- Improved satisfaction with grievance resolutions resulting in dramatically lower appeal rates  
- Reduced late submission of critical incident reports |
| FY 2020 Strategy | Alliance will build upon these successes by restructuring the Continuous Quality Improvement committee to facilitate additional cross departmental collaboration on quality initiatives. |

a. QM Department

As of June 30, 2019, the Alliance QM Department consisted of a QM Director who oversaw three teams:

Grievance and Incidents: 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 five 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, one Power Analyst, and two Data Consultants.

**FY 2019 Goal**
QM will utilize the addition of the data team to meet the needs of internal and external stakeholders working on quality initiatives with speed and accuracy.

**FY 2019 Performance**
The Quality Improvement team has successfully managed cross functional improvement efforts as well as assisting other business units with process mapping and evaluation of existing work procedures. The QM data team has produced reports analyzing data for a wide range of departments. These reports have been used to identified utilization trends as well as potential quality improvement targets. This effort has allowed for a more focused use of internal resources where they can be utilized most effectively. The Grievance and Incidents team has worked with providers to improve the timely submission of critical incident reports, allowing more prompt notification and resolution.

**FY 2020 Strategy**
Transition oversight of accreditation and appeals to the Quality Management department and integrate those function into the existing team.

**b. Quality Committees**

Alliance’s continuous quality improvement program is reviewed and approved by the Global Quality Management Committee, a subcommittee of Alliance’s Board of Directors. The internal CQI Leadership Committee oversees quality improvement activities through seven subcommittees:

- Budget and Finance
- Community Relations
- Compliance
- Information Technology
- Provider Networks
- Provider Quality
- Utilization Management

**FY 2019 Goal**
Continue to streamline the CQI committee and subcommittees to support quality initiatives as nimbly as possible.

**FY 2019 Performance**
Alliance continues to make great use of the Provider Quality Committee as a formal subcommittee of CQI. The purpose of this committee is threefold: a) to engage Alliance Health (AH) providers in developing, evaluating
and approving guidelines for clinical practice across the network, b) to engage AH providers in the systematic monitoring and evaluation of provider performance measures required by DMA and DMH and included in Alliance provider contracts, and c) to provide a forum for bidirectional communication between Clinical and Medical directors and AH.

Alliance has continued to make good use of this committee structure. However, due to the organization of the subcommittees by department there is a risk for initiatives to become isolated into a single department rather than explored cross functionally as intended. This risk will be mitigated by a restructuring of the CQI subcommittees.

**FY 2020 Strategy**

Restructure CQI by quality function rather than department in order to ensure that stakeholders from across different departments are engaged in quality activities.

c. **Provider Participation in the QM Program**

The Global Quality Management Committee is required to include non-voting provider representatives. In addition, the QM Department is required to update the Alliance Provider Advisory Committee on QM activities annually.

**FY 2019 Goal**

Alliance will continue to seek provider involvement in quality activities such as including performance metrics in provider contracts, developing best practice guidelines, and other ad hoc issues through existing committees.

**FY 2019 Performance**

Alliance continues to make great use of the Provider Quality Committee as a formal subcommittee of CQI. The purpose of this committee is threefold: a) to engage Alliance Health (AH) providers in developing, evaluating and approving guidelines for clinical practice across the network, b) to engage AH providers in the systematic monitoring and evaluation of provider performance measures required by DMA and DMH and included in Alliance provider contracts, and c) to provide a forum for bidirectional communication between Clinical and Medical directors and AH.

Provider representatives serve as two non-voting members of the Global Quality Management Committee. Additionally, providers sit on all relevant QIP advisory teams and a variety other work groups related to provider issues.

Providers also work with Alliance and community leadership in seven collaboratives focusing on quality efforts related to specific populations or service lines.

**FY 2020 Strategy**

Reorganizing the CQI structure by functional rather than Alliance department will create opportunities for providers to participate in additional CQI subcommittees.

d. **Member Participation in the QM Program**

The Global Quality Management Committee includes voting member/family representatives. In addition, the QM Department provides updates on QM activities to update the Alliance Consumer and Family Advisory Committee (CFAC) at least annually.

**FY 2019 Goal**

Alliance will continue to identify opportunities to expand individual/family representative participation in quality improvement activities.
FY 2019 Performance
During FY 2019, Alliance met the requirement for individual/family participation in the QM program by maintaining voting CFAC members on the Global Quality Management Committee.

FY 2020 Strategy
Reorganizing the CQI structure by functional rather than Alliance department will create opportunities for members to participate in additional CQI subcommittees.

3. Quality Work Plan Evaluation

The quality work plan contains a wide range of quality initiatives, the largest in scale and impact are listed below in this section.

a. Quality Improvement Projects

A QIP is an organization-wide initiative to assess and improve the processes and outcomes of health care services and delivery. Alliance must conduct various QIPs in order to meet requirements set by the state, URAC and the federal government:

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

  State Contracts: Alliance must conduct at least 3 QIPs, of which at least one must be clinical and at least one non-clinical).

- 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 at least one year after project goals are met.

NOTE: Details about each QIP and its current status are available separately on formal QIP Report Forms.

FY 2019 Goal
Alliance will meet all contract and accreditation requirements for QIPs.

FY 2019 Performance
Alliance had ten QIPs open during FY19:

- Access to Care – Routine/Urgent
- Access to Care – Emergent
- MHSUD Care Coordination
- Post-acute stabilization services (UM Expedite Care)
- TCLI – Expedite Housing
- Call Center – LTSS Communication Timeliness
- Utilization Management – Member Adverse Decision Notifications
- Provider Network – Provider Profile Upgrades
- Intensive In-Home Services
- UM TAT for Innovations
Analysis: Alliance met the federal, state and URAC requirements for the number and types of QIPs.

The following six QIPs were closed after achieving the performance goals:
- First Responder
- TCLI Private Landlords
- Innovations Engagement of Services
- Access to Care – Emergent
- UM TAT for Innovations
- Intensive In-Home Services

Seven QIPs will be continued into FY20:
- Access to Care – Routine/Urgent
- MHSUD Care Coordination
- Post-acute stabilization services (UM Expedite Care)
- TCLI – Expedite Housing
- Call Center – LTSS Communication Timeliness
- Utilization Management – Member Adverse Decision Notifications
- Provider Network – Provider Profile Upgrades

**FY 2020 Strategy**

Alliance will continue the QIPs identified above which have not yet met performance targets. Alliance will add additional QIPs in order to meet contract and accreditation requirements. The new QIPs for FY20 are:
- MHSUD Care Coordination
- Call Center – LTSS Communication Timeliness
- Utilization Management – Member Adverse Decision Notifications

**b. Network Adequacy and Accessibility Analysis**

Alliance is required to produce an annual Community Needs Assessment and Gaps Analysis to identify community service needs and gaps. The report informs and guides provider network development activities via a formal Network Development Plan.

**FY 2019 Goal**

Alliance submitted the FY 2018 Needs Assessment Report to the state on September 21, 2018. Alliance identified the following priorities:
- Expand capacity for crisis, hospital diversion and respite services for all ages/disabilities
- Increase interventions and supports for individuals with complex needs
- Develop an array of recovery-oriented, individualized and person-centered services that promote community inclusion
- Improve service outcomes by addressing social determinants of health
- Improve public awareness of services
- Improve service availability and access
- Develop and enhance the continuum of care for individuals with Substance Use Disorders
- Improve access to services for individuals with I/DD who are not on Innovations waiver

**FY 2019 Performance**

Alliance has made progress on a number of significant needs and gaps that were identified as priorities for the FY2019 Network Development Plan. Over the past year, we have:
- Implemented Enhanced Mobile Crisis Pilot in Wake County
- Implemented Behavioral Health Urgent Care in Wake County
- Improved timely access to aftercare appointments following inpatient, facility-based crisis or non-hospital detoxification treatment
- Continued implementation / expansion of Day Treatment services in Cumberland
- Transitioned PSR programs to recovery-oriented psychiatric rehabilitation models
- Improved quality and consistency of Peer Support services through revision of the Peer Support service definition and technical assistance for providers
- Expanded vocational and educational services & supports
- Continued housing initiatives, including Supportive Housing and Group Living Step Down projects
- Developed services to address transportation challenges
- Implemented Health Literacy initiatives
- Improved availability of information to the public about service availability and access
- Improved access to services for non-English speaking consumers
- Expanded opioid treatment availability
- Implemented behavior plans, services for individuals on Innovations waitlist, services for individuals with autism spectrum diagnosis

For additional details about identified needs and progress towards meeting them please review the full Network Adequacy and Accessibility Analysis Report on our website: [https://www.alliancehealthplan.org/](https://www.alliancehealthplan.org/)

**FY 2020 Strategy:**

Alliance submitted the FY 2019 Network Adequacy and Accessibility Analysis Report on July 1, 2019. Alliance will take the findings from the report and develop network interventions to address gaps that have been identified.
4. Alliance Network Performance
   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, and Appendix B for raw scores for these measures.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Goal</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call Abandonment Rate</td>
<td>&lt;5%</td>
<td>✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔</td>
</tr>
<tr>
<td>Live Answer within 30 seconds</td>
<td>&gt;95%</td>
<td>✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔</td>
</tr>
<tr>
<td>Access to Care - Emergent(^1)</td>
<td>&gt;97%</td>
<td>✔ ✔ ✔ ✔ ❌ ❌</td>
</tr>
<tr>
<td>Access to Care - Urgent(^2)</td>
<td>&gt;82%</td>
<td>❌ ❌ ❌ ❌ ❌</td>
</tr>
<tr>
<td>Access to Care - Routine(^3)</td>
<td>&gt;75%</td>
<td>❌ ❌ ❌ ❌ ❌</td>
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<tr>
<td>Contract Super Measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid - Mental Health 7-Day Follow Up</td>
<td>&gt;40%</td>
<td>✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔</td>
</tr>
<tr>
<td>Medicaid - Substance Use 7-Day Follow Up(^4)</td>
<td>&gt;40%</td>
<td>❌ ❌ ❌ ❌ ✔ ✔ ✔ ✔ ✔ ✔</td>
</tr>
<tr>
<td>Medicaid - Innovations Waiver Primary Care</td>
<td>&gt;90%</td>
<td>✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔</td>
</tr>
<tr>
<td>Non-Medicaid - Mental Health 7-Day Follow Up(^5)</td>
<td>&gt;40%</td>
<td>❌ ❌ ❌ ✔ ✔ ✔ ✔ ✔ ✔</td>
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<tr>
<td>Non-Medicaid - Substance Use 7-Day Follow Up(^6)</td>
<td>&gt;40%</td>
<td>❌ ❌ ❌ ❌ ❌ ❌ ❌ ❌ ❌ ❌</td>
</tr>
<tr>
<td>TCLI - Housing</td>
<td>&gt;88</td>
<td>✔</td>
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<tr>
<td>Care Coordination Assignment</td>
<td>&gt;85%</td>
<td>✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔</td>
</tr>
<tr>
<td>Authorizations Processed within Timeframes</td>
<td>&gt;95%</td>
<td>✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔</td>
</tr>
<tr>
<td>Claims Proceed within 30 Days</td>
<td>&gt;90%</td>
<td>✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔</td>
</tr>
<tr>
<td>Resolution of Grievances within 30 Days(^7)</td>
<td>&gt;90%</td>
<td>✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔ ✔</td>
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</table>

\(^1\) Access to care Emergent – The benchmark was missed in Q3 (96%) and Q4 (96%) however, due to the low volume of calls that meet this criteria (57 and 48 respectively) and the very high benchmark of 97%, only one caller can be missed per quarter and in each of the two quarters that fell below the benchmark two callers received care outside of the timeframe.

\(^2\) Access to care Urgent - Performance for all four quarters fell below the benchmark (37%, 37%, 40%, 43% for each respective quarter). However, the intervention of using Mobile Crisis Services for callers who need care within 8 hours of phone call has been successful and is reflected in the improvement over the last year.

\(^3\) Access to care Routine – Performance for all four quarters fell below the benchmark (43%, 43%, 49%, and 44% for each respective quarter). During this year Alliance started a transport pilot to assist members getting to their appointments and to pharmacies using ride sharing companies. Use of the service has been low and we are adapting our strategies to drive higher utilization of the service.

\(^4\) Medicaid Substance Use Follow Up – Performance by month: 29.4%, 38.6%, 37.8%, 36.5%, 42.6%, 38.7%, 46.2%. Two of the last three validated measurement periods have met the benchmark suggesting that the wide variety of efforts to improve performance have begun to show impacts. The data show a trend of improvement in this measure over the year.

\(^5\) Non-Medicaid Mental Health Follow Up – Performance by month: 38.7%, 33.5%, 33.7%, 40.0%, 31.3%, 30.1%, 33.8%. This measure was met for one month. Alliance continues to identify creative solutions by leveraging our care coordination team, providers, and quality resources. However, many of these efforts are impacted by funding cuts and some potential interventions are not feasible given the current funding levels.

\(^6\) Non-Medicaid Substance Use Follow Up – Performance by month: 21.8%, 21.9%, 27.0%, 23.6%, 25.7%, 19.8%, 34.0%. Performance on this measure has fell below the benchmark for every reported month. Alliance continues to identify creative solutions by leveraging our care coordination team, providers, and quality resources. However, many of these efforts are impacted by funding cuts and some potential interventions are not feasible given the current funding levels.

\(^7\) Grievances – Staff turnover resulted in a temporary decrease in the number of complaints resolved within 30 days during March (86%), April (79%) and June (85%). Staff have been hired and trained and this issue should not reoccur due to...
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<th>Metric</th>
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<th>M</th>
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<tbody>
<tr>
<td>Members receiving services within 45 days of ISP</td>
<td>85%</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
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<tr>
<td>Percent of Actions Taken to Protect the Beneficiary</td>
<td>85%</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Incidents reported within timeframes</td>
<td>85%</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.</td>
<td>85%</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Medication errors resulting in medical treatment.</td>
<td>&lt;15%</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Beneficiaries who received appropriate medication</td>
<td>85%</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Incidents where required LME/PIHP follow-up interventions were completed</td>
<td>85%</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Percentage of incidents referred to the DSS or DHSR</td>
<td>85%</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Percentage of restrictive interventions resulting in medical treatment.</td>
<td>&lt;15%</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Level of Care evaluations completed at least annually for enrolled beneficiaries</td>
<td>85%</td>
<td>✓</td>
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<tr>
<td>Level of Care evaluations completed using approved processes and instrument</td>
<td>85%</td>
<td>✓</td>
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<tr>
<td>New Level of Care evaluations completed using approved processes and instrument</td>
<td>85%</td>
<td>✓</td>
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<tr>
<td>Individual Support Plans that address identified health and safety risk factors</td>
<td>85%</td>
<td>✓</td>
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<tr>
<td>PCPs that are completed in accordance with DMA requirements.</td>
<td>85%</td>
<td>✓</td>
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*Measure has not yet been reported for this Fiscal Year.

Innovations annual and the second semi-annual measures are not reported for FY 2019 in this document as they are not due until November.

changes in how grievances according to resolution timeframe requirements.

Innovations Members Receiving Services within 45 Day – This measure was not met for two of the three quarters reported (100%, 75%, and 75% respectively). However, only three of twenty six individuals failed to hit this measure for the year so far which puts the overall performance for the year above the benchmark. Each of the three had extenuating circumstances that our care coordination team was aware of and managing. This performance gap appears to be driven by the timeframe in which new members arrive on the innovations waiver and a few individual circumstances.

Innovations Incidents Reported within Timeframes – This measure was not met for one of the three quarters reported (72%, 93%, and 90% respectively). A procedure was developed at the start of FY19 to address timely submission of incident reports, to include sanctions for providers who did not demonstrate improvement. Implementation of this procedure was closely monitored during 1st quarter to evaluate response and effectiveness. At the beginning of 2nd quarter, thresholds were refined to reduce leniency in the number of late submissions that would trigger a written warning and/or plan of correction. This change has a resulted in improved performance which has been sustained.
b. Transition to Community Living Initiative

The Transitions to Community Living Initiative is the result of the State of North Carolina entering into a settlement agreement with the United States Department ofJustice (USDOJ) on August 23, 2012. The purpose of this agreement is to assure that persons with mental illness are allowed to reside in their communities in the least restrictive settings of their choice.

Housing:

**FY 2019 Goal**
Alliance’s goal for FY19 was to increase the number of individuals maintained in supportive housing by 74.

**FY 2019 Performance**
Alliance increased the number of individuals housed by 81 individuals, exceeding the goal.

**FY 2020 Strategy**
Alliance will build on successes and support individuals so that they can remain in their communities.

Supported Employment: Part of the settlement state that North Carolina will use an evidence-based practice to assist individuals in preparing for, identifying, and maintaining integrated, paid, competitive employment.

**FY 2019 Goal**
Alliance’s goal for FY19 was to engage 60 individuals meeting priority population criteria in supported employment services.

**FY 2019 Performance**
Alliance served 53 individuals meeting priority population criteria in supported employment services. This fell below the benchmark by 7 individuals served.

**FY 2020 Strategy**
Alliance will work with providers of supported employment and build referral pipelines to ensure that the benchmark is met in FY19. Additionally, this performance will be explored as a potential QIP.

c. Grievances

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.

**FY 2019 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.

**FY 2019 Performance**

<table>
<thead>
<tr>
<th>Primary Nature of Complaint</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
<th>Pct.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse, Neglect, Exploitation</td>
<td>17</td>
<td>19</td>
<td>22</td>
<td>9</td>
<td>67</td>
<td>11.8%</td>
</tr>
<tr>
<td>Access to Services - Difficulty or Inability to obtain services</td>
<td>40</td>
<td>40</td>
<td>21</td>
<td>11</td>
<td>112</td>
<td>19.7%</td>
</tr>
<tr>
<td>Administrative Issues by Provider</td>
<td>21</td>
<td>21</td>
<td>5</td>
<td>4</td>
<td>51</td>
<td>9.0%</td>
</tr>
<tr>
<td>Basic Needs</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>10</td>
<td>1.8%</td>
</tr>
<tr>
<td>Authorization/ Payment/ Billing - Provider ONLY</td>
<td>12</td>
<td>13</td>
<td>4</td>
<td>4</td>
<td>33</td>
<td>5.8%</td>
</tr>
<tr>
<td>Authorization/ Payment/ Billing - LME-MCO ONLY</td>
<td>5</td>
<td>7</td>
<td>3</td>
<td>4</td>
<td>19</td>
<td>3.3%</td>
</tr>
<tr>
<td>Confidentiality/ HIPAA</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>8</td>
<td>1.4%</td>
</tr>
</tbody>
</table>
### Client Rights

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
<th>Pct.</th>
</tr>
</thead>
<tbody>
<tr>
<td>LME-MCO Functions</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>5</td>
<td>35</td>
<td>6.2%</td>
</tr>
<tr>
<td>(excluding Authorization/Payment/Billing)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Choice</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Quality of Care by</td>
<td>71</td>
<td>39</td>
<td>38</td>
<td>42</td>
<td>190</td>
<td>33.5%</td>
</tr>
<tr>
<td>Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Coordination</td>
<td>5</td>
<td>10</td>
<td>0</td>
<td>4</td>
<td>21</td>
<td>3.7%</td>
</tr>
<tr>
<td>Between Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>10</td>
<td>0</td>
<td>6</td>
<td>21</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

*Measure has not yet been reported for this Fiscal Year.

Source: FY 2019 Alliance Quarterly Complaints Reports

### Investigations

<table>
<thead>
<tr>
<th>Investigations</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints that Resulted in an Investigation</td>
<td>11</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Complaints that Did Not Result in an Investigation</td>
<td>182</td>
<td>159</td>
<td>114</td>
<td>92</td>
<td>547</td>
</tr>
</tbody>
</table>

*Measure has not yet been reported for this Fiscal Year.

Source: FY 2019 Alliance Quarterly Complaints Reports

### Number of Complaints Not Investigated that Were:

<table>
<thead>
<tr>
<th>Resolved By</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolved By Working with Provider</td>
<td>48</td>
<td>46</td>
<td>35</td>
<td>35</td>
<td>164</td>
</tr>
<tr>
<td>Resolved By Referral to Community Resource and/ or Advocacy Group</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Resolved by Providing Information or Technical Assistance to Complainant</td>
<td>116</td>
<td>99</td>
<td>59</td>
<td>51</td>
<td>325</td>
</tr>
<tr>
<td>Resolved By Referring to an External Licensing or State Agency</td>
<td>18</td>
<td>11</td>
<td>18</td>
<td>6</td>
<td>53</td>
</tr>
<tr>
<td>Referred to Another LME/ MCO for resolution</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Resolved By Mediating With Parties</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: FY 2019 Alliance Quarterly Complaints Reports

### Analysis:

During FY2019, Alliance received a total of 568 complaints. The largest number of these (190 or 33.5%) were related to the Quality of Care of provider services. 3.8% of complaints required a formal investigation by Alliance. Most (89.4%) of the complaints that did not require investigation were resolved by working with the provider or providing information or technical assistance to the complainant.

### FY 2020 Strategy:

Continue to address the concerns of each complainant ensure excellent care is delivered to our members and to minimize appeals of grievance resolutions.

d. **Adverse Incident Reports**

Alliance tracks the submission of Level 2 and 3 critical incidents reported by providers.
**FY 2019 Goal**
Ensure that all critical incidents are appropriately addressed to ensure member safety.

**FY 2019 Performance**

**Level 2 Critical Incident Reports**

<table>
<thead>
<tr>
<th></th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY19</td>
<td>184</td>
<td>195</td>
<td>161</td>
<td>202</td>
<td>356</td>
<td>276</td>
<td>276</td>
<td>283</td>
<td>240</td>
<td>221</td>
<td>230</td>
<td>173</td>
</tr>
</tbody>
</table>

Source: FY 2019 Alliance LME-MCO Monthly Reports

**Level 3 Critical Incident Reports**

<table>
<thead>
<tr>
<th></th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY19</td>
<td>28</td>
<td>45</td>
<td>21</td>
<td>35</td>
<td>26</td>
<td>30</td>
<td>42</td>
<td>24</td>
<td>35</td>
<td>30</td>
<td>27</td>
<td>26</td>
</tr>
</tbody>
</table>

Source: FY 2019 Alliance LME-MCO Monthly Reports

Analysis: The trend of more level 3 incidents beginning last year continued. This was expected due to updated guidance from the state shifting some categories of incidents to level 3 from level 2. However, due to a number of late incident submissions Alliance implemented plans of corrections for providers with patterns of late submissions. This change has reduced the late submission of incidents from over 30% late to only 9% late during FY19.

**FY 2020 Strategy:**
Continue to work with providers, members, and other state agencies to ensure that all critical incidents are addressed appropriately to ensure member safety.

e. **Member Authorization Appeals**

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

**FY 2019 Goal**
Ensure that appeals are appropriately addressed to ensure that members receive the care they need.

**FY 2019 Performance**

<table>
<thead>
<tr>
<th></th>
<th>FY19Q1</th>
<th>FY19Q2</th>
<th>FY19Q3</th>
<th>FY19Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Member Authorization Appeals Received</td>
<td>38</td>
<td>38</td>
<td>53</td>
<td>43</td>
</tr>
<tr>
<td>Rate of Member Authorization Appeals per 1,000 Persons Served</td>
<td>1.96</td>
<td>1.96</td>
<td>2.74</td>
<td>2.22</td>
</tr>
<tr>
<td>Number of Authorizations Overturned or Partially Overturned due to Member Appeals</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: FY 2019 Alliance LME-MCO Monthly Reports

Alliance continues to have 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.

**FY 2020 Strategy:**
Continue to process appeals and provide feedback to the utilization management department about trends as they arise.

f. **Surveys**

a. **Provider Satisfaction Survey**
The 2018 DHHS Provider Satisfaction Survey was conducted by the Carolina Centers for Medical Excellence (CCME) under contract with DHHS.

**FY 2019 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.

**FY 2019 Performance**

- At or above state average for all questions
- Significantly higher than state average for:
  - Provider Network meetings are informative and helpful
  - Overall satisfaction with Provider Network
  - LME/MCO staff are referring consumers whose clinical needs match the service(s) my practice/agency provides
  - LME/MCO staff is easily accessible for information, referrals, and scheduling of appointments
  - Our interests as a network provider are being adequately addressed in the local Provider Council
- Claims was the most improved area from 2017 to 2018 — significant increase in processing time
- Clinical Coverage Policies and Quality Management/Reporting remain the two highest areas of training requested — since 2014. Training requests overall have decreased

**NOTE:** For full results of the visit our website: https://www.alliancebhc.org/providers/quality-management/

**FY 2020 Strategy**

**Areas of focus:**

- **Appeals:**
  - Satisfaction with the appeals process was the lowest score
  - Although appeals remained one of the least requested trainings, the percentage of requests increased the most out of all trainings

**b. 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.

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.

**FY 2019 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.

**FY 2019 Performance**

**Adult Survey Findings:**

- General Satisfaction: Ranked 6th out of 7 – AH 93% vs. state 93%
- Domains with scores at or above state average:
  - Access
  - Treatment Planning
  - Quality and Appropriateness
  - Outcomes
Social Connectedness
General Satisfaction

Domains with scores lower than state average:
- Functioning (AH 77% vs. state 78%)

Youth Survey Findings:
- General Satisfaction: Ranked 4th out of 7 – AH 86% vs. state 85%
- Domains with scores at or above State average:
  - Treatment Planning
  - Cultural Sensitivity
  - Outcomes
  - General Satisfaction
- Domains with scores lower than state average:
  - Access (AH 76% vs. state 81%)

Family Survey Findings:
- General Satisfaction: Ranked 5th out of 7 – AH 92% vs. state 93%
- Domains with scores at or above state average:
  - Cultural Sensitivity
  - Social Connectedness
- Domains with scores lower than state average:
  - Access (AH 86% vs. state 91%)
  - Treatment Planning (AH 93% vs. state 94%)
  - Child Functioning (AH 66% vs. state 70%)
  - Child Outcomes (AH 66% vs. state 70%)
  - General Satisfaction (AH 92% vs. state 93%)

LME-MCO Network Findings:
- Scored below state average for all five measures
- Transportation cost/availability scored highest for obstacles to receiving services (AH 10% vs. state 11%)

Physical Health Measure Findings:
- Health status scored improved from 63% in 2017 to 70% saying they are in “good,” “very good,” or “excellent” health (AH 70% vs. state 68%)
- 63% of respondents reported having a routine physical health check-up in the past year (state 63%)
- 36% of respondents reported having a routine dental care visit in the past year (state 38%)
- High blood pressure (33%) was the most frequently reported chronic condition, followed by asthma (20%) and high cholesterol (20%)
- 44% of respondents reported that they do not smoke or use tobacco/nicotine (state 37%)
- 51% of respondents reported having an emergency plan, 32% reported having an emergency kit, and 62% reported having a behavioral health crisis plan – all scores were below state average

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

FY 2020 Strategy
Areas of focus:
- Access – scores declined for all survey groups
- Scores for 5 out of 7 of the family domains were below the state average. Child outcomes and child functioning were the lowest scores for AH.
c. 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.

FY 2019 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.

FY 2019 Performance

Adult Survey Findings:
- Ranked 3rd overall for Rating of Counseling and Treatment
- Above state average: How Well Clinicians Communicate and Getting Treatment; Information from the Plan
- Below state average: Perceived Improvement; Information about Treatment Options

Child Survey Findings:
- Ranked 2nd overall for Rating of Counseling and Treatment
- Above state average: How Well Clinicians Communicate (statistically significantly) and Perceived Improvement
- Below state average: Getting Treatment Quickly (statistically significantly) and Getting Treatment and Information from the Plan

NOTE: For full results of the visit our website: [https://www.alliancebhc.org/providers/quality-management/](https://www.alliancebhc.org/providers/quality-management/)

FY 2020 Strategy

The ECHO survey findings are presented with prioritization based upon scoring and correlation with satisfaction scores. Below is a summary of those findings:

Adult Survey:
- Top priority: Getting Treatment Quickly; Perceived Improvement
- Medium priority: Information about Treatment Options; Getting Treatment and Information from the Plan
- Low priority: How Well Clinicians Communicate

Child Survey:
- Ranked 4th overall for Rating of Counseling and Treatment
- Maintain high performance: How well Clinicians Communicate
- Medium priority: Perceived Improvement; Getting Treatment Quickly; Getting Treatment and Information from the Plan

d. National Core Indicators

The National Core Indicator (NCI) survey was administered March 2018 – June 2018 to adult members as well as families/guardians of children under the age of 18 that live at home, families/guardians of adults 18 or older who live at home, and families/guardians of adults 18 or older who do not live at home. The purpose of this
The survey is to track individual changes and systematic performance for people with intellectual and developmental disabilities (IDD) and their families. NCI is a collaboration between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Service Research Institute (HRSI). The survey consists of questions associated with five main domains including (1) outcomes, (2) family outcomes, (3) health, welfare and rights, (4) staff stability and competence, and (5) system performance. LME-MCOs are required to provide samples for the Child Family Survey (CFS), Adult Family Survey (AFS), Family/Guardian Survey (FGS), and the In-Person Survey (IPS). In addition, each LME-MCO is required to obtain consents and complete background surveys for members who have agreed to participate in face-to-face IPS.

### FY 2019 Goal

Alliance works with DHHS and CIDD to administer the NCI surveys in order to gather information about what IDD services are working well and those that need improvement.

### FY 2019 Performance

**Survey Findings:**

- **Satisfaction with services:**
  - **Above** state and national averages
    - In-Person Adult (AH 98% vs. state 92% vs. national 92%)
    - Family/Guardian (AH 96% vs. state 90% vs. national 89%)
  - **Below** state and national averages
    - Adult/Family (AH 73% vs. state 79% vs. national 85%)
    - Child/Family (AH 69% vs. state 74% vs. national 80%)

**NOTE:** For full results of the visit our website: [https://www.alliancebhc.org/providers/quality-management/](https://www.alliancebhc.org/providers/quality-management/)

### FY 2020 Strategy

**Areas of focus:**

- Access and Delivery of Supports – scored below state and national averages for all surveys
- Understanding of and input in service plan
- Ability to work in the community and volunteer if appropriate
- Choice of living arrangement
### Appendix A: Measure Definitions

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Call Center</strong></td>
<td></td>
</tr>
<tr>
<td>Call Abandonment Rate</td>
<td>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.</td>
</tr>
<tr>
<td>Answer within 30 seconds</td>
<td>The number of calls answered by a live voice within 30 seconds</td>
</tr>
<tr>
<td>Call Blockage Rate</td>
<td>The frequency with which an individual calling the Alliance Call Center experiences of busy signal.</td>
</tr>
<tr>
<td>Calls Answered Live</td>
<td>The number of calls answered by a live voice</td>
</tr>
<tr>
<td>Access to Care - Emergent</td>
<td>Number Calls Requesting MH/IDD/SU Services Determined To Need Emergent Care For Which Care Was Provided Within 2 Hours 15 Minutes Of Request</td>
</tr>
<tr>
<td>Access to Care - Urgent</td>
<td>Number Calls Requesting MH/IDD/SU Services Determined To Need Urgent Care For Which A Service Was Provided Within 2 Calendar Days Of Request</td>
</tr>
<tr>
<td>Access to Care - Routine</td>
<td>Number Calls Requesting MH/IDD/SU Services Determined To Need Routine Care For Which A Service was Provided Within 14 Calendar Days Of Request</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td></td>
</tr>
<tr>
<td>Medicaid - Mental Health 7-Day Follow Up</td>
<td>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.</td>
</tr>
<tr>
<td>Medicaid - Substance Use 7-Day Follow Up</td>
<td>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.</td>
</tr>
<tr>
<td>Medicaid - Innovations Waiver Primary Care</td>
<td>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.</td>
</tr>
<tr>
<td>Non-Medicaid - Mental Health 7-Day Follow Up</td>
<td>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.</td>
</tr>
<tr>
<td>Non-Medicaid - Substance Use 7-Day Follow Up</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Contract Super Measures</strong></td>
<td></td>
</tr>
<tr>
<td>TCLI - Housing</td>
<td>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.</td>
</tr>
<tr>
<td>Care Coordination Assignment</td>
<td>Of all readmits (MH or SA) during the month, indicate the number that were assigned to a Care Coordinator upon readmission.</td>
</tr>
<tr>
<td><strong>Innovations Waiver Measures</strong></td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Authorizations Processed within Timeframes</td>
<td>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.</td>
</tr>
<tr>
<td>Claims Proceed within 30 Days</td>
<td>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 &gt;30 days after the end of the month being reported.</td>
</tr>
<tr>
<td>Resolution of Grievances within 30 Days</td>
<td>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</td>
</tr>
<tr>
<td>Members receiving services within 45 days of ISP</td>
<td>Proportion of new waiver beneficiaries who are receiving services according to their ISP within 45 days of ISP approval.</td>
</tr>
<tr>
<td>Percent of Actions Taken to Protect the Beneficiary</td>
<td>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.</td>
</tr>
<tr>
<td>Incidents reported within timeframes</td>
<td>Percentage of level 2 and 3 incidents reported within required timeframes</td>
</tr>
<tr>
<td>Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.</td>
<td>Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.</td>
</tr>
<tr>
<td>Beneficiaries who received appropriate medication</td>
<td>Percentage of beneficiaries who received appropriate medication</td>
</tr>
<tr>
<td>Incidents where required LME/PIHP follow-up interventions were completed</td>
<td>Number and percentage of level 2 or 3 incidents where required LME/PIHP follow-up interventions were completed as required</td>
</tr>
<tr>
<td>Percentage of incidents referred to the DSS or DHSR</td>
<td>Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required</td>
</tr>
<tr>
<td>Level of Care evaluations completed at least annually for enrolled beneficiaries</td>
<td>Proportion of Level of Care evaluations completed at least annually for enrolled beneficiaries</td>
</tr>
<tr>
<td>Level of Care evaluations completed using approved processes and instrument</td>
<td>Proportion of Level of Care evaluations completed using approved processes and instrument</td>
</tr>
<tr>
<td>New Level of Care evaluations completed using approved processes and instrument</td>
<td>Proportion of New Level of Care evaluations completed using approved processes and instrument</td>
</tr>
<tr>
<td>Individual Support Plans that address identified health and safety risk factors</td>
<td>Proportion of Individual Support Plans that address identified health and safety risk factors</td>
</tr>
<tr>
<td>PCPs that are completed in accordance with DMA requirements.</td>
<td>Proportion of PCPs that are completed in accordance with DMA requirements.</td>
</tr>
</tbody>
</table>
## Appendix B: Performance Data

All Data have been rounded to the nearest whole percent.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Goal</th>
<th>J</th>
<th>A</th>
<th>S</th>
<th>O</th>
<th>N</th>
<th>D</th>
<th>J</th>
<th>F</th>
<th>M</th>
<th>A</th>
<th>M</th>
<th>J</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Call Abandonment Rate</td>
<td>&lt;5%</td>
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<tr>
<td>Live Answer within 30 seconds</td>
<td>&gt;95%</td>
<td>99%</td>
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<tr>
<td>Access to Care - Emergent</td>
<td>&gt;97%</td>
<td>100%</td>
<td>99%</td>
<td>96%</td>
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<tr>
<td>Access to Care - Urgent</td>
<td>&gt;82%</td>
<td>37%</td>
<td>37%</td>
<td>40%</td>
<td>43%</td>
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<tr>
<td>Access to Care - Routine</td>
<td>&gt;75%</td>
<td>43%</td>
<td>43%</td>
<td>49%</td>
<td>44%</td>
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<td>Contract Super Measures</td>
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<tr>
<td>Medicaid - Mental Health 7-Day Follow Up</td>
<td>&gt;40%</td>
<td>54%</td>
<td>50%</td>
<td>46%</td>
<td>53%</td>
<td>56%</td>
<td>48%</td>
<td>46%</td>
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<tr>
<td>Medicaid - Substance Use 7-Day Follow Up</td>
<td>&gt;40%</td>
<td>29%</td>
<td>39%</td>
<td>38%</td>
<td>37%</td>
<td>43%</td>
<td>39%</td>
<td>46%</td>
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<tr>
<td>Medicaid - Innovations Waiver Primary Care</td>
<td>&gt;90%</td>
<td>95%</td>
<td>96%</td>
<td>96%</td>
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<tr>
<td>Non-Medicaid - Mental Health 7-Day Follow Up</td>
<td>&gt;40%</td>
<td>39%</td>
<td>34%</td>
<td>34%</td>
<td>40%</td>
<td>31%</td>
<td>30%</td>
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<tr>
<td>Non-Medicaid - Substance Use 7-Day Follow Up</td>
<td>&gt;40%</td>
<td>22%</td>
<td>22%</td>
<td>27%</td>
<td>24%</td>
<td>26%</td>
<td>20%</td>
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<tr>
<td>TCLI - Housing</td>
<td>&gt;88</td>
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<tr>
<td>Care Coordination Assignment</td>
<td>&gt;85%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>88%</td>
<td>92%</td>
<td>96%</td>
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<tr>
<td>Authorizations Processed within Timeframes</td>
<td>&gt;95%</td>
<td>100%</td>
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<tr>
<td>Claims Proceed within 30 Days</td>
<td>&gt;90%</td>
<td>96%</td>
<td>97%</td>
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<tr>
<td>Resolution of Grievances within 30 Days</td>
<td>&gt;90%</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>98%</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>86%</td>
<td>79%</td>
<td>93%</td>
<td>85%</td>
<td>97%</td>
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<tr>
<td>Innovations Waiver Measures</td>
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<tr>
<td>Members receiving services within 45 days of ISP</td>
<td>85%</td>
<td>100%</td>
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<tr>
<td>Percent of Actions Taken to Protect the Beneficiary</td>
<td>85%</td>
<td>93%</td>
<td>89%</td>
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<td></td>
<td></td>
<td></td>
<td>95%</td>
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<tr>
<td>Incidents reported within timeframes</td>
<td>85%</td>
<td>72%</td>
<td>93%</td>
<td></td>
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<td></td>
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<td>90%</td>
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</tbody>
</table>

*Note: * indicates data not available or not applicable.
| Percentage of deaths where required LME/PIHP follow-up interventions were completed as required. | 85% | 100% | 100% | 100% | * |
| Medication errors resulting in medical treatment. | <15% | 0% | 0% | 0% | * |
| Beneficiaries who received appropriate medication | 85% | 100% | 100% | 100% | * |
| Incidents where required LME/PIHP follow-up interventions were completed | 85% | 100% | 100% | 100% | * |
| Percentage of incidents referred to the DSS or DHSR | 85% | 92% | 91% | 95% | * |
| Percentage of restrictive interventions resulting in medical treatment. | <15% | 0% | 0% | 0% | * |
| Level of Care evaluations completed at least annually for enrolled beneficiaries | 85% | 100% | 100% | 100% | * |
| Level of Care evaluations completed using approved processes and instrument | 85% | 99% | 99% | 99% | * |
| New Level of Care evaluations completed using approved processes and instrument | 85% | 100% | 100% | 100% | * |
| Individual Support Plans that address identified health and safety risk factors | 85% | 98% | 98% | 98% | * |
| PCPs that are completed in accordance with DMA requirements. | 85% | 98% | 98% | 98% | * |