2014-2015 Quality Management Program Description and Plan

Revised August 31, 2014
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INTRODUCTION

Description of Alliance

Alliance Behavioral Healthcare was created on July 1, 2012 with the merger of the Durham Center and the Wake County LME. On February 1, 2013, Alliance begins managed care operations under the Medicaid 1915 (b)/(c) waivers in Durham, Wake, Cumberland and Johnston Counties, with responsibility for approximately 186,000 individuals eligible for Medicaid and a total population in excess of 1.7 million. Over 900 providers are credentialed and enrolled initially in the Alliance Provider Network. At the end of FY 2013, Alliance merges with the Cumberland County LME in a process that is largely seamless for the citizens of that county, and its staff become employees of Alliance. The network now includes over 2000 credentialed providers.

Alliance has the second largest Medicaid population among the 10 MCOs in North Carolina:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardinal</td>
<td>345,073</td>
</tr>
<tr>
<td>Alliance</td>
<td>222,721</td>
</tr>
<tr>
<td>Eastpointe</td>
<td>200,945</td>
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<tr>
<td>Centerpointe</td>
<td>195,716</td>
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<tr>
<td>Sandhills</td>
<td>185,637</td>
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<tr>
<td>Smoky Mountain</td>
<td>175,984</td>
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<tr>
<td>Partners</td>
<td>157,328</td>
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<tr>
<td>ECBH</td>
<td>104,952</td>
</tr>
</tbody>
</table>

Alliance's Mission Statement

Alliance pursues a community effort dedicated to supporting the lives of citizens affected by mental illness, developmental disabilities, and substance abuse by assuring a collaborative, accessible, responsive, and efficient system of services and supports. An overlying philosophy of Alliance Behavioral Healthcare is to be an organization whose management focuses on its responsibility to maintain a fiscally sound agency, but will never permit this focus to undermine its responsibility to the delivery of exceptional care to those in need.

Alliance’s Vision

Alliance is a community with energy and momentum that embraces people with disabilities as equal partners and valued citizens. Alliance believes that when citizens with disabilities reach their full potential, the entire community benefits.

What Alliance Values
• Discovering ways to nurture community strengths in order to accomplish what none of us can do alone;
• Involving stakeholders for the advancement of all citizens in our diverse community;
• Partnerships with community agencies that assure that best practices are applied through person-centered planning;
• Community resources that offer enduring ways to support people with disabilities;
• Community partners that leverage dollars and develop in-kind partnerships to respond to the mental health, developmental disabilities and substance abuse services needs of all citizens;
• Advocacy efforts that challenge the MH/DD/SAS delivery system to improve continuously;
• Accountability of all parties in the system;
• Exemplary practices that lead to meaningful outcomes and are cost effective;
• High consumer and family satisfaction;
• Collaboration with our community partners and stakeholders;
• Building community capacity that includes the identification of existing community resources and gaps.
• Services and supports that are consumer and family friendly, age appropriate and culturally competent;
• The flexibility of the MH/DD/SAS system to provide programs and supports when needed, at the level needed and in the amount necessary, so people may enter and exit components of the system as their needs change and without fear of re-entry complications;
• Ongoing community education that assists in the elimination of stigma and discrimination.

Alliance Behavioral Healthcare upholds the highest integrity for the staff, enrollees, families, providers, and all other stakeholders to ensure that enrollees receive:
• Access to high quality clinical and human services
• Best practice programs and innovative ideas to shape and trend services, outcomes, and community needs
• The highest level of customer service to address needs

Alliance Customers

The four counties that make up Alliance Behavioral Healthcare are racially and ethnically diverse. A greater percent of racial and ethnic minorities live in Durham and Johnston Counties, as compared to the rest of the state. Fifty-four percent (54%) of residents identified themselves as non-white or as multiracial, as compared to 32% of all North Carolinians who self-identify as non-white or multiracial.

The total population for the Alliance catchment area for calendar year 2011 was estimated to be 1,700,652 (US Census Bureau, State and County QuickFacts, 2011 http://quickfacts.census.gov). The chart below shows the breakdown of population by county in contrast to the Medicaid population.
The Medicaid populations as a percentage of the total population vary from a low of 8.24% in Wake County to a high of 15.46% in Johnston. Due to the overall size of Wake County within the catchment area, the average number of Medicaid eligibles is about 11% of the total population. Alliance Staff

Alliance Staff

During its first year of operations, Alliance grew from a professional staff of 142 to nearly 350. Staff making the transition to Alliance from The Durham Center and the LMEs in Wake, Cumberland and Johnston counties formed the nucleus and brought with them invaluable expertise and experience. From that point staffing more than doubled to accommodate MCO operations.

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. To meet that goal, Alliance considered over 2000 provider applications in a credentialing, enrollment and contracting process that can take up to 20 hours per provider.

Alliance assembled a vibrant, engaged Consumer and Family Advisory Committee (CFAC) and Provider Advisory Council representing the four counties in its region. Existing CFACs and PACs in each county continue to meet locally and offer feedback to the corporate advisory groups.

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.

PURPOSE OF THE ALLIANCE QM PROGRAM

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

Quality Management will play a major role in ensuring the MCO 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 ensure that its employees and the provider staff of its Provider Network 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 MCO 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.

PURPOSE OF QUALITY MANAGEMENT PLAN

The Quality Management (QM) 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. The Quality Management Plan 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.

GOALS AND OBJECTIVES OF THE QM PROGRAM

The Quality Management Department’s ongoing goals mirror many of the goals of the Medicaid Waiver. While Quality Management will play a major role in ensuring Alliance is successful at meeting performance outcomes and contract requirements, the goals listed below are of particular focus due to direct involvement of QM staff and organization-wide QM activities.

1. To ensure the allocation of the most resources to individuals with the greatest disabilities;
2. To transition local systems toward treatment with effective practices that result in real life recovery outcomes for people with disabilities, as possible;
3. To promote community acceptance and inclusion of individuals with disabilities; to provide outreach to people in need of services; to promote and ensure accommodation of cultural values in services and supports; and to serve people in their local communities wherever possible;
4. To provide for easy access to the System of Care;
5. To ensure quality management that focuses on health and safety, protection of rights, achievement of outcomes, accountability, and that strives to both monitor and continually improve the System of Care;
6. 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;
7. To empower Alliance Behavioral Healthcare – 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
8. To demonstrate an interactive, mutually supportive, and collaborative partnership between the State agencies and Alliance – in the implementation of public policy at the local level and realization of the State’s goals of healthcare change.
PRINCIPLES AND STRATEGIES OF THE QM PROGRAM

Continuous Quality Improvement

There are four main assumptions that the MCO should embrace to encourage a quality culture within the value chain:

- To understand that it is better to prevent errors than to fix them
- To detect defects for early prevention
- To reduce testing and audit processes to reduce costs
- To determine root causes of errors and problems as they occur

Continuous Quality Improvement demands that staff and providers answer three basic questions:
1. Are we doing the right things?
2. Are we doing things right?
3. How can we be certain that we do things right the first time, every time?

Experts in the quality management field agree that one of the most complex challenges related to quality management and improvement is how to maximize quality and outcomes given economic constraints. One method to meet this challenge is the collaborative quality management life cycle. Questions that are continually asked in this process are: When do we delay action? How do we act early on? What are the costs to errors and barrier? Can we deliver services on time and in a quality manner?

Quality management is a lifecycle activity that affects everyone involved in a project. Having data stored in one central location that all staff can utilize assures accuracy and consistency. Instead of different department staff each individually completing an analysis or report, and possibly duplicating efforts, the collaborative cycle can reduce time and costs related to project development, analysis and utilization.

This cycle ensures accuracy of the data – as long as quality management staff is involved in every aspect of planning, testing, and production of reports. This requires support from senior leadership in the entire lifecycle.

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 three areas: Utilization Management, Call Center, and Health Network.

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.

In August 2014, Alliance will complete the process for URAC accreditation in a fourth area, Credentialing.

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 Alliance CQI Committee and its various subcommittees.

Board of Directors

Alliance is governed by a Board of Directors that is responsible for comprehensive planning, budgeting, implementing and monitoring of community-based mental health, developmental disability and substance abuse services to meet the needs of individuals in the Alliance region. The Alliance Board consists of community stakeholders from Durham and Wake counties that are appointed by their respective County Commissioners, as well as representation from Cumberland and Johnston counties. Service providers do not serve as members of the Board.

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 five voting members — three Board members and two members of the Consumer and Family Advisory Committee (CFAC). Other non-voting members include at least one MCO employee and one provider representative from each county.

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 quarterly 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. Further, the Committee evaluates the effectiveness of the QM Program and reviews the QM Plan annually.

**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.

**Continuous Quality Improvement Committee**

The CQI Leadership Team is the internal review venue for the assessment and review of all data for Alliance. This committee is composed of the Alliance CEO, Medical Director, Chief of Staff, Compliance Officer, Chief Clinical Officer, Chief of Network Development and Evaluation, Chief Finance Officer, Chief Information Officer, Director of Analytics and Quality Management, Chief of Community Relations, and Director of Consumer Affairs. Agendas and minutes are recorded. The CQI Committee meets at least monthly to review clinical and provider network performance data and review operations. The CQI Committee is responsible for the implementation and evaluation of the Alliance Quality Management Plan, monitoring of quality improvement goals and activities and identifying opportunities for improvement within the provider network and Alliance operations. This committee examines data and information for trends, to identify areas of risk for the organization, and to areas where there has been or needs to be performance improvement. This committee also reviews state reports, information and reports to be shared with the board of directors, and quality reports. Information reviewed with strategies for improvement are shared with the Global Quality Management Committee of the Board for additional review, feedback, recommendations and approval.
Subcommittees of the CQI Committee

Budget and Finance Committee: The Budget and Finance Committee exists for the purpose of providing an internal review of expenditures, allocations, trends, and an overall financial picture of the agency in regards to services and programs. It also assures a fair system is in place for allocating or de-allocating funds. The Committee acts as the recommending body to the Chief Financial Officer (CFO) as to the manner in which funds should be distributed or de-allocated by reviewing financial/service data and reports. The Committee prevents one sole authority, namely the CFO, from having a programmatic or service impact to the community without input from key stakeholders such as Senior Management, Clinical, Quality Management, and local sites. The B&F Committee is a mandatory committee comprised of representatives from Clinical Operations, Network Operations, Quality Management, and local sites.

Community Relations Committee: This committee discusses community relations issues and concerns, and brainstorms on systemic solutions. The committee takes input from the Community Advisory Committee(s) to problem solve and submit requests through the CQI and/or leadership for approval. The Community Relations Director Chairs this committee.

Corporate Compliance Committee: This committee consists of senior level staff to review and evaluate organizational and network compliance to applicable state and federal regulations and contract requirements. Committee membership includes representatives from Quality Management. It is chaired by the Corporate Compliance Officer and reports matters of significant non-compliance trends such as fraud and abuse to the Continuous Quality Improvement Leadership Team. This committee meets at least monthly.

Clinical Care Management Team: This committee consists of senior level clinical staff and has representation from QM and Provider Networks and meets at least monthly to review consumer deaths, serving as a mortality/morbidity committee, and conducting root cause analyses related to death and other serious incidents. CCMT will alert the CQI Leadership Team of concerning trends or potential risks identified through the review of these events and make recommendations to enhance consumer safety. Other responsibilities include reviewing cases of concern referred to the MCO or elicited by MCO staff and conducting case conference for complex clinical cases. This committee is chaired by the Medical Director.

Utilization Management Committee: This is a cross-functional committee with membership comprised of representatives from all clinical departments, Senior Clinical Staff, QM, Provider Networks, and Finance. The committee monitors the effectiveness of and measures outlined in the UM Plan, (including utilization risk indicators), compliance with key URAC and waiver performance measures, and monitors for outliers and over and underutilization and monitors progress. The committee also reviews both UM and Call Center IRR studies. The Committee makes recommendation for corrective actions and monitors the effects of corrective action plans when trends, areas of risk or out of compliance are detected.
Provider Network Management Committee: This committee meets at least monthly. The primary charge of this committee is to review provider related data, identify and address service gaps, explore trends and make policy recommendations based upon this information. Additionally, the Provider Network Management Committee examines the implications of state and federal funding changes on the services that are provided within the community and makes recommendations on how to address these issues from a system and network perspective. All significant findings and recommendations are sent to the CQI Leadership Team.

Crisis Continuum Committee: This committee is charged with reviewing Alliance's crisis management network, identifying issues in the crisis continuum of care, and implementing efforts to improve the quality of that care. This committee meets at least monthly.

IT Committee: The committee meets monthly to review the development of internal data systems; oversee Alliance's relationship with its external IT vendor, AlphaCMA; assess data integrity; and implement quality activities addressing IT issues. This committee meets at least monthly.

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 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 is scheduled to undergo its first EQR in November 2014.

QM DEPARTMENT ORGANIZATION

The Alliance QM Department consists of a QM Director, who oversees three teams: Quality Review, Data Management and Provider Review. In addition, the QM Director oversees a Business Analyst and a Statistical Research Assistant. The QM Director reports directly to the Chief of Program Development and Evaluation. Alliance's Medical Director provides collaboration and guidance.
QM DEPARTMENT STAFF

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 established geographic area. The QM Director develops and designs measurement tools for meeting contractual performance criteria and accreditation requirements. The QM Director produces written and oral presentations and reports for a variety of internal and external audiences are developed. The QM Director works closely with the Alliance IT Department to develop and/or design reports for other departments and staff to streamline data collection and reporting processes. 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.

Quality Review: The QR Manager oversees the Quality Improvement processes to ensure appropriate type and number according to URAC and contracts; implements Performance Improvement Projects (PIPs) as identified; monitors by accuracy of QIPs, timeliness and correct process flows to ensure the QIPs are completed on time and are accurate; manages the accreditation process for the URAC Core, Call Center, and Health Network Standards; and ensures that the MCO obtains and maintains URAC accreditation.

The QR Manager also ensures contract requirements for PCP reviews, quality audits, Inter-rater reliability, certain survey projects, committee reviews of the data, and collaboration with other MCO departments are met; ensures that analyses and write-ups to are accurate and professional; is responsible for overall supervision of all unit employees; oversees the coordination of the MCO Strategic Planning Process, and/or Network Capacity Studies by working with Department and site Directors, QM staff, QM Director and external stakeholders; and oversees the Credentialing Reviews/Audits and processes.

The Quality Review Manager currently oversees a team of four Quality Review Coordinators.

Data Management: The QM Data Manager manages the daily/weekly/monthly data processes, such as Incident Reporting and Analysis (IRIS), NC-TOPPS, NC-SNAP, SIS, and Utilization Management, Call Center Statistics, daily crisis continuum census reports, network monitoring, and the grievance process. Accuracy and timeliness must be within the DMH required standards. Ensures reports are accurate with professional charts/graphs and analysis. Manages and coordinates and/or participates in survey projects such as: Consumer, provider and stakeholder satisfaction. Creates charts, graphs and develops reports for stakeholder input. Ensures the automation of management reports. The QM Data Manager works closely with the IT Department to facilitate implementation of reports to be automated. The Grievance Reporting requirements and staff assigned to the grievance reporting process are managed by the QM Data Manager. As requested to coordinate and/or assist with other data.
analyses/processes/reports. This may include assistance with the strategic planning and/or the provider capacity study process. Ensures contract requirements for Innovations Health and Safety measures, access to care, incidents, and complaints. Ensures that analyses and reports are accurate and professional. Responsible for overall supervision of the Quality Assurance Unit.

The QM Data Manager currently oversees a team of five Quality Assurance Analysts.

**Provider Network Evaluation:** The Provider Network Evaluator Manager is responsible for managing the provider monitoring activities performed by the Provider Network Evaluators. This position will provide leadership, mentoring and clinical oversight to Evaluators to ensure the monitoring activities adhere to MCO rules and guidelines so that sufficient, safe, and effective services are being provided to consumers who have been identified as having Mental Health, Intellectual/Developmental Disabilities or Substance Abuse needs. The Provider Network Evaluator Supervisor will ensure that staff has the necessary assistance, support, training, and education to perform effective monitoring and review activities so that providers can succeed and continue to serve consumers. The Provider Network Evaluator Supervisor will assist the Director of Quality Management and Chief of Network Development and Evaluation to develop policies, procedures and quality indicators for the Provider Network and to ensure that all required monitoring data is maintained.

The Provider Network Evaluation Manager currently oversees a team of nine Provider Evaluators.

**QM Business Analyst:** The QM Business Analyst reviews business workflows for Alliance departments and sites; develops processes and key data elements in order to develop specified reports for the MCO; works closely with IT staff to provide content and context to reports; writes specifications and develop reports independently and/or with IT assistance; develops required Business Intelligence charts, graphs, and other Report formats as required by management. Works with IT staff to ensure the data elements and desired outcome of the BI tools are accurate; conducts Quality Assurance testing on IT projects as they apply to reporting, data collection, and analyses; create databases as required by the QM Director, and other management staff; develops enhancements for Alpha as staff identify data issues; and serves as liaison between departments and IT to coordinate data automation efforts.

**QM Statistical Research Assistant:** The Statistical Research Assistant develop reports, databases, spreadsheets, and surveys; develop maps specific to requests from QM and Provider Network; develop required Business Intelligence charts, graphs, and other Report formats as required by the QM Director; analyzes data for QM Department such as claims data, residential capacity and utilization, DHSR findings, and Quality of Care Concerns tracking; work with QM Director and managers to facilitate survey and other quality improvement studies/projects, such as the NCI state project, Perception of Care surveys, and provider
capacity surveys across counties in the catchment area; and helps coordinate, manage survey dissemination, tracking and analysis.

DATA SYSTEMS

**AlphaMCS:** Alliance has contracted with AlphaCM of Wilmington, NC to provide database and processing support. The AlphaCMS 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 AlphaCMS features and reports. QM staff participates in a weekly AlphaCMS user group teleconference; beta tests new features and reports; and produces AlphaCMS reports for QM and other departments.

**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 II 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.

QM PROGRAM RELATIONSHIPS

Continuous Quality Improvement must be not only ongoing but also pervasive. The Alliance QM Program is the responsibility of all staff, and the QM Department has ongoing relationships with all Alliance departments.

**Administration:** Alliance's Administration Department is led by the Alliance Chief Executive office 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 Senior Leadership team by the Chief of Network Development and Evaluation.

**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 serves as co-chair of the CQI Committee.

**Provider Networks:** The Provider Networks Management and Development Department. The QM Department is part of the Provider Networks Department, and the QM Director reports directly to the Chief of Network Development and Evaluation. The QM Director is a member of
the Provider Networks leadership team. QM staff assist Provider Networks by developing reports and data sets for Provider Networks staff, reviewing provider contracts, and identifying quality issues with providers undergoing recredentialing.

**Utilization Management Department:** Alliance's UM Department reviews and approves Service Authorization Requests (SARs) from providers for Medicaid, IDD and IRPS services. At the request of UM Department leadership, the QM Department's Quality Review Team reviews UM activities and documentation. The QR 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. During FY 2014, Care Coordination and QM Department collaborated on studies focusing on the accuracy of Care Coordination documentation and the effectiveness of services. During FY 2015, the QM Department will conduct a formal Quality Improvement Project (QIP) on CC services.

**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 QR team also participates in the development and administration of Inter-Rater Reliability testing of Access staff to determine the accuracy and consistency of communications with consumers.

**Finance Department:** 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 Relations:** The Alliance Community Relations 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 at crisis services providers, and participates on county-wide Crisis Collaboration provider groups. In particular, QM staff works directly with Community Relations' Crisis and Incarceration Manager.

**Information Technology:** The Information Technology Department works with Alliance's IT vendor AlphaMC 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.
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.

**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.

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 collect to establish a statistical baseline, interventions are implemented, and post-intervention data are collected.

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.

**FY 2015 QIPs**

1. **Reduction of Visits to Emergency Rooms (ongoing):** Although Alliance’s overall average rate of consumers presenting to Emergency Rooms (ER) is lower than the state average, the total number presenting and the care our consumers receive are concerning. Additionally, Alliance will be responsible for paying for visits directly related to a consumers’ behavioral health disorder.

   **Need:** Reduce ER visits, particularly for high-risk individuals such as Medicaid recipients with unstable medical conditions, and frequent utilizers of crisis services.

   **Goal:** The project is expected to reduce hospitalizations at community and state hospitals in addition to ERs.

2. **Inter-Rater Reliability (ongoing):** Alliance needs to maintain a high level of reliability between UM Care Managers to support the quality of their decision-making. Discrepancies detected during a reliability study can highlight areas that require clinical discussion and consensus or, at the very least, checks of UM activity against published standards.

   The project involves the administration of inter-rater reliability studies of UM MH/SA and I/DD Care Managers using a tool consisting of at least five vignettes, questions about policies and procedures, and questions about clinical decisions. Care Managers who score below 80% will receive one-on-one supervision to address concerns. Additional variances will be addressed through training or other interventions. At the end of study, QM will determine if results have significantly changed due to interventions.
**Need:** As per Medicaid and URAC requirements, Alliance needs to conduct a study of inter-rater reliability of UM Managers’ service authorization decisions at least quarterly. Data from previous QIP indicate that Care Managers did not achieve benchmark of 80% agreement for UM Department.

**Goal:** The goal is to reach the benchmark of 80% required for the UM Department.

3. **First Responder Evaluation of Providers (ongoing):** The QM Department will conduct First Responder studies of enhanced services providers on a tiered basis based upon results from previous QIP. Crisis numbers will be obtained by reviewing Crisis Plans (Basic and Comprehensive) for consumers receiving services that have first responder requirements. Data obtained would include telephonic answer rate, telephonic response time, face to face response time, and credentials of staff serving as first responders (at a minimum).

Interventions include offering additional PCP/Crisis plan trainings; adding Crisis Coverage an item to routine provider monitoring tool; referring poor performers to compliance; and terminating providers services.

**Need:** The rates of unreturned crisis calls has not decreased. Only 1 of the 5 benchmarks for Crisis Response from the previous QIP was met. The previous monitoring tool did not fit mobile crisis. Difficultly obtaining accurate information about crisis numbers for providers.

**Goal:** The primary goal is to improve the response rate for live answers and calls returned within 1 hour. Secondary goals include creating a list of crisis numbers for active EB MH/SA providers, and collecting data on frequency of Comprehensive Crisis Plan use.

4. **Mystery Shopper - Access Center & UM (ongoing):** In order to ascertain what has prevented or has caused Access staff to not be notified of an appointment missed by a member, a review of "pending" call activity will occur. Due to the nature of the activity, quarterly review will occur (estimation of 20-30 pending calls a month). QM is also proposing a review of network providers to determine and implement an intervention to address problems resulting from over-capacity of needed services.

**Need:** Alliance Access staff link members to the appropriate services requested. If an appointment has been scheduled and the member attends, the Provider indicates the appointment has been completed. If a member does not attend appointment, the "pending" appointment information (that the appointment was not completed) is designed to automatically notify Access Center staff that the appointment was not completed. It is a concern that this notification has not been reliable in notifying Access staff that follow-up with the member is in order.

**Goal:** The Call Center will contact consumers who miss appointments. This follow-up includes two phone calls and a contact letter.
5. Care Coordination (new): Since February 1, 2014, Alliance has served over 4,500 unduplicated consumers in care coordination providing linkage to services, supports and resources in an effort to optimize clinical outcomes, decrease recidivism to crisis facilities, and foster longer periods of community tenure. As of April 1, 2014, more than 1,500 consumers have active cases in MH/SA care coordination. The impact of care coordination services to consumers is a concern given the high caseloads. In January 2014, a brief review was completed analyzing the care coordinators adherence to the Intensity Level Checklists. That review yielded an average rate of 61% adherence across all four counties. These results have been a catalyst to revamping and redefining interventions and parameters to caseloads. The project will re-evaluate adherence to the care coordination model, and evaluate additional criteria. The interventions to improve adherence may include training, coaching, and direct supervision of Care Coordinators, along with considering a change in the intensity of Care Coordination contact depending on individual consumer needs.

Need: Alliance must determine which care coordination interventions are making the biggest impact, and revamp/redefine care coordination interventions and parameters to reduce caseloads.

Goals: (1) Reduce crisis admissions of consumers connected with Care Coordination; (2) Increase adherence to Care Coordination procedures.

6. Access to Care: URAC-Call Center & Health Network (new): Access staff link members to the appropriate services requested. If an appointment has been scheduled and the member attends, the provider indicates the appointment has been completed. If a member does not attend appointment, the ‘pending’ appointment information (that the appointment was not completed) is designed to automatically notify Access Center staff that the appointment was not completed. It is a concern that this notification has not been reliable in notifying Access staff that follow-up with the member is in order.

Need: In order to ensure that consumers follow up on scheduled appointments, Call Center staff contact consumers who miss appointments. This follow-up includes two (2) phone calls and a contact letter.

Goals: In order to ascertain what has prevented or has caused Access staff to not be notified of an appointment missed by a member, a review of "pending" call activity will occur. Due to the nature of the activity, quarter review will occur (estimation of 20-30 pending calls a month). QM is also proposing a review of network providers to determine and implement an intervention to address problems resulting from over-capacity of needed services.

Other Quality Activities

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.

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.

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.

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. QM staff currently conduct ongoing analyses of crisis data, management reports, utilization, STR, MCO operations, financial, performance of network, and System of Care data.

Surveys: QM staff develop and disseminate surveys to gather and incorporate feedback. Surveyees include consumers, providers, Area Board members and stakeholders.

GRIEVANCES AND COMPLAINTS

The QM Department's Data Management Team is responsible for processing grievances submitted from within and outside Alliance. 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. Alliance will respond to grievances received concerning providers or Alliance staff in the Alliance catchment area.

INCIDENTS

The QM Department's Data Management 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 Behavioral Healthcare Closed Network.

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 shall be reported in the state's web-based Incident Response Improvement System.
All crisis providers are required to report incidents that occur during the provision of crisis services. Provider submit quarterly reports of all Level I incidents.

**PROVIDER MONITORING**

The DHHS Provider Monitoring process is designed to promote North Carolina’s commitment to ensuring high quality services for individuals with mental health, intellectual/developmental disabilities, and substance abuse issues. It is the vehicle used for entry into the provider network, for the evaluation of service providers against quantitative and qualitative measures, and for determining advanced placement status, using a series of monitoring tools. The provider monitoring process is used to monitor both Medicaid and State-funded behavioral health services.

A new process for routine provider monitoring was implemented March 1, 2014. The Provider Monitoring process is used statewide by the LME-MCOs to monitor providers of publicly-funded MH, IDD and SA services, regardless of funding source, and includes the tools and guidance for monitoring licensed independent practitioners (LIPs) and MH, IDD and SA provider agencies. Routine provider monitoring consists of two components--a routine review and a post-payment review.

**QM PROGRAM OBJECTIVES – FY 2015**

The process of Continuous Quality Improvement includes the establishment of new goals by Alliance's QM program. The Alliance QM Department has set the following goals for FY 2015:

**Meet 100% of performance measures:** The QM Department is committed to ensuring that Alliance meets all performance measures established in Alliance's contracts with the DMA and DMH. These measures cover the range of Alliance's activities, including performance by Alliance's Clinical, Utilization Management, Call Center and QM Departments.

**Establish QM reporting in 100% of Alliance committees:** Alliance is committed to a QM program that is data-driven. The QM Department will review the activities and data requirements of the Global QM Committee, CQI Committee, and various Alliance subcommittee. The QM Department will facilitate the development of relevant reporting, including the creation of "dashboards" to assess fundamental performance, and the development of reports required by contract or accreditation.

**Review 100% of Alliance committee reports to identify new QM risk factors:** The QM Department will review all reports created by the various Alliance committees, identify areas of risk or non-performance, and facilitate the mitigation of these issues.

**Create a rapid QM response program and train 100% of department heads on its use:** The QM Department has identified the need for a quick and user-friendly way for Alliance departments to request QM assistance. QM staff will develop an online request form for QM assistance and
associated training materials. QM staff will train 100% of department heads on how to access the system and submit a request for QM review.

**Review HEDIS standards and implement relevant performance measures:** Developed by the NCQA, the HEDIS program is a set of performance measures that allow MCOs to better evaluate their performance against national standards. The QM Department will review the HEDIS measures, identify the measures that are relevant to Alliance's behavioral health activities, and facilitate the creation of reports on those HEDIS measures.

**Develop provider QM education and inform 100% of providers:** Continuous quality improvement is the responsibility of all stakeholders in Alliance, including providers. The QM Department will create guidances, templates and training materials to help providers create effective QM programs. The QM Department will inform 100% of providers about the availability of these materials.

**Evaluate the establishment of provider outcomes:** The establishment of provider outcomes is the next great step in improving the effectiveness and efficiency of patient care. The QM Department will evaluate current methods for establishing outcomes; and assess the relevancy of those methods to Alliance.