Sandhills Center
LME-MCO

Quality Management Committee Executive Summary

October-December 2016

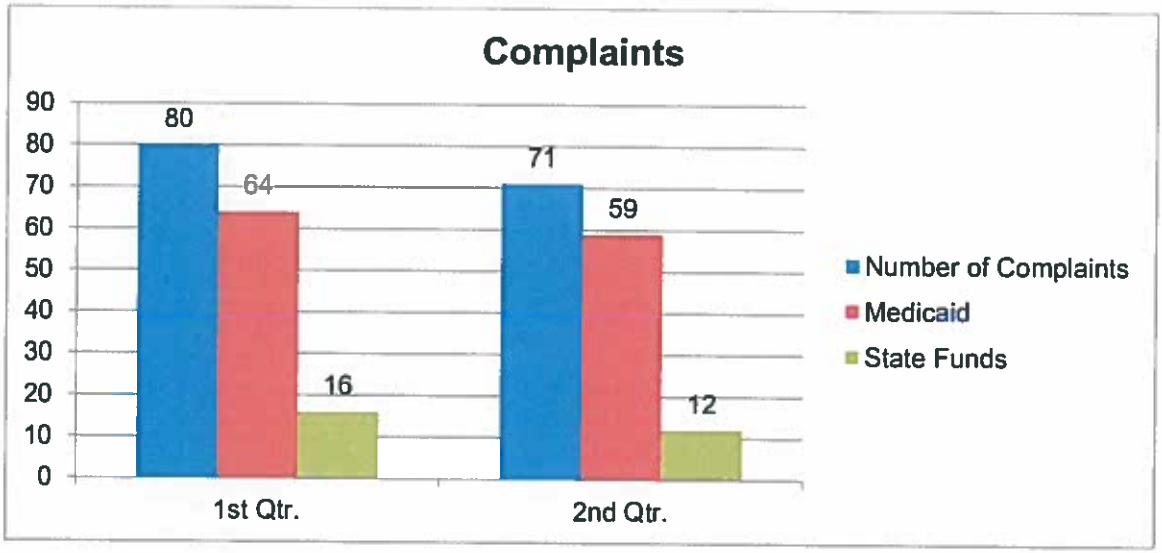
Quality Management Committee
Executive Summary
Time Period Covered October - December 2016
2nd Quarter FY 16-17

The Quality Management Committee (QMC) met face-to-face twice for regular meetings during the 2nd quarter of this fiscal year, and had 35 reviews for approval of policies, procedures and other documents. There were 17 additional documents reviewed though the expedited process, for a total of 52 for the quarter. The Executive Summary includes Quality Management Program activities that systematically monitor the quality and effectiveness of Sandhills Center's internal systems, as well as ensuring the provision of high quality services delivered by the Provider Network to consumers. The Quality Management Program's design helps ensure adherence to the Sandhills Center mission to develop, manage and assure that persons in need have access to quality mental health, intellectual/developmental disabilities and substance abuse services.

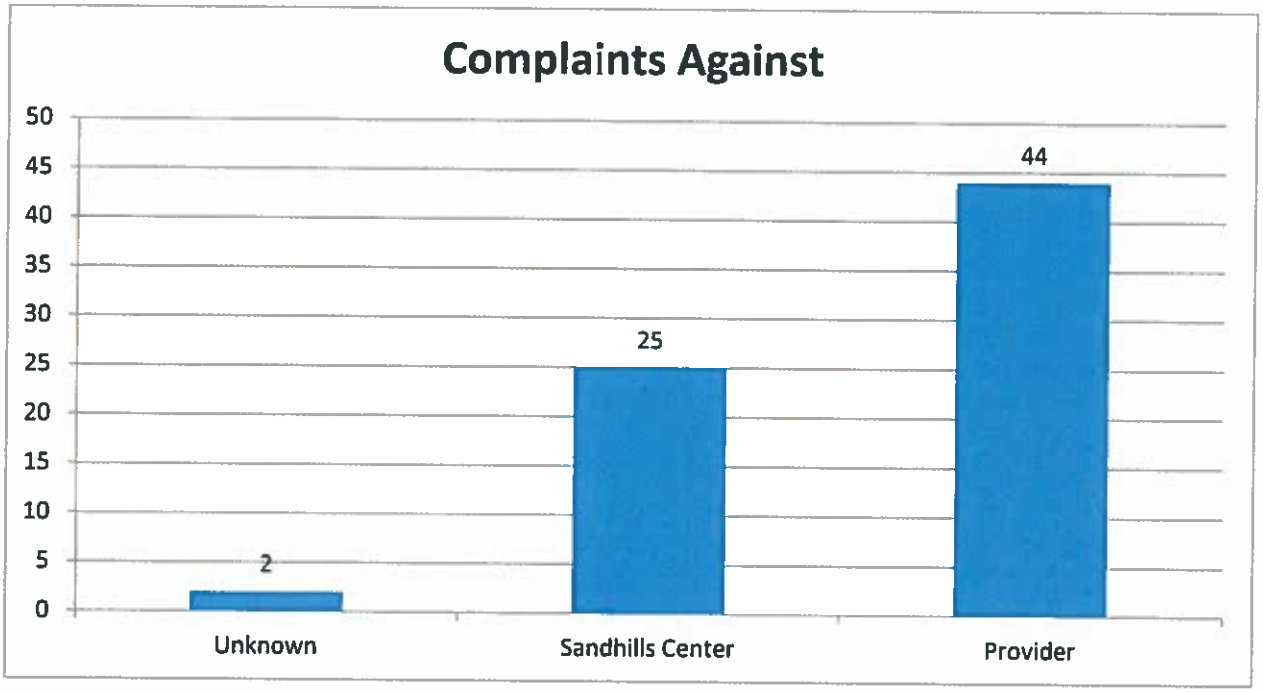
Complaints, Incident Reporting and Quality of Care Concerns

Quarterly Complaints Report

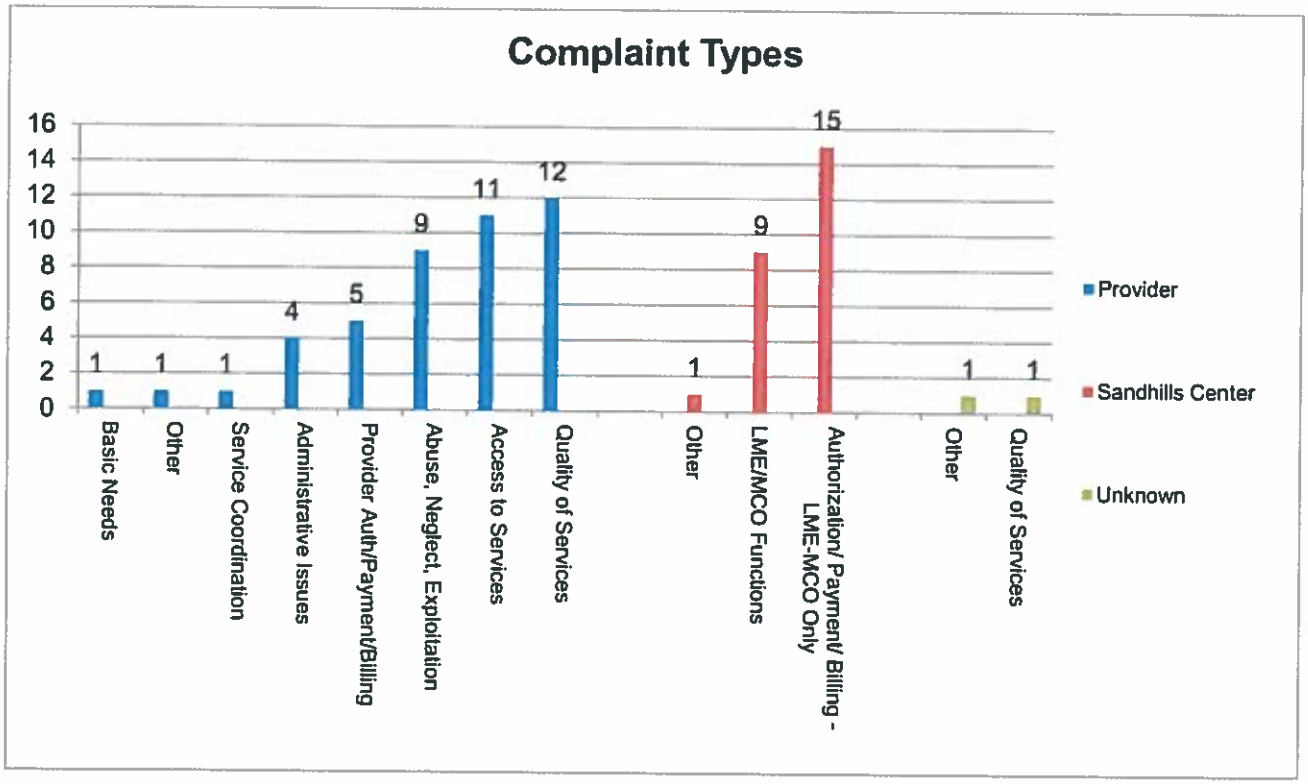
Brief Description of the Report: This report reflects the number and type of Complaints received.



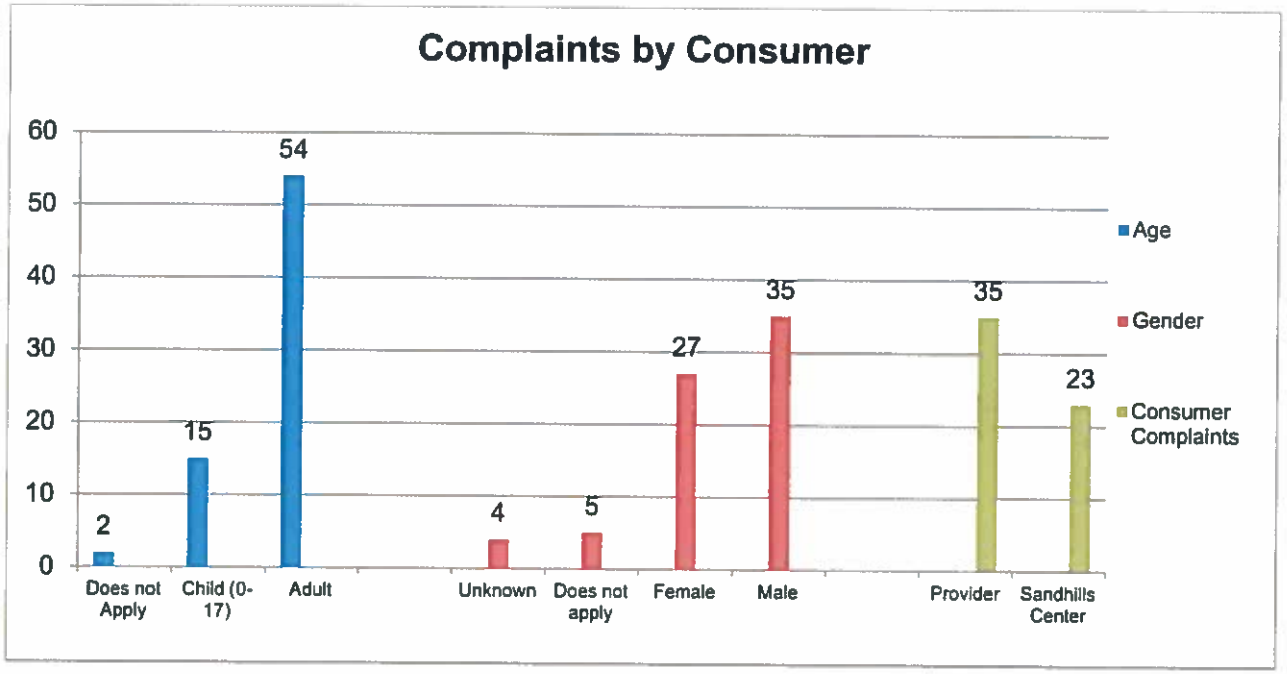
Complaints have decreased from the 1st quarter.



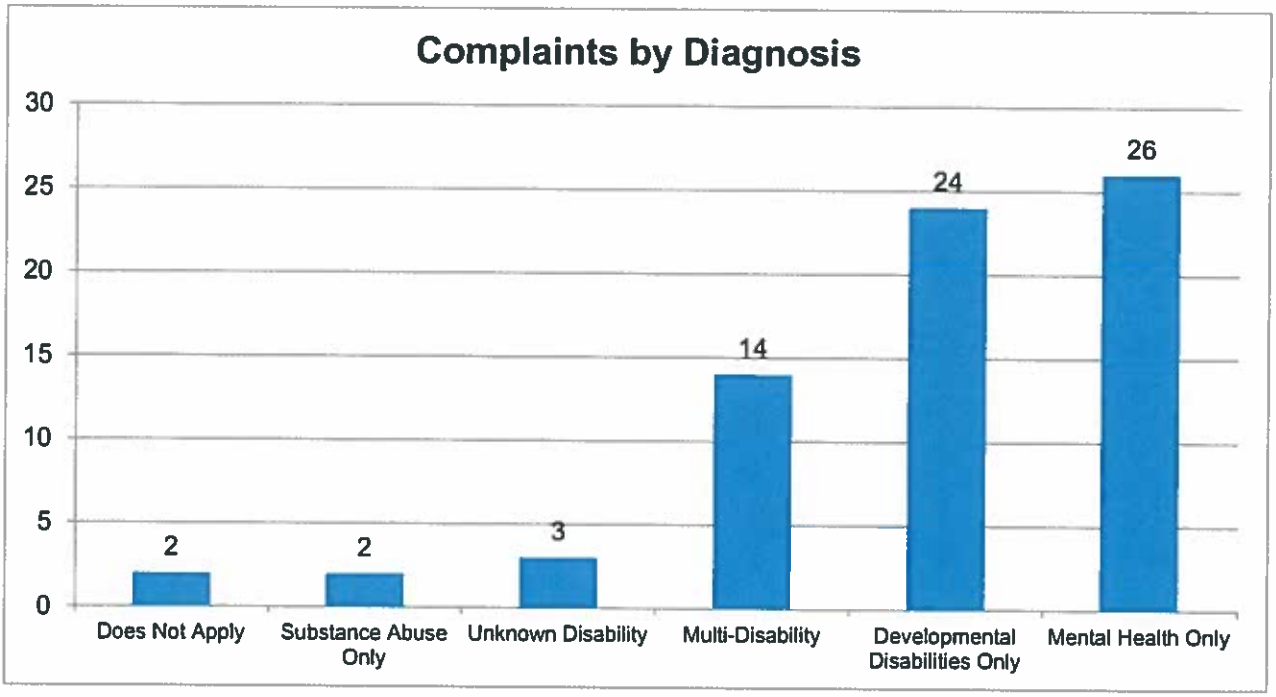
The largest numbers of complaints are against provider. The number of complaints against Sandhills Center increased this quarter as a result of a change in Innovations Budget Planning.



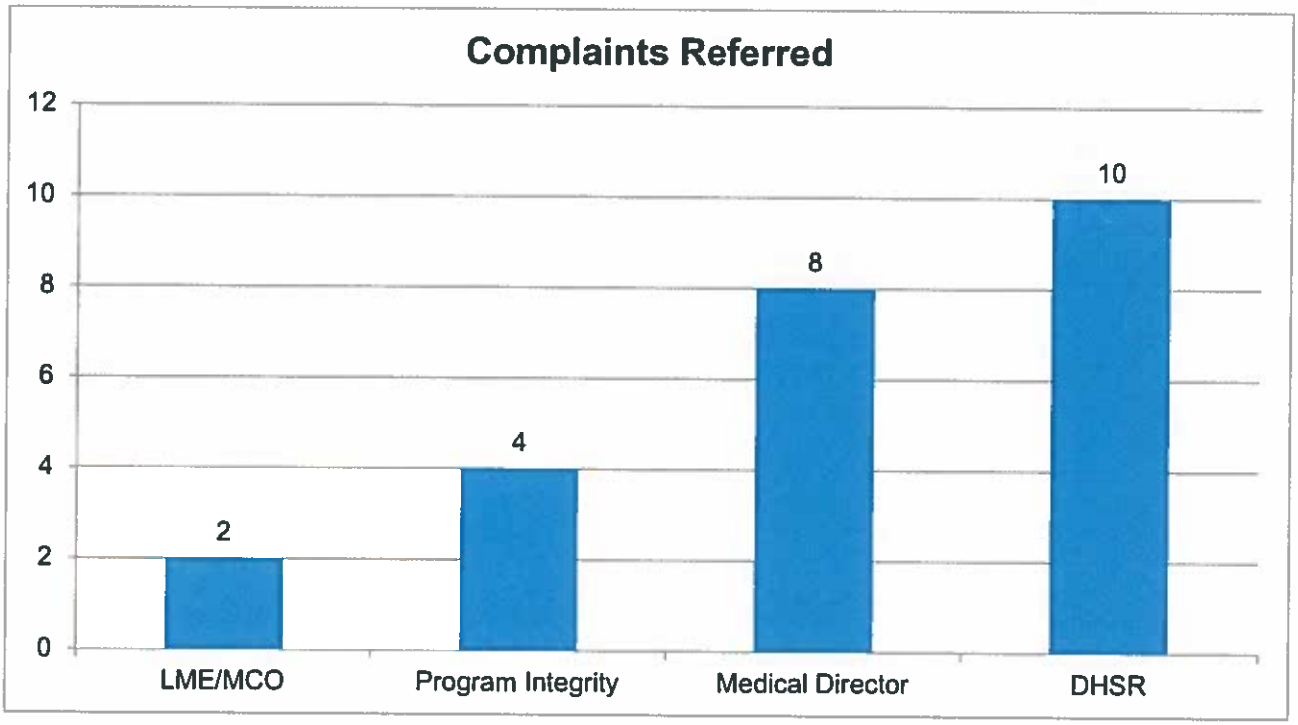
The largest type of complaint is Auth/Payment/Billing as a result of a change in Innovations Budget Planning.



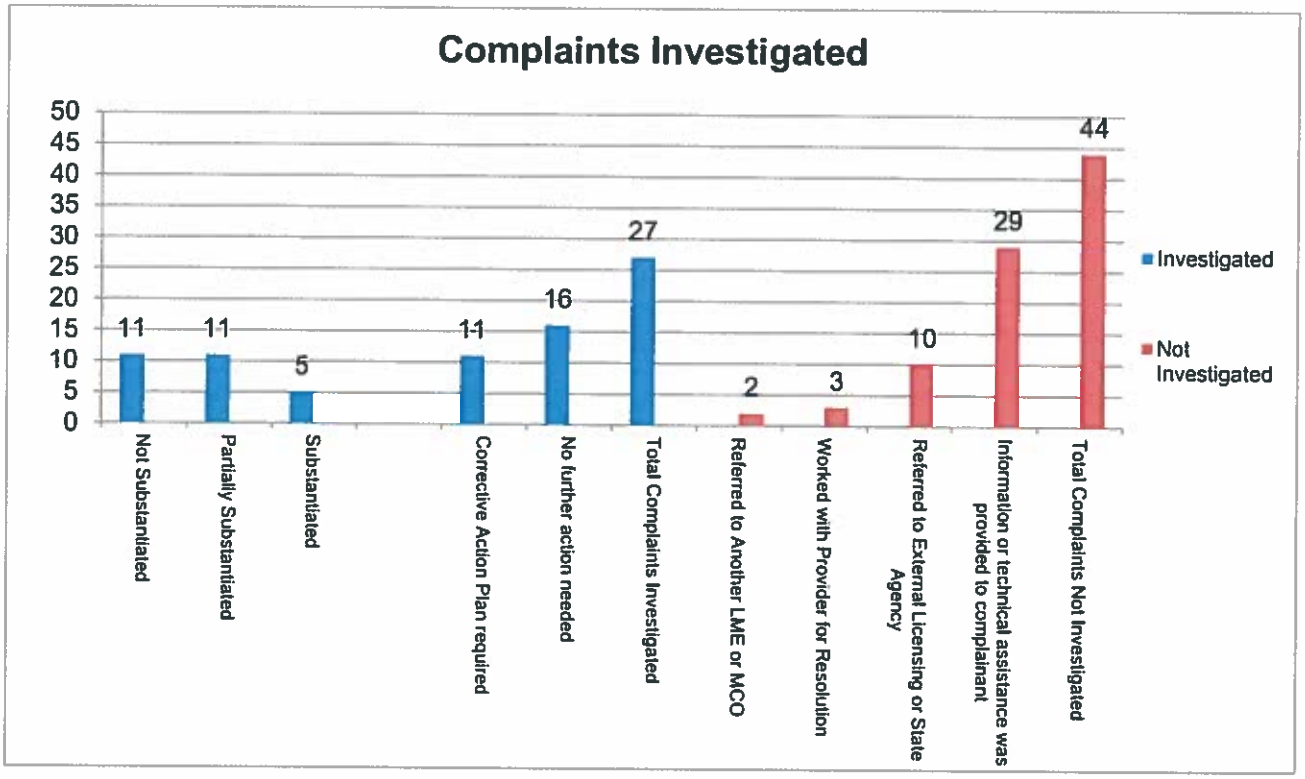
The majority of complaints were made by males; this is the same from last quarter. The majority of complaints were made on behalf of adult consumers. Consumers' complaints increased this quarter against Sandhills Center as a result of a change in Innovations Budget Planning.



The majority of complaints continue to come from members with a Mental Health Disability.

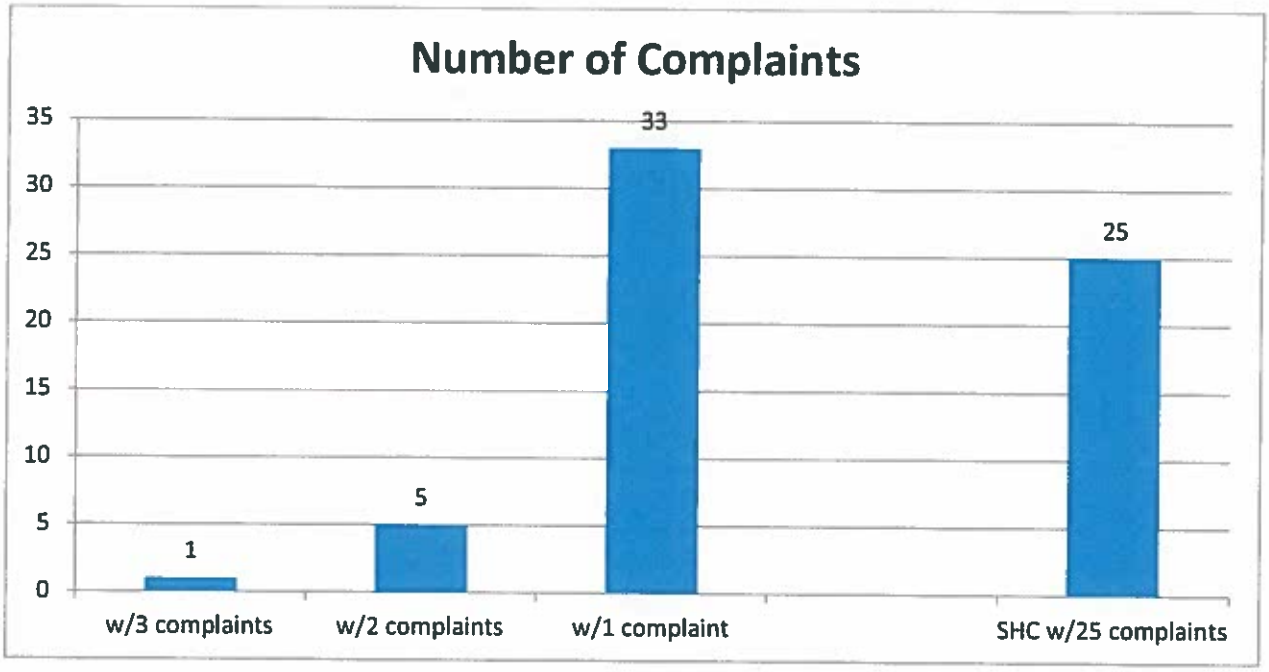


Sandhills Center continues to refer the most complaints to DHSR as these complaints are from licensed facilities. Health and Safety complaints are referred to the Medical Director.

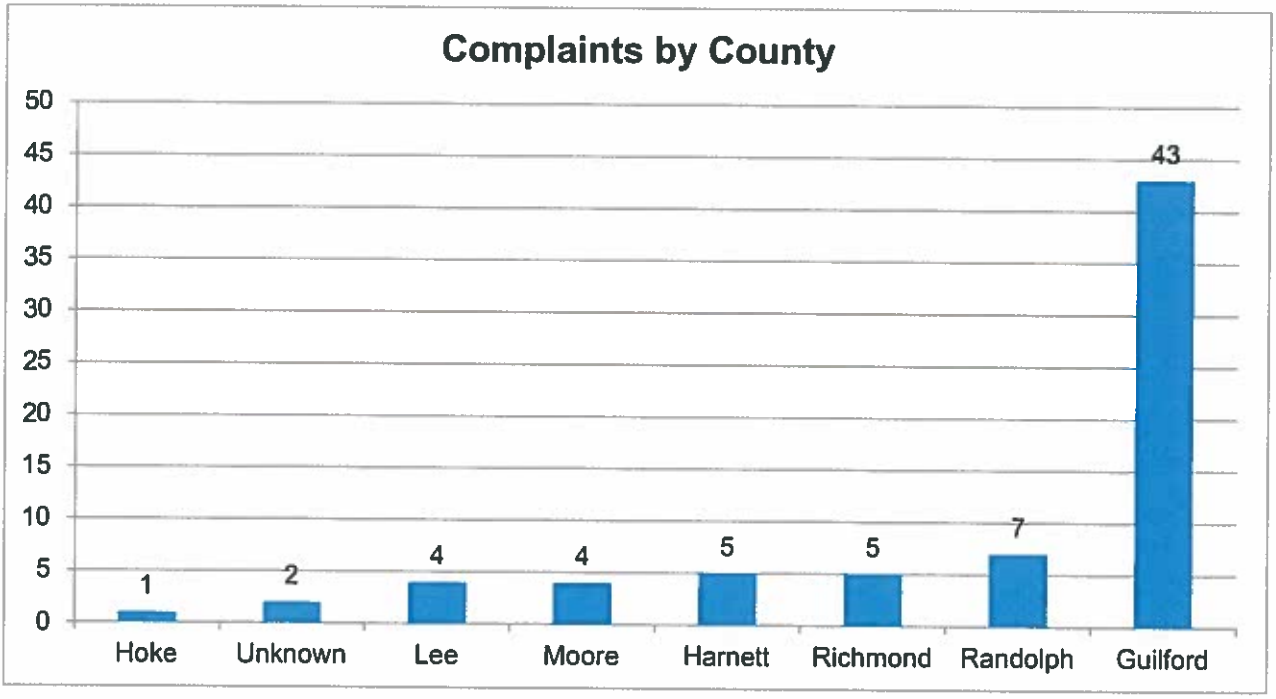


Complaints are reviewed and determined if an investigation is required. Majority of complaints were found to be partially substantiated or not substantiated.

*complaints may be referred and investigated



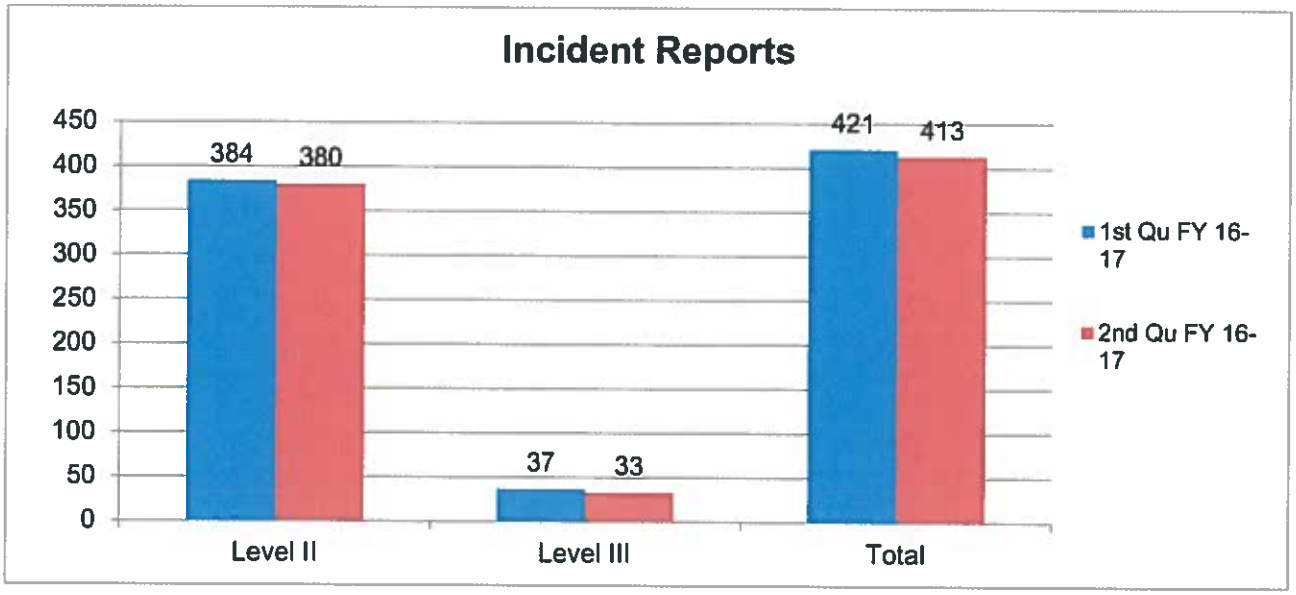
Thirty-three providers had a single complaint, two providers had five complaints and one provider had three complaints against them. Twenty-five complaints were against Sandhills Center complaints as a result of a change in Innovations Budget Planning.



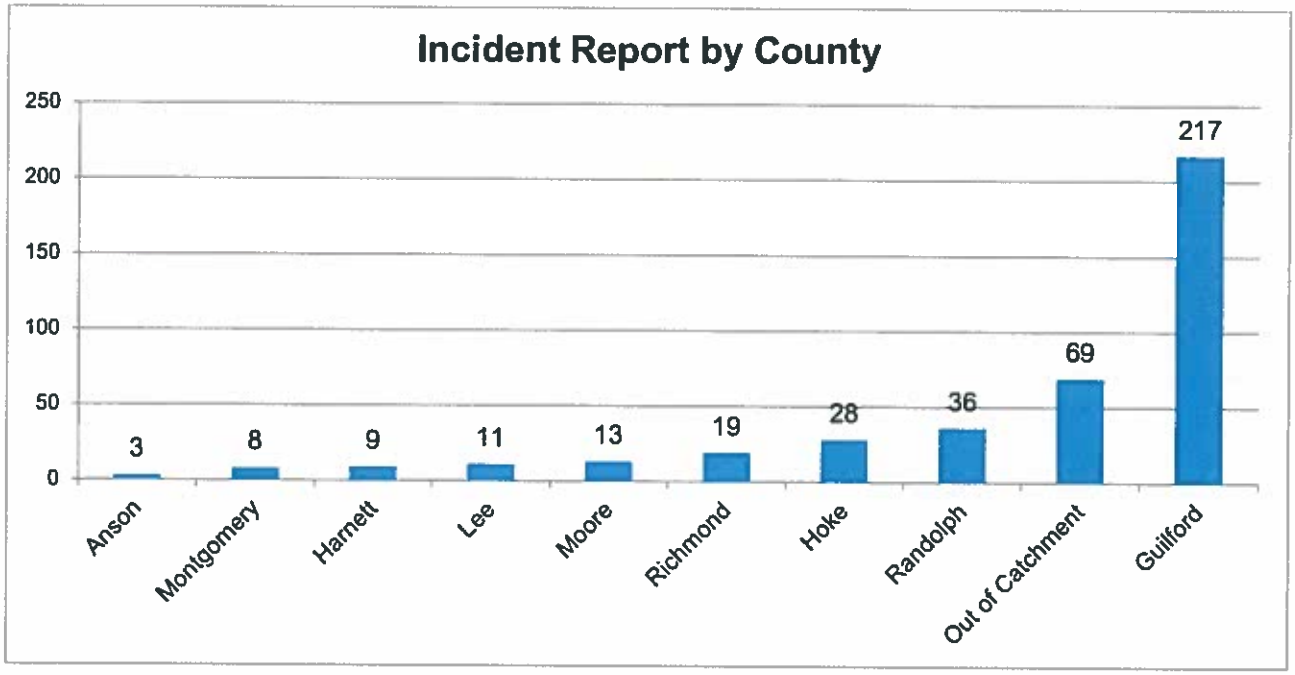
Majority of complaints continue to come from Guilford County.

Quarterly Level II/III Incident Reports

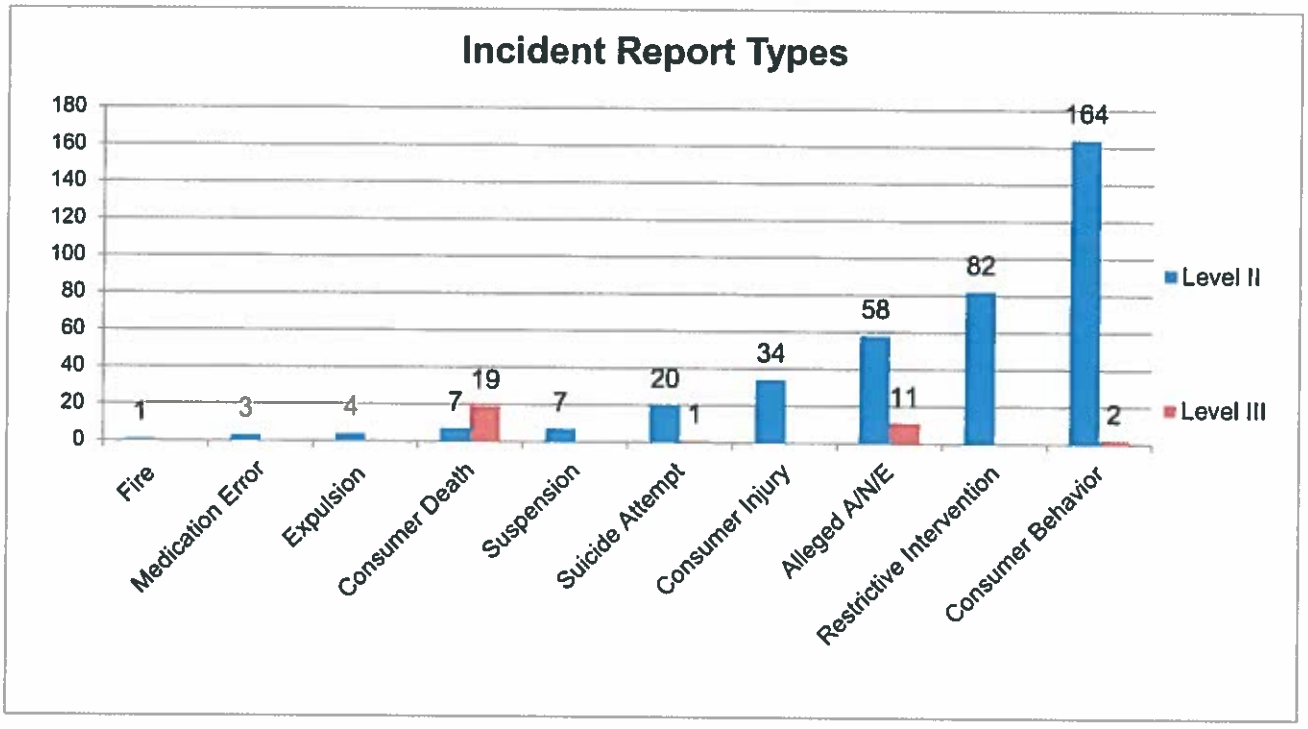
Brief description of the Report: The report shows the Level II and III Incident results.



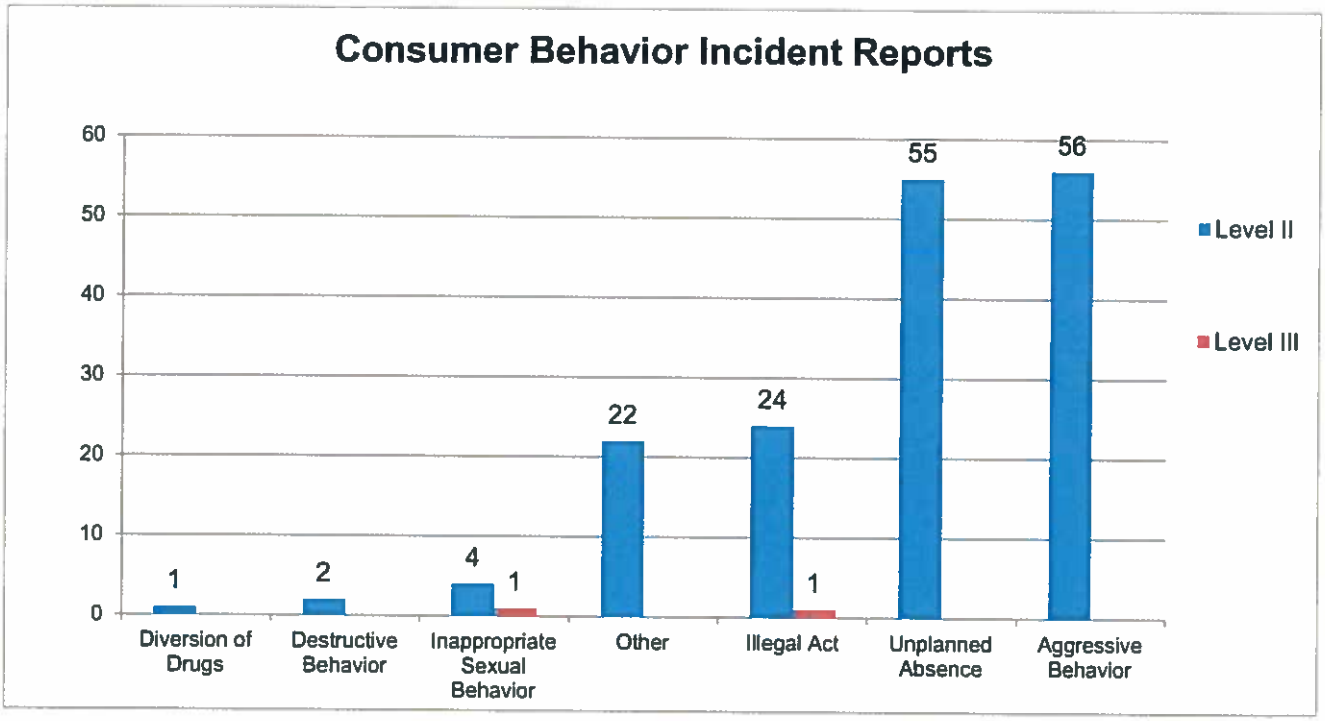
There was a slight reduction in the number of Incident Reports in the 2nd quarter from the 1st quarter.



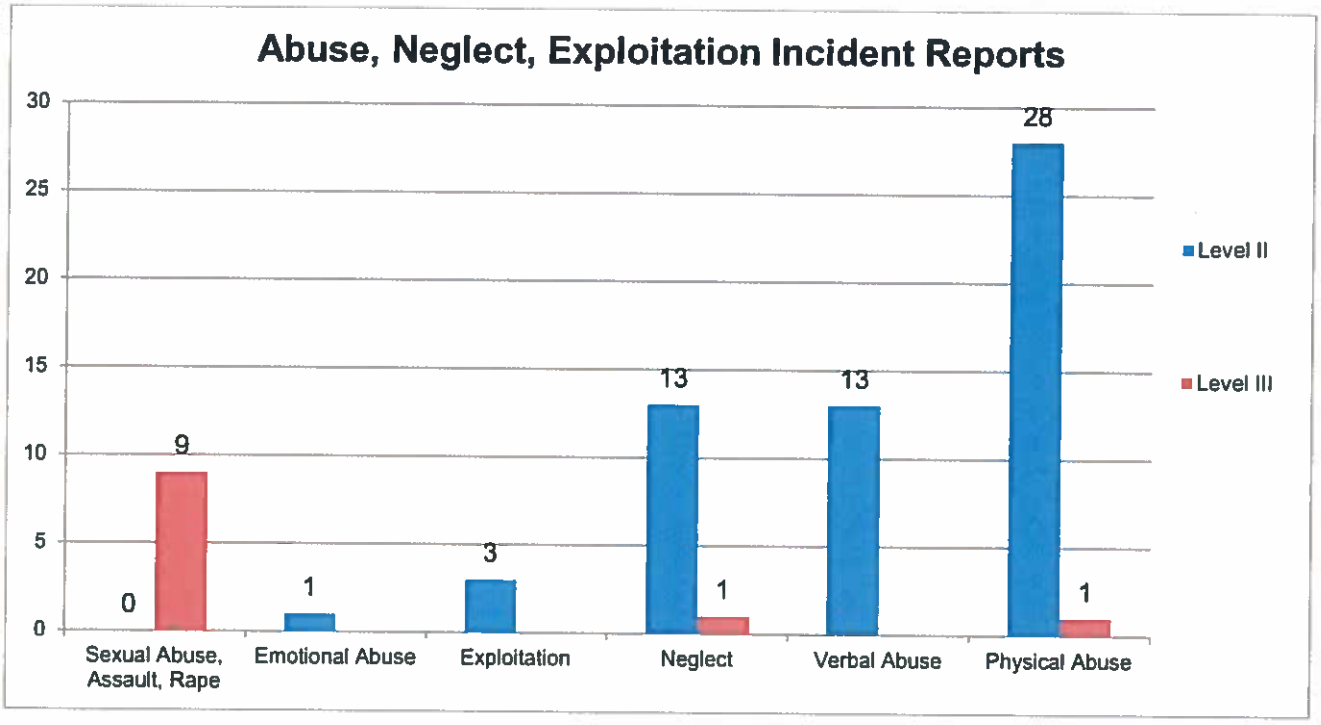
Guilford continues to have the highest number of incidents reported.



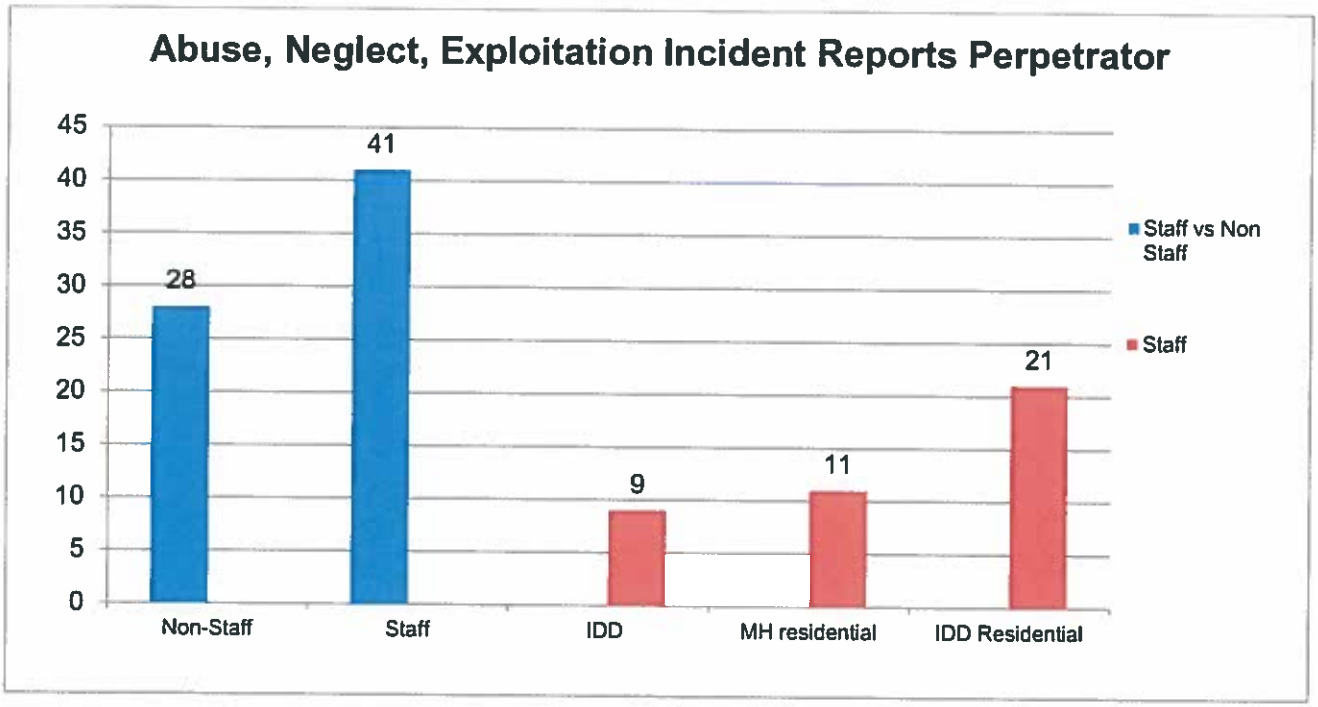
The highest type of incident reports received continues to be with consumer behavior. This number decreased from the previous quarter. Restrictive Intervention incident reports decreased from the previous quarter.



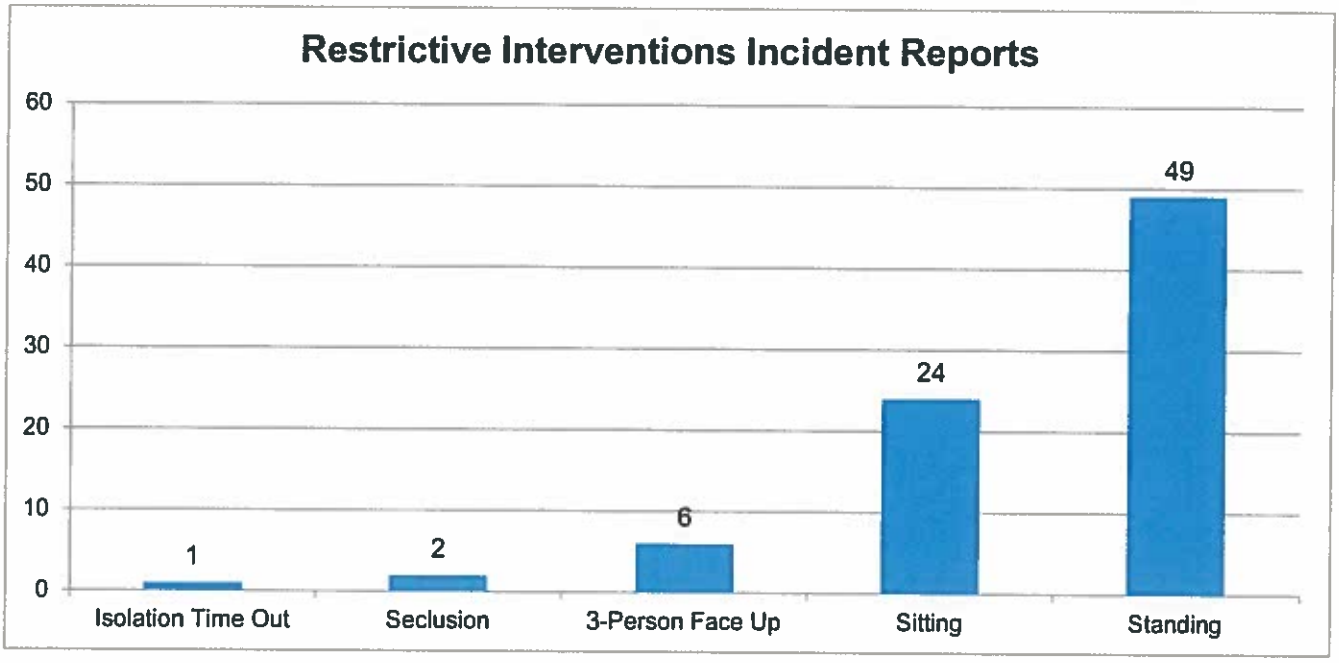
Unplanned Absence and Aggressive Behavior were the highest incident report types.



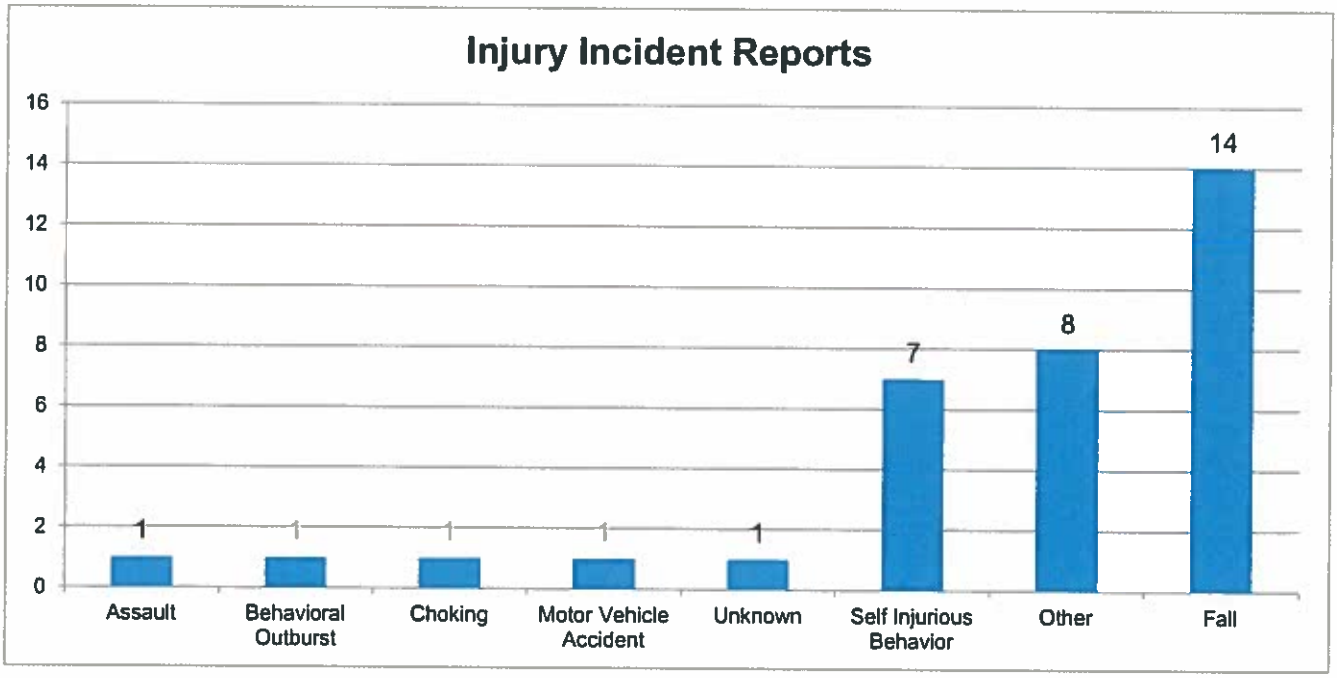
Physical abuse incident reports account for the highest number of Level II A/N/E incident reports. Sexual abuse incident reports continue to account for the highest number of Level III A/N/E incident reports. Abuse incident reports are reviewed to ensure the proper authorities have been notified.



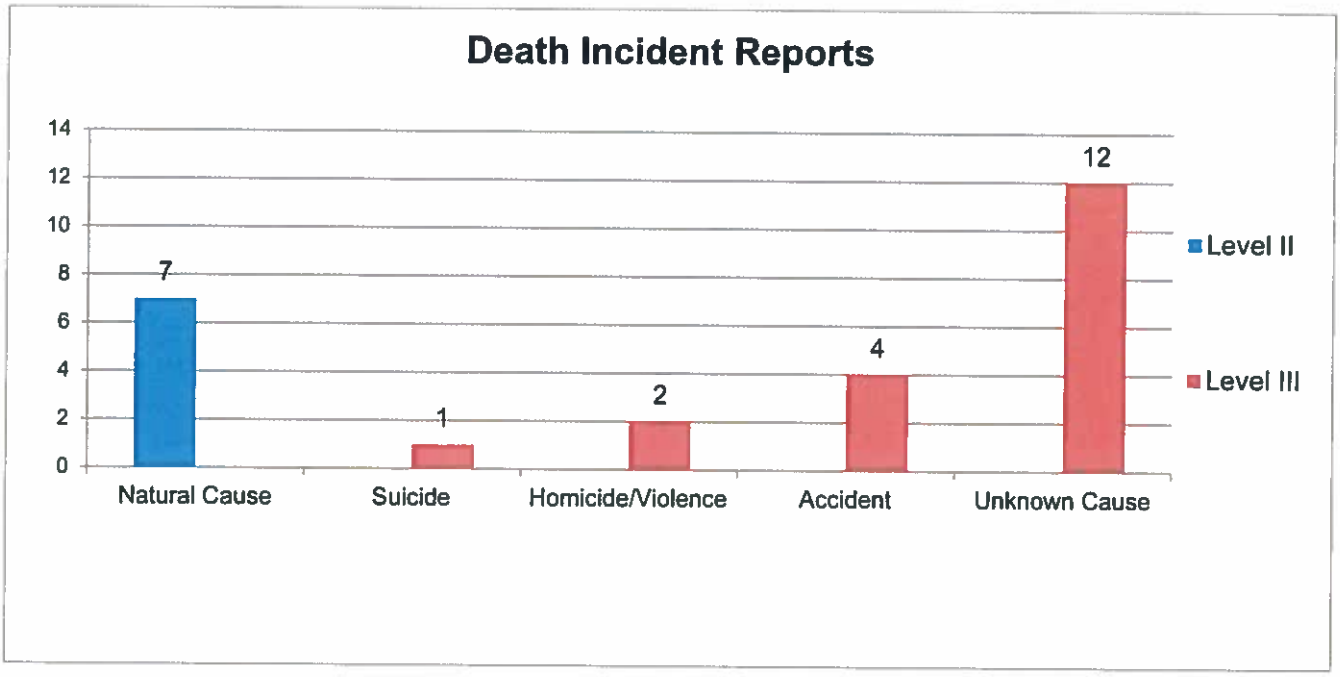
The majority of the A/N/E Incident Reports documented staff as the alleged perpetrator. The majority of these incidents took place at IDD Residential Facilities.



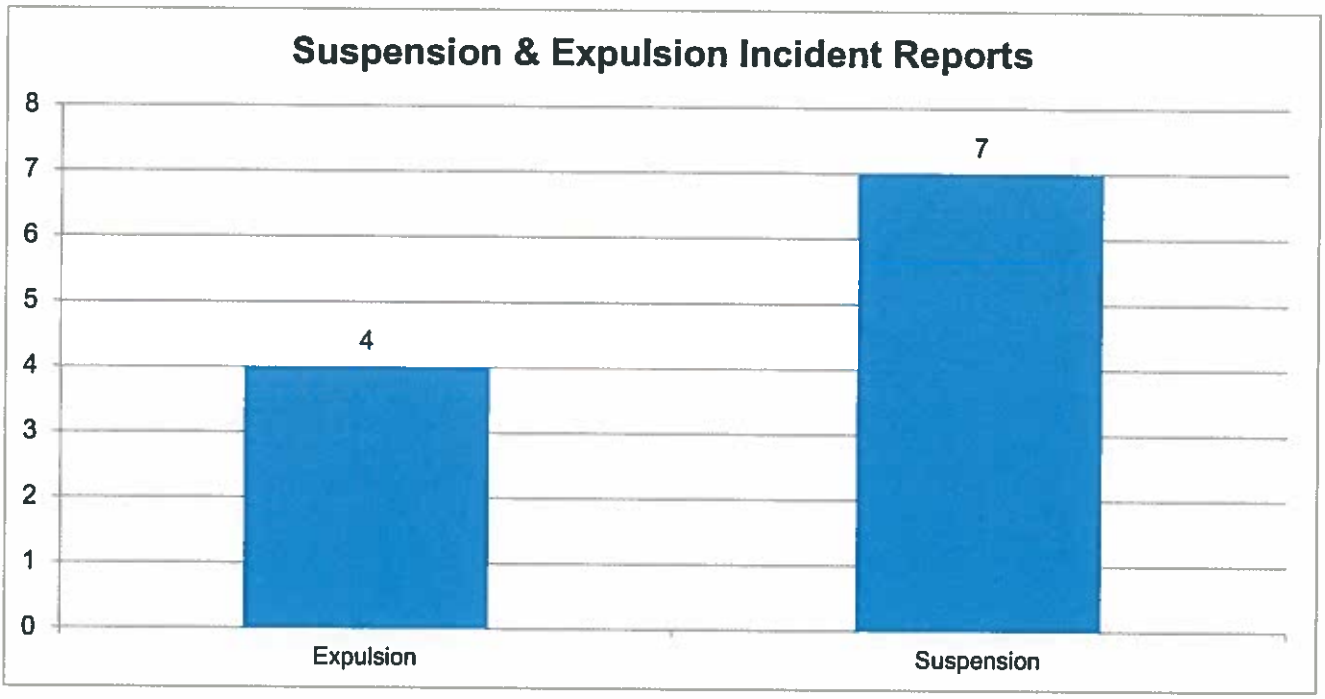
Standing Restraint continues be the leading cause of restrictive intervention incidents reports. There were no Level III incidents for this category. Restrictive intervention incident reports are reviewed for consumer safety and staff training.



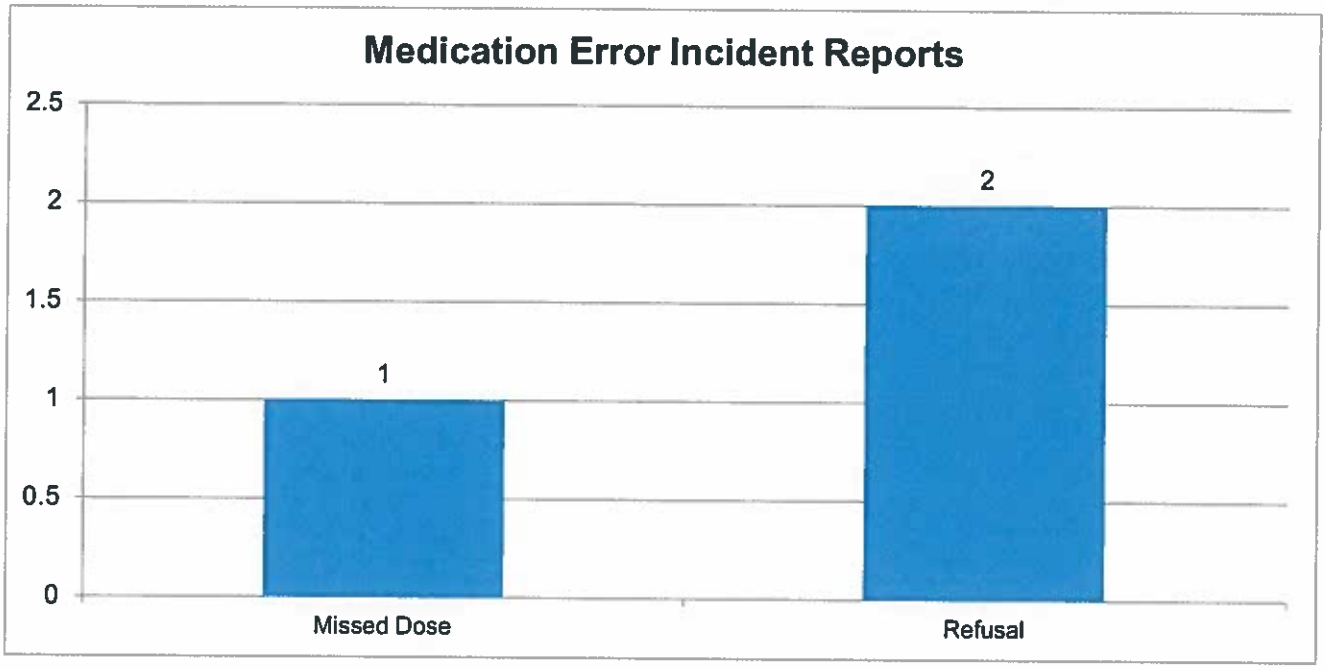
Falls continue to account for the largest number of injury incident reports.



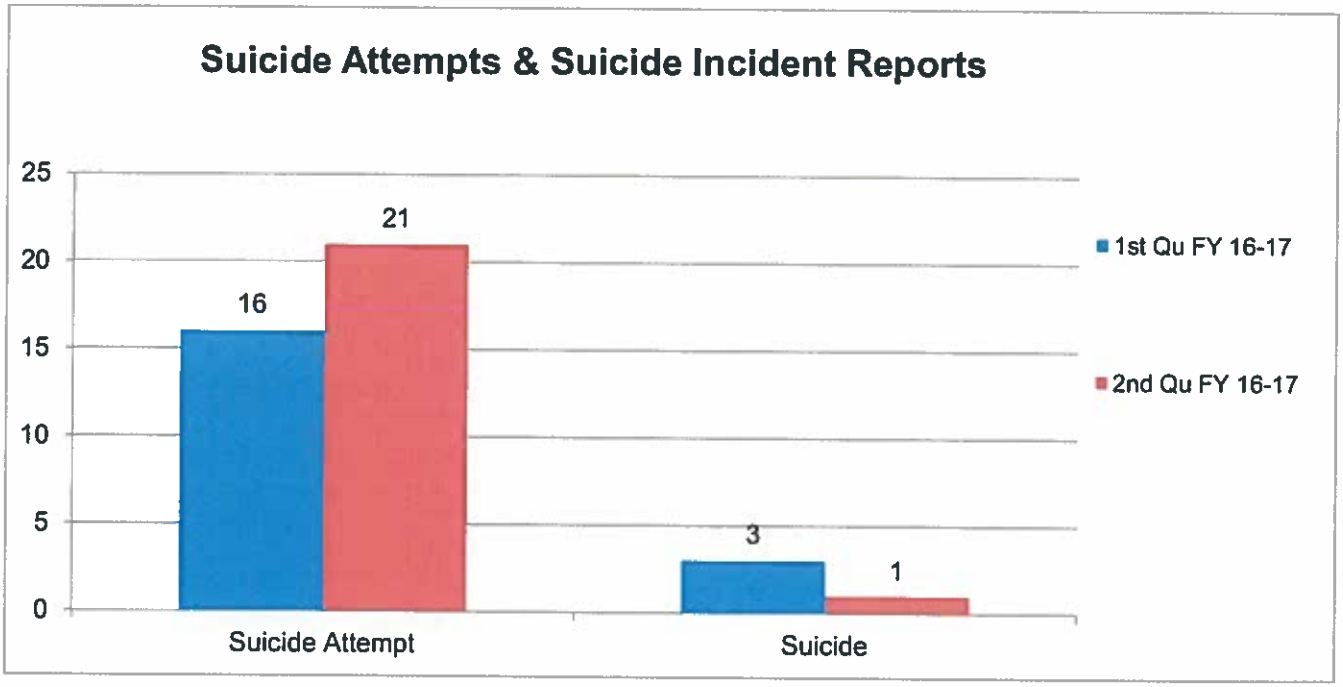
All death incident reports are submitted as Level III incident reports. They may be downgraded to a Level II once the death report is submitted, detailing the cause of death.



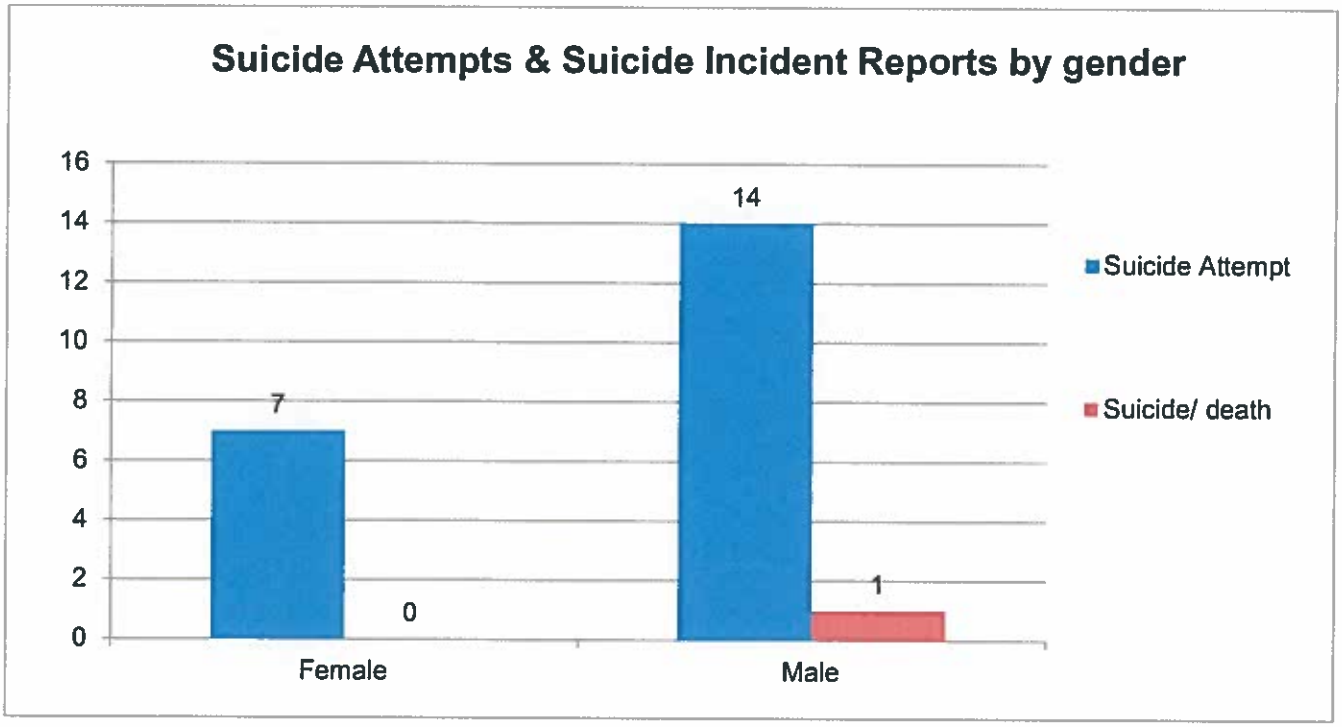
The majority of Suspension and Expulsion incident reports were submitted by Substance Abuse providers.



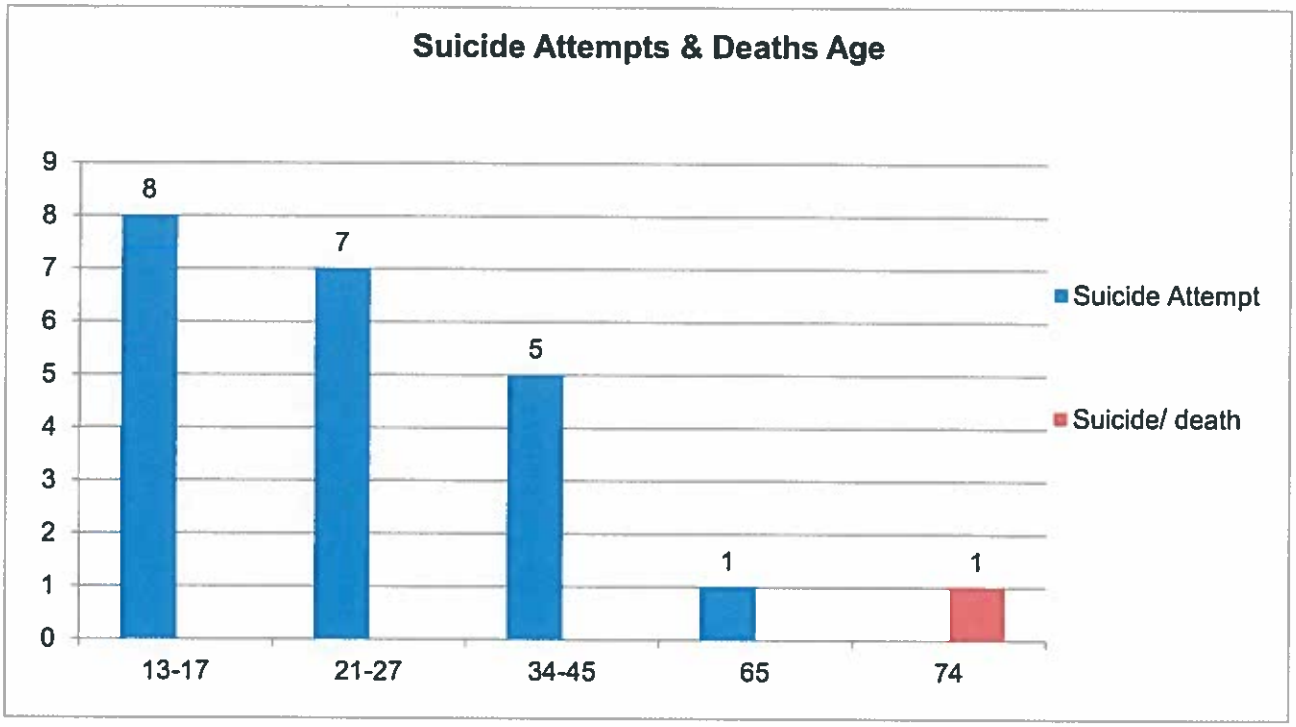
There were no Level III incidents reported for this category.



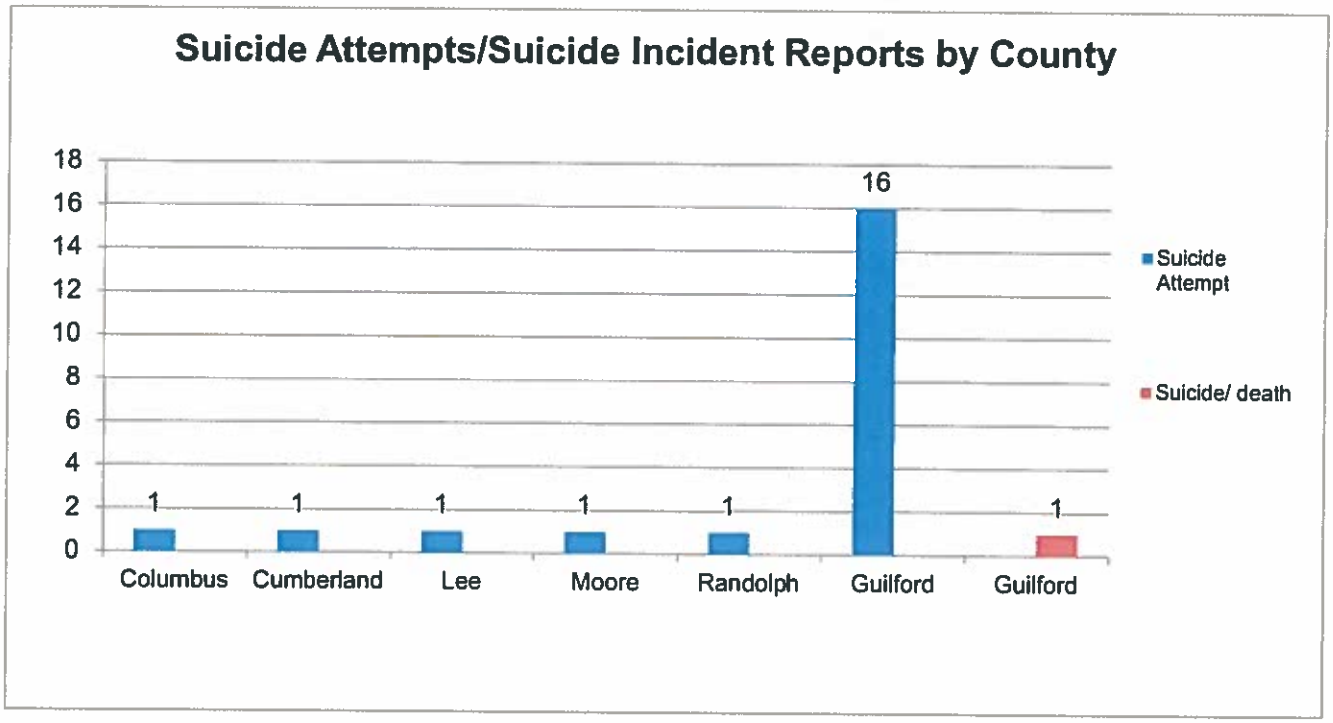
There was an increase in suicide attempts for 2nd quarter from 1st quarter and a decrease in suicide for 2nd quarter from 1st quarter.



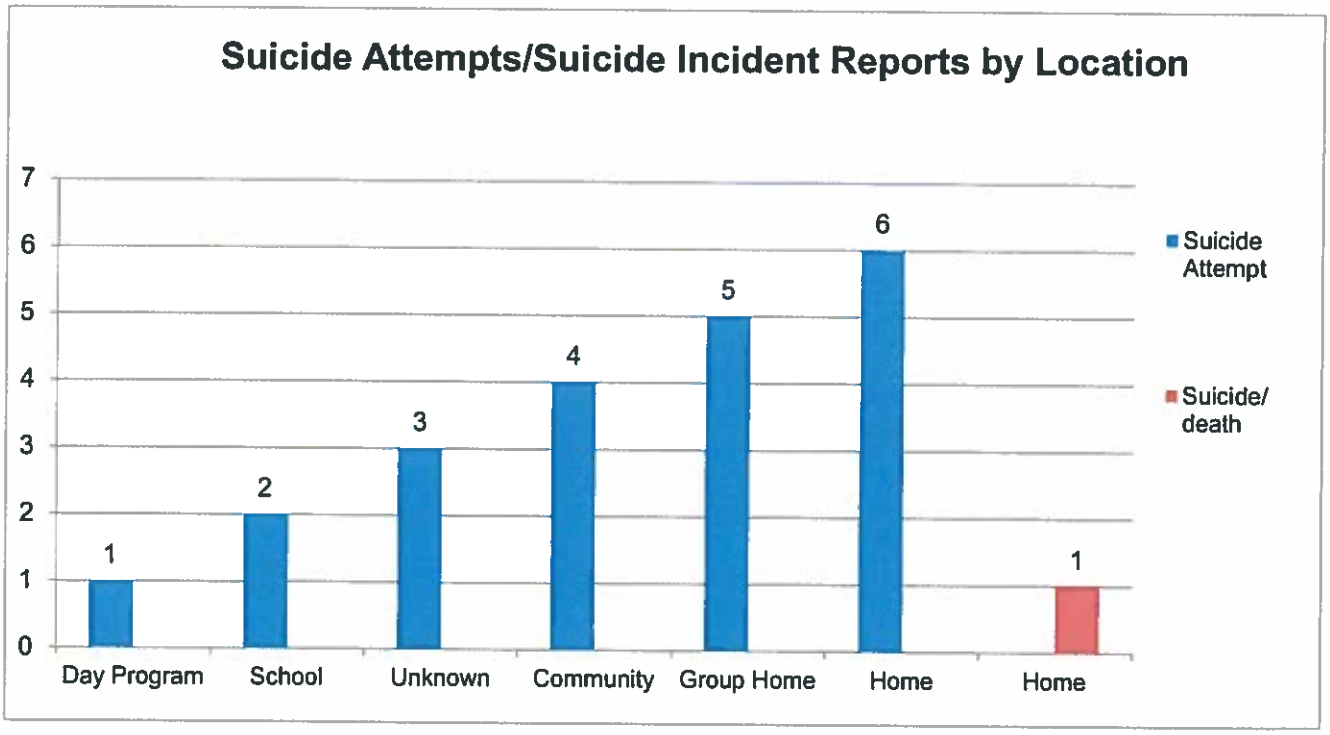
Seven females and 13 males attempted suicide (one male attempted two times). One death by suicide was male.



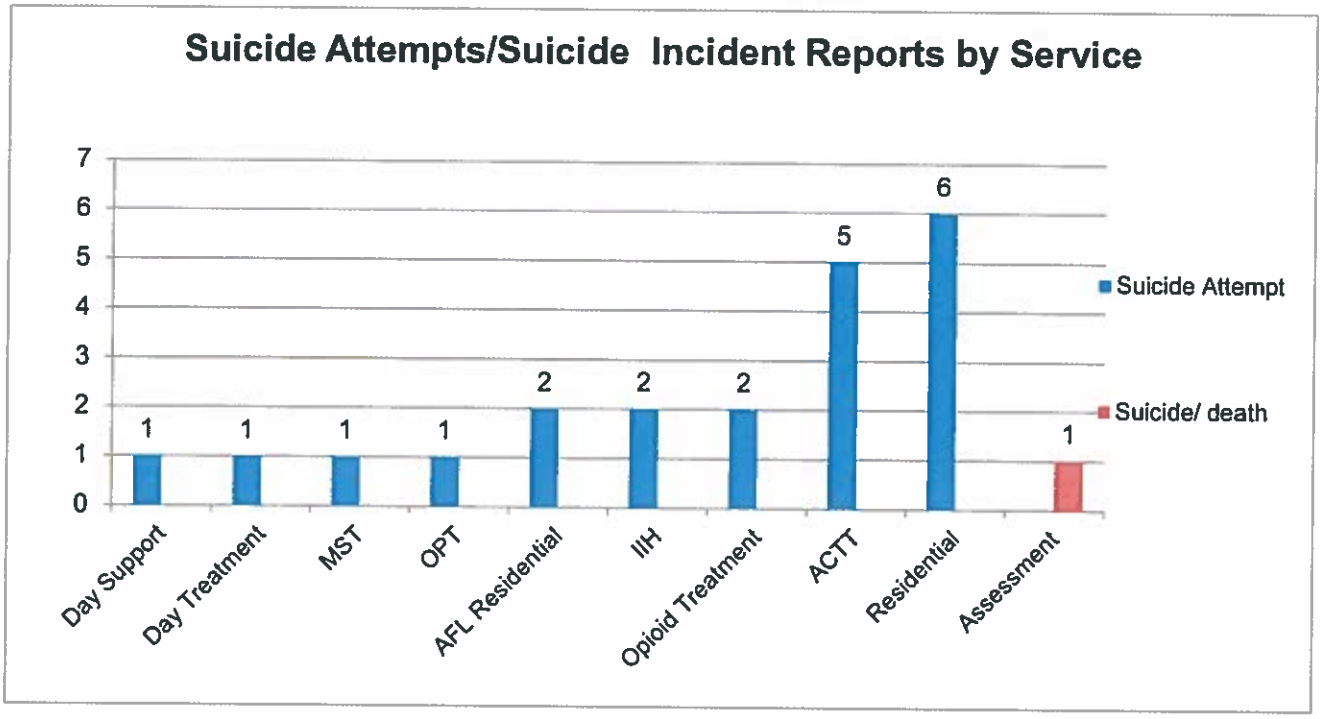
The highest number of suicide attempts was in the age group 13-17. The one suicide was age 74.



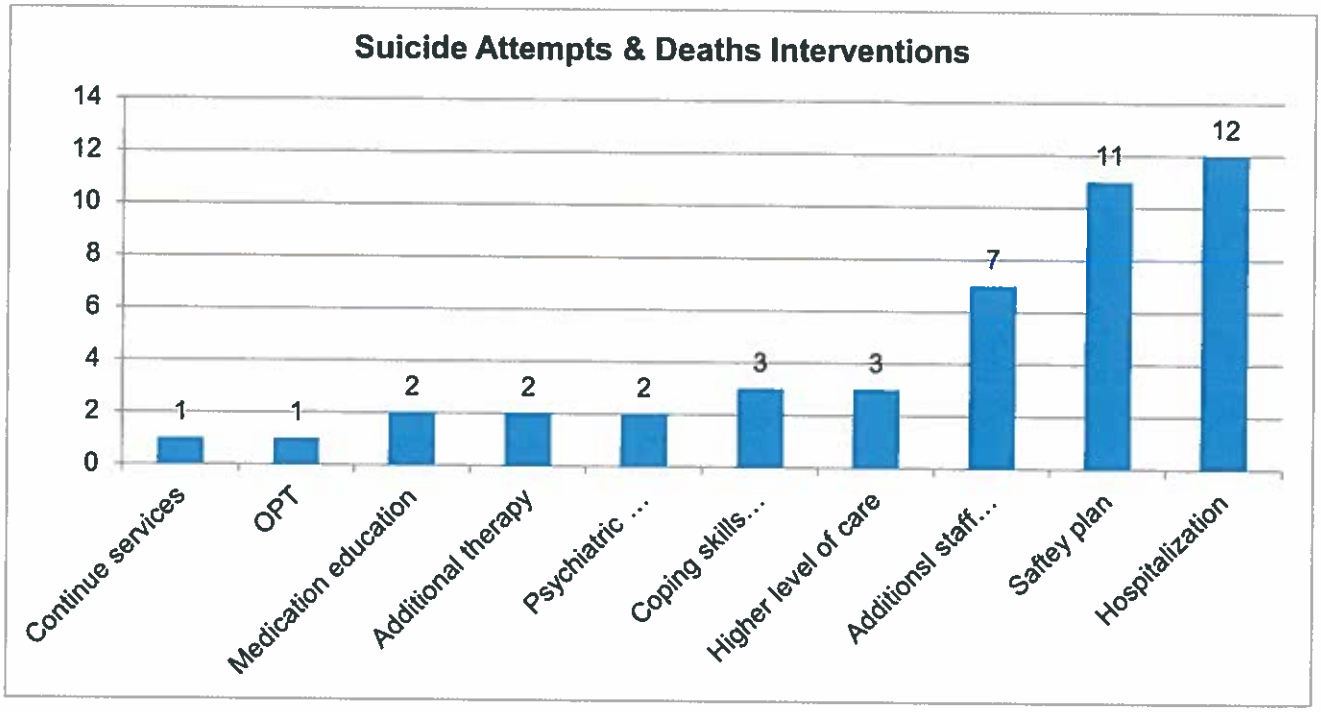
Guilford County continues to have the largest amount of suicide attempts. The one suicide was also in Guilford County.



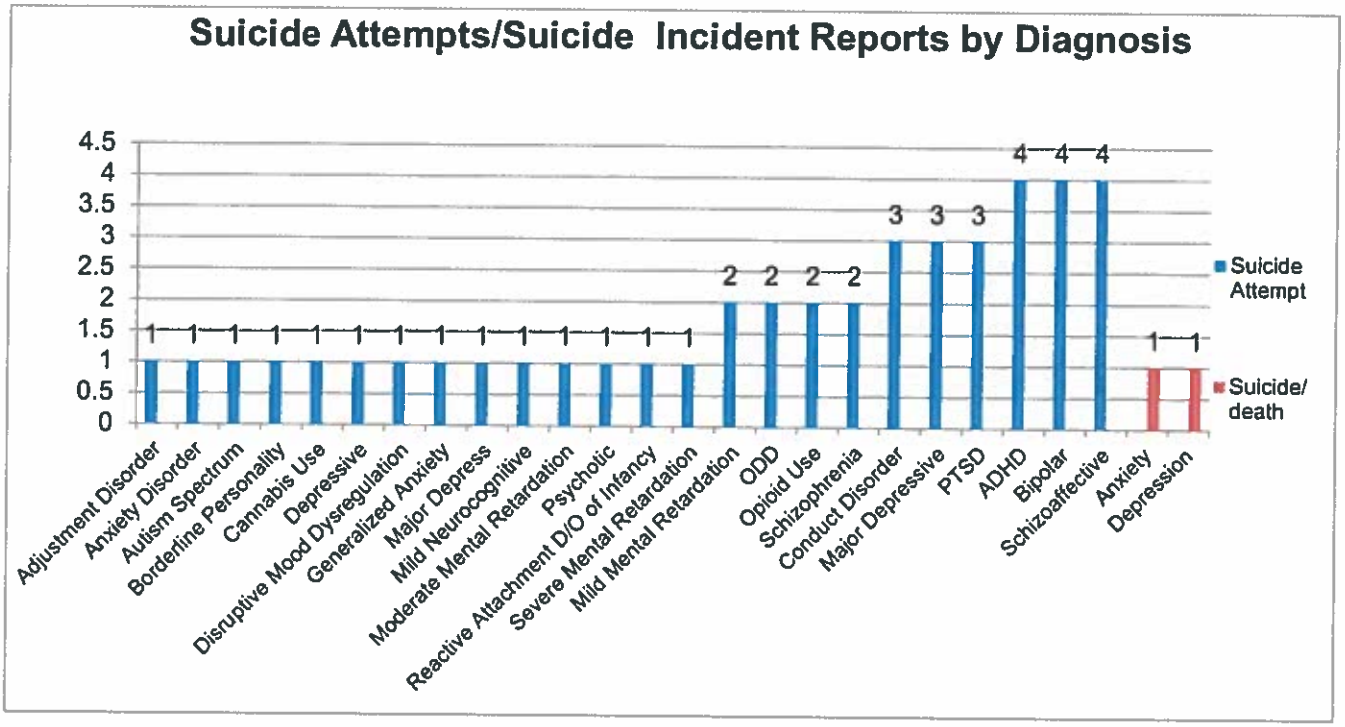
The highest number of the suicide attempts occurred in the home followed by group home. The one suicide occurred at home.



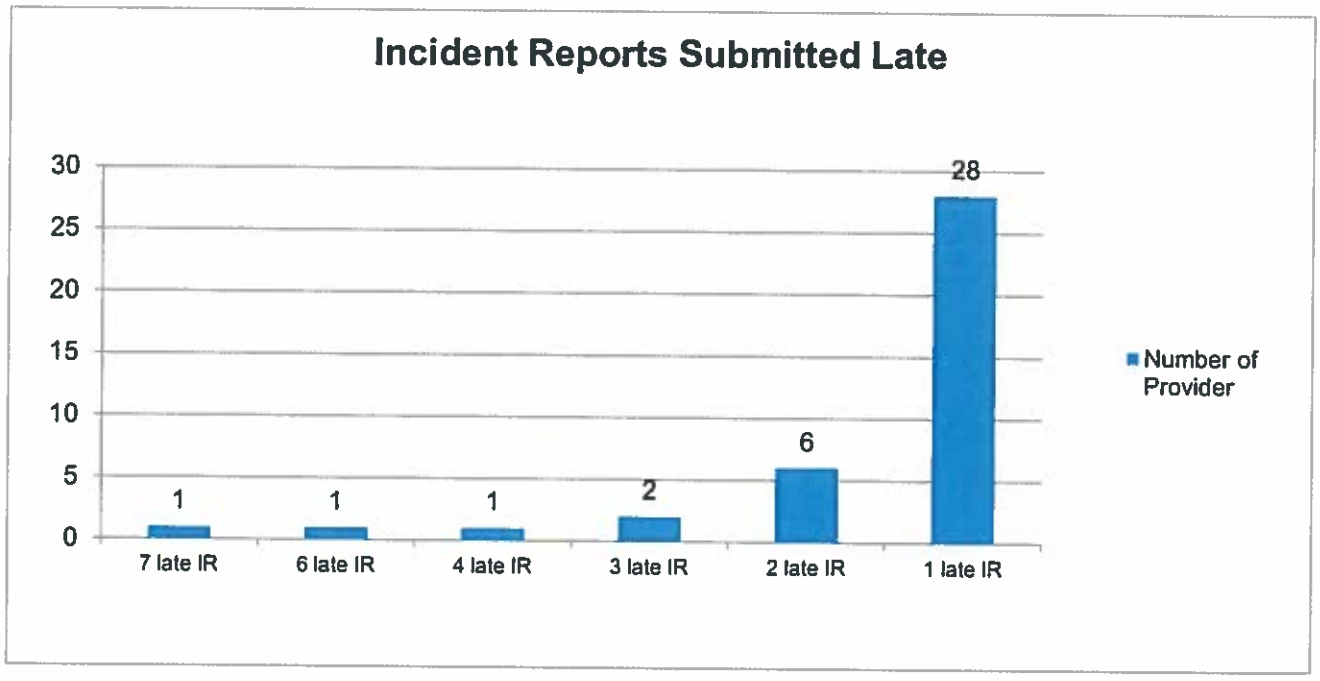
The highest number of suicide attempts occurred in residential placement. Assessment was the service for the one suicide.



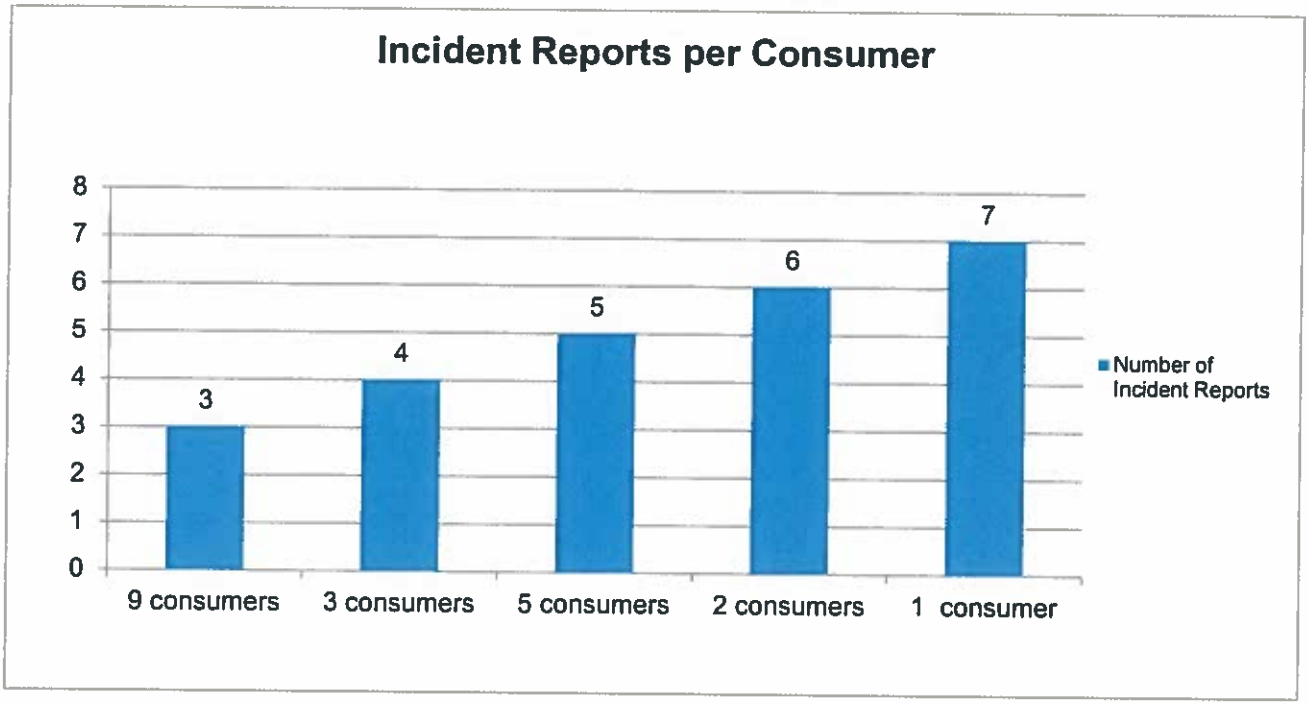
The highest intervention method for the suicide attempts was hospitalization followed by safety plan. *The number of interventions may be larger than the number of suicide attempt and suicide incident reports because consumers may have more than one intervention.



The highest numbers of diagnoses for suicide attempts are ADHD, Bipolar, and Schizoaffective. Anxiety and Depression were the diagnoses for the one suicide. *The number of diagnoses may be larger than the number of suicide attempt and suicide incident reports because consumers may have more than one diagnosis.



Incident Reports are due within 72 hours of the provider learning of the incident. In the case of a death, the providers have 24 hours to submit an incident report after calling Sandhills Center. One provider had seven late Incident Reports (38.89% of this provider's IRs were late). One provider had six late Incident Reports (25% of his provider's IRs were late).



The largest number of incident reports per consumer is seven. All incident reports are tracked for trends.

Quality of Care Concerns Report
2nd Quarter FY 16 – 17

Brief Description of the Report: The report shows the Quality of Care (QOC) referrals received including referral source and type of QOC concerns.

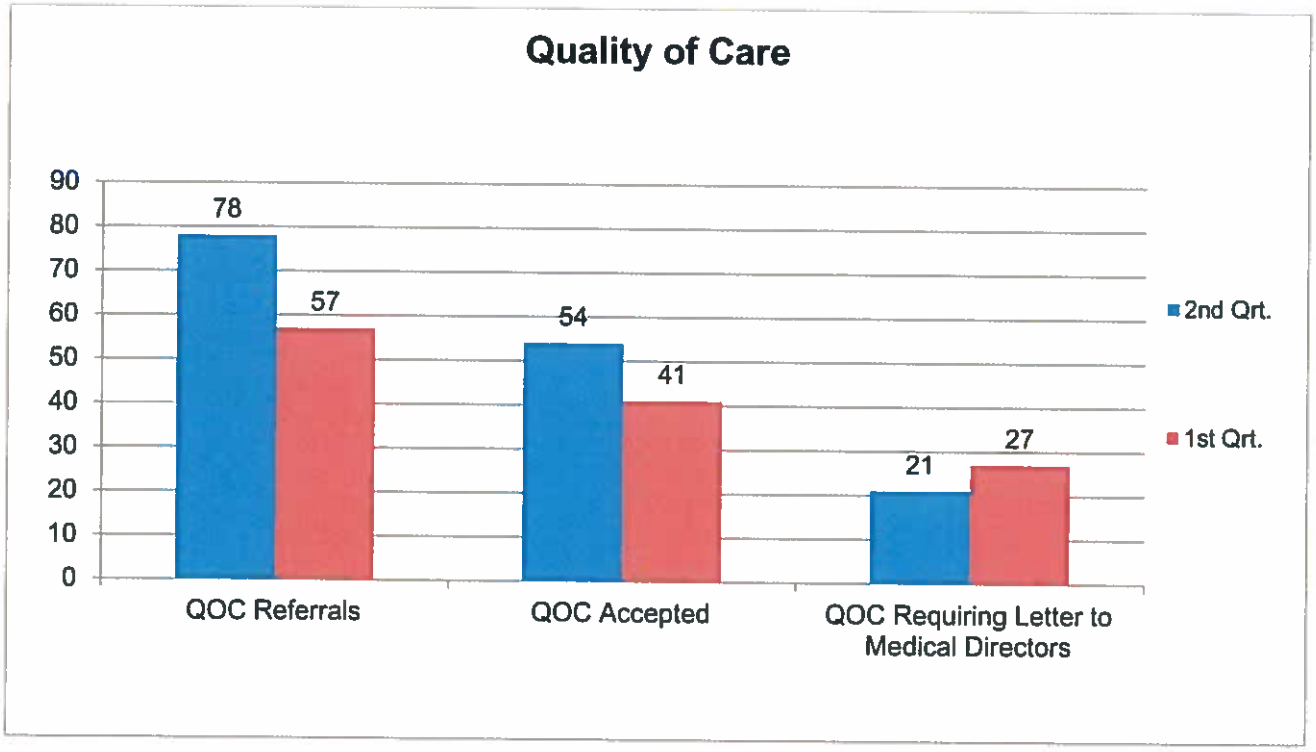
Analysis and Trends:

Strategy for reviewing QOCs and resolution changed during this quarter. In addition to polypharmacy and diagnoses concerns, all QOCs with clinical concerns are sent out for an independent psychiatric review. Those results are then reviewed by our in-house psychiatrist and letters are sent from the QM Director and the Medical Director, offering technical assistance by sharing the results of the reviews and recommendations. This process remains in place and 21 letters following these reviews were sent out this quarter.

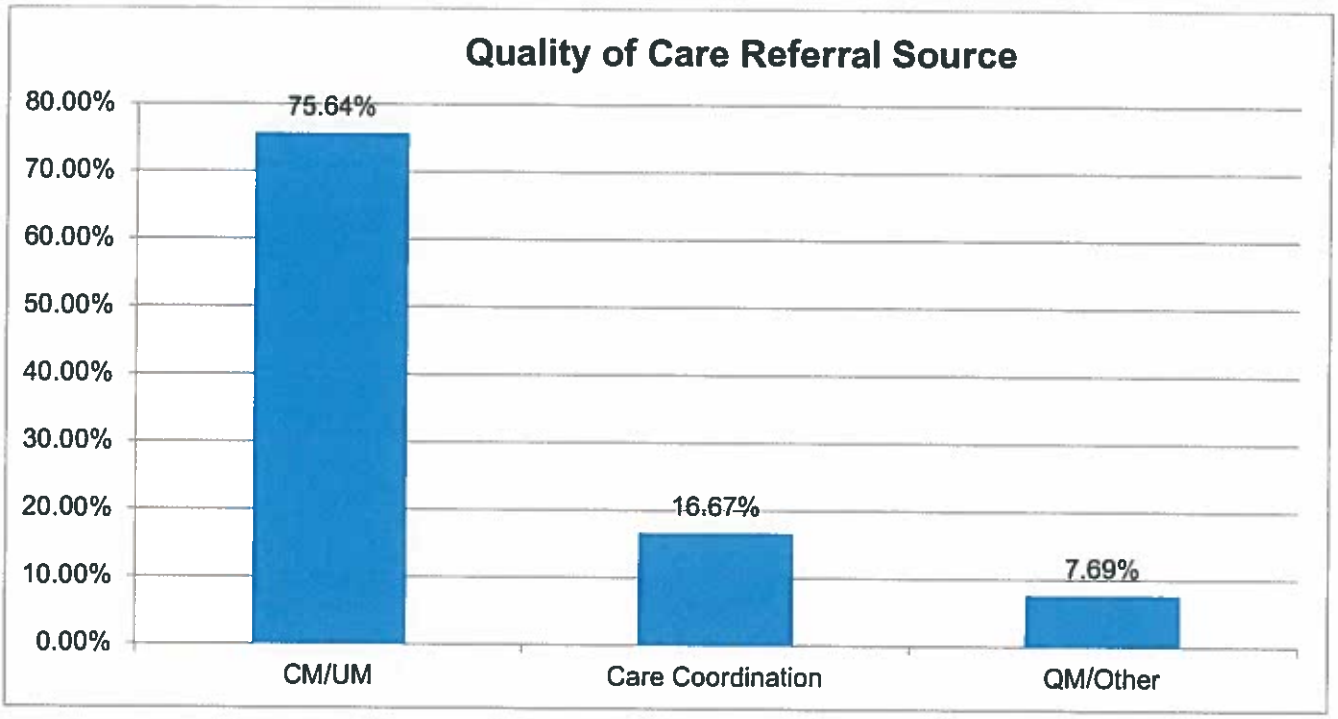
Cases that pertain to multiple consumers or potentially not true to the model may be sent to Network monitoring for onsite to determine cause of problem.

Cases with non-clinical issues will have an internal chart review by the QM Department and may subsequently be referred for psychiatric review or technical assistance is offered by the QM Department. Plans of correction are not being sent, in an attempt to achieve better results with technical assistance, rather than as punitive action. Results will be tracked for progress in eliminating concerns.

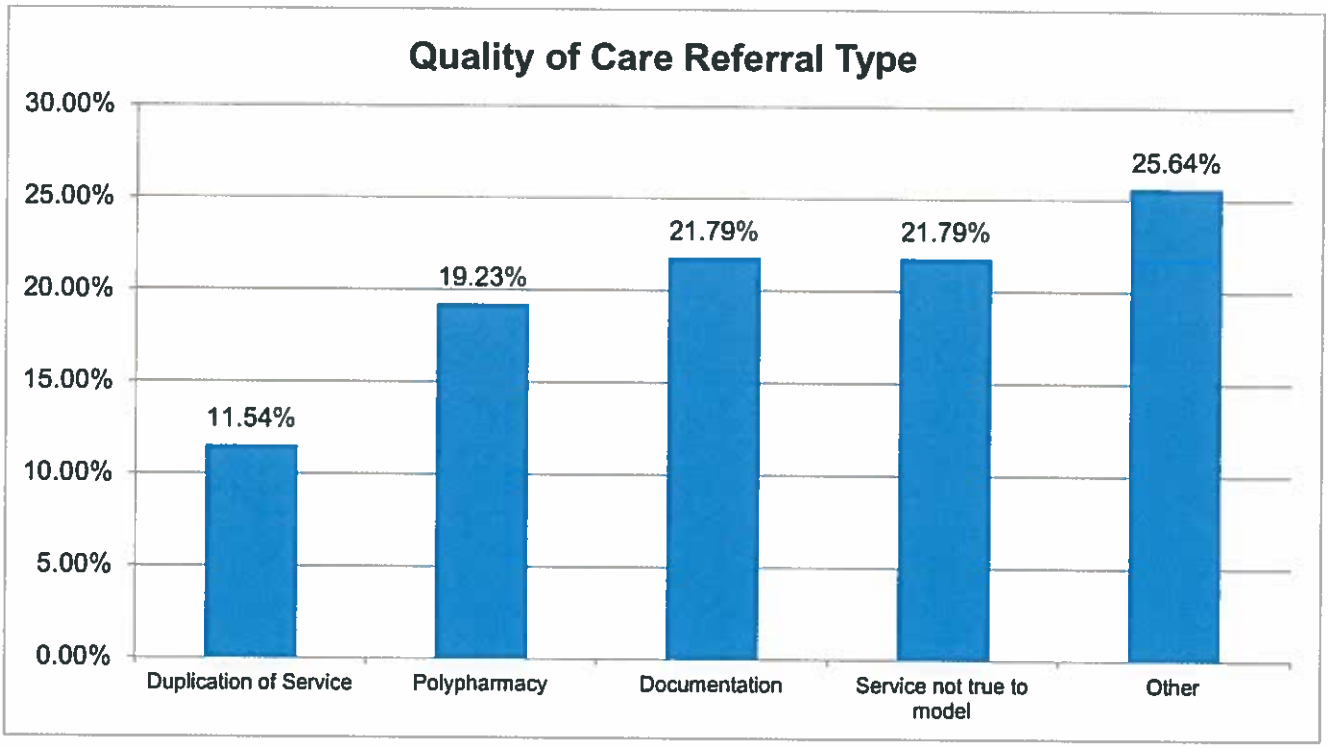
The number of Quality of Care accepted increased from 1st quarter (41) when compared to 2nd quarter (54).



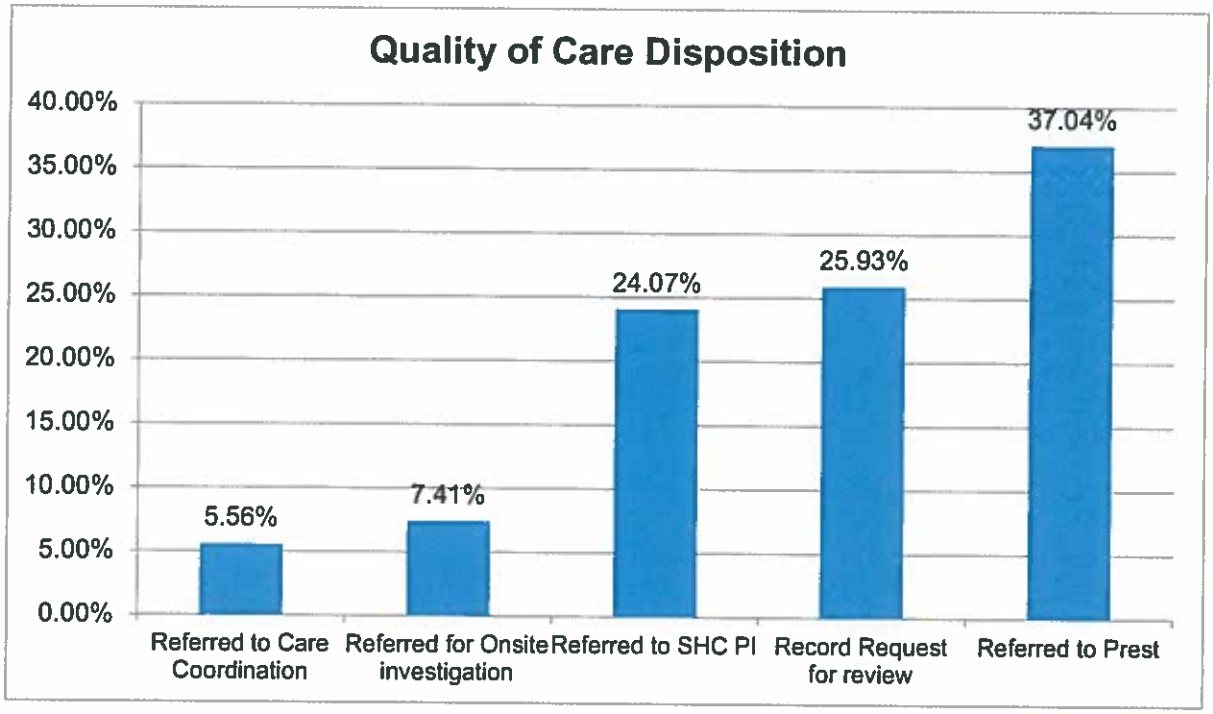
The number of Quality of Care referrals has increased from the 1st quarter (57) when compared to 2nd quarter (78).



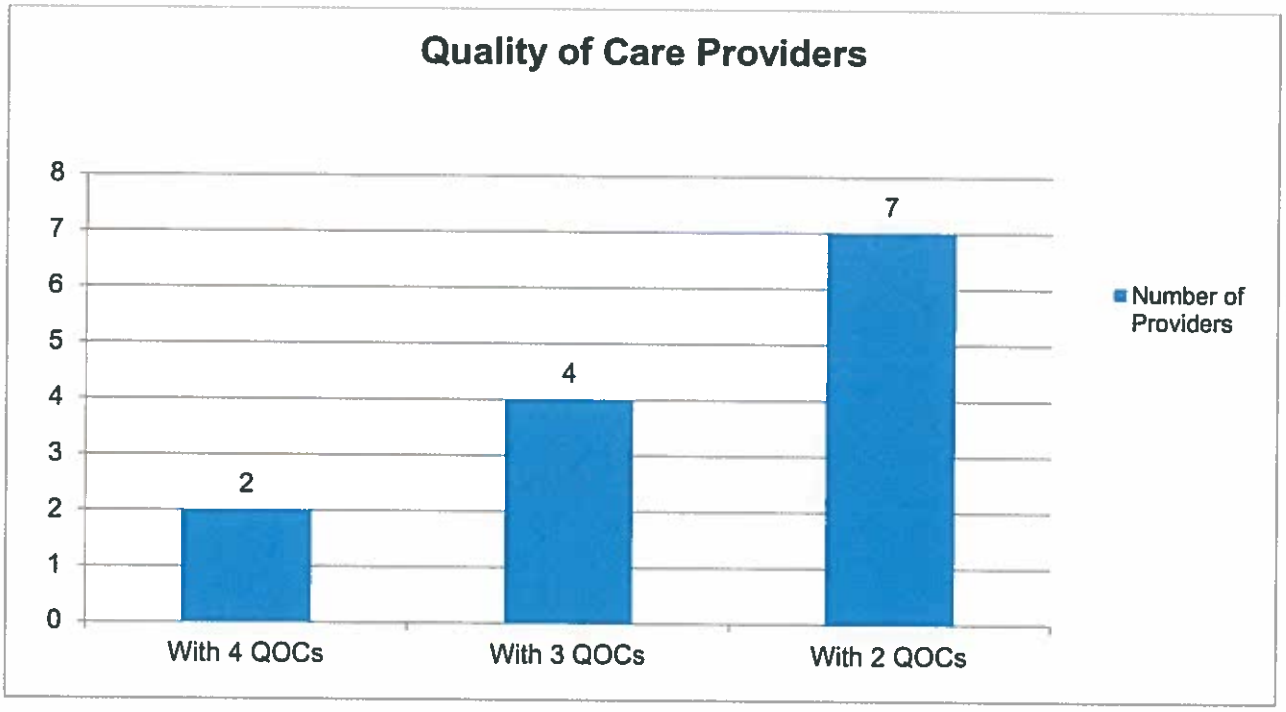
CM/UM continues to be the largest referral source for Quality of Care concerns.



Service not true to model and documentation continue to be the largest number of QOCs submitted.



All QOCs with clinical concerns are sent out for an independent psychiatric review. Those results are then reviewed by in-house psychiatrist and letters are sent from the QM Director and the Medical Director.



Provider profiles are updated as needed for QOC referrals.

Appeals: During the 2nd quarter, no appeals related to complaint resolution, provider disputes or utilization management were brought to the QMC for review.

Executive Summaries: Were received from the following programs:

- Care Management/Utilization Management
- Health Network and Network Leadership Council
- Customer Services

Reports: The following reports were reviewed by the QM Committee and QM Program Committees, as well as stakeholders, Consumer and Family Advisory Committee [CFAC], Client Rights Committee, Network Leadership Council [NLC], LME-MCO Executive Management Team, and the Board of Directors:

- Quarterly Level II and III Incident Reports
- Quarterly Complaint Reports
- Quarterly Quality of Care Concerns
- Quarterly Evidence-based Practices Reports

Critical Incident Reports (CIR) Quarterly Report: The Committee met monthly and reviewed a total of 63 incidents (These are also included in the larger Level II-III report). The Committee reviewed 21 suicide attempts. There was one suicide this quarter. All suicide attempts are being referred for clinical review by an external review organization and a second expert review by our Associate Medical Director. Letters have been sent to Medical Directors/Directors of agencies, offering technical assistance and recommendations. In addition, expulsions are being tracked to determine where consumers went after expulsion and whether a referral for further services was made.

Access to and Monitoring of Services: The Program QM Committees reviewed the identified performance indicators during the quarter. No access to services concerns were brought to QMC this quarter.

olicies, procedures, correspondence and other materials presented for QOC approval:

OCTOBER 2016

Document Name	Policy/ Procedure #	Reason/Type
Fraud, Waste and Abuse Monitoring	ADM 11 ADM 11a	Policy and procedure revised to address Carolina's Centers for Medical Excellence (CCME) External Quality Review (EQR) report findings
Ownership and Control Disclosures	ADM 14 ADM 14a	New policy and procedure developed to address Carolina's Centers for Medical Excellence (CCME) External Quality Review (EQR) report findings
Prevention and Detection of Provider Network Fraud and Abuse	FIN 9a	Procedure revised to address Carolina's Centers for Medical Excellence (CCME) External Quality Review (EQR) report findings
Concealed Handgun Permit	HIM 25 HIM 25a	New policy and procedure to document the process for disclosure of clinical records to the sheriff's office for the purpose of determining if an applicant is disqualified for a concealed handgun permit, pursuant to N.C. G.S. 14-415.13(a)(5)
Non-Certification Appeals Process	HUM 33a	Revised standard appeals – non urgent process to include notification of member within one business day of receipt of decision from clinical appeal

(Medicaid)		reviewer
Standard Appeals Process Timeframe	HUM 39	Revised to include conditions in which timeline for appeal may be extended.
Investigative	PI 1a	Procedure revised to address Carolina's Centers for Medical Excellence (CCME) External Quality Review (EQR) report findings.

NOVEMBER 2016

Accounts Payable Medicaid Procedure	FIN 26d	Procedure updated due to changes made to weekly Medicaid Checkwrite process since switching from Quantum to Great Plains.
Reconciliation of Capitation Payment (820) to Benefit Enrollment (834) Procedure	FIN 31e	Procedure updated since the implementation of Chaipas and we no longer use Monarch software.
Balancing Between the Accounts Payable System and the Managed Care System for the Weekly Check Write	FIN 32d	Procedure updated to correct job title.
Individual Budget Tool (IBT) Letter Generation- NC Innovations Waiver	I/DD- CC 20 I/DD- CC 20a I/DD- CC 20 – Appendix A	New policy/procedure developed to address the NC Innovation Technical Amendment changes effective 11/01/2016 for implementation of Resource Allocation of Innovation waiver funding.
Individual Budget Tool (IBT) –NC Innovations Waiver	I/DD- CC 21 I/DD- CC 21a I/DD- CC 21- Appendix A-J	New policy/procedure developed to address the NC Innovation Technical Amendment changes effective 11/01/2016 for implementation of Resource Allocation of Innovation waiver funding.
NC Innovations Waiver Template Process	I/DD- CC 22 I/DD- CC 22a	New policy/procedure developed to address the NC Innovation Technical Amendment changes effective 11/01/2016 for implementation of Resource Allocation of Innovation waiver funding.
Resource Allocation- NC Innovations Waiver	I/DD-CC 23 I/DD-CC 23a	New policy/procedure developed to address the NC Innovation Technical Amendment changes effective 11/01/2016 for implementation of Resource Allocation of Innovation waiver funding.

Monitoring the Provision of Evidence-Based Best Practice Services	NM 7 NM 7a	Removed "routine & post payment" from the policy & procedures so EBP Assessment tools may be used on all types of monitoring reviews.
Participating Provider Violations and Dispute Resolutions (Medicaid)	NM 13a, 14, 15, 16a	Revised from Network "Management Manager" to Network "Director". Providers are to submit disputes to the Network Director or designee.
Participating Provider Violations and Dispute Resolutions (State Funds)	NM 13a, 14, 15, 16a	Revised from Network "Management Manager" to Network "Director". Providers are to submit disputes to the Network Director or designee.

EXPEDITED REQUESTS

Care Coordination	Housing Summit Breakfast letter	Communication for community/providers
Regulatory Affairs (QM)	Access2Care Bookmark	for community/providers
Health Network	Dr. Carraway letter re EBP	for providers
Health Network	Core 6a, N-CR 1,4, N-CR 9a, N-CR 13a, N-CR 14, 14a, N-CR 15A, n-cr 17A,	Policies & procedures included within N-CR 1a-18a, N-NM 3a
CM-UM	Initial Clinical Review Process	HUM 13a
Communications/Community Relations	Letterhead	Revision of SHC letterhead to show TTY number
Finance	ACH Direct Deposit letter	Information and letters for providers
Health Network	Gaps Analysis Consumer and Stakeholder surveys; Relative Guardian letter	for providers; for consumers
Finance	Unclaimed Property Procedure & Letters	FIN 32h
Health Network	My Individual Survey (MIE),Home & Community Based Setting Self Assessment (HCBS) letters	For providers

The QMC recommended approval of the above policies, procedures, and other documents, following approval by the respective Program Committees and departments.

Delegation Contracts: The QMC received Delegation of Function Report for PREST and determined PREST is meeting contract expectations.

CM/UM Appeals: During the 2nd quarter, there were 29 Medicaid appeals and one State dollar appeal. Most appeals continue to be with PSR services and intensive in-home.

Community Care of North Carolina: Sandhills Center continues to work with three CCNC networks. A monthly teleconference is attended by representatives from the three networks and with Sandhills Center Care Coordination staff and Quality management Director. The Sandhills Center Medical Director continues to maintain oversight of the meetings.

Sandhills Center partnered with Community Care of the Sandhills and other stakeholders in a five year SBIRT Initiative that began in 2011. The initiative came to a close in early November 2016. Data collected by the Governor's Institute during the course of the initiative indicated that the screenings and brief interventions completed during the initiative netted positive results.

Community Care of North Carolina staff members engage in and maintain relations with Sandhills Center staff in the Sandhills Center integrated care initiative, the Network Leadership Council, the Clinical Advisory Council, and the Continuous Quality Improvement committee.

The Sandhills Center Quality Management Director has been asked to explore ways that Sandhills Center might partner with Community Care of the Sandhills to address speedy access to services for mothers that evidence symptoms of post-partum depression.

Integrated Care Project: The 3rd Integrated Care newsletter Opioid Use in Pregnancy was published this quarter, including the scripts used by Sandhills Center staff. This information was also shared at the Provider Forum.

Deb Carbone has been hired as the Integrated Care Outreach Clinician, reporting to Dr Carraway to work more closely with our providers and give technical assistance as needed. Additionally, she is working on the next newsletter which will come out next quarter.

Calls with our integrated care partners were started to check on progress with use of CMT data. A spread sheet has been developed and information requested for baseline data. This information is due in January.

Bi-weekly CMT/SHC project meetings are held and meeting minutes are shared with the team. Project plans and action items are monitored weekly.

Monthly Internal Integrated Care meetings began in May and continue to focus on project status updates and other pertinent information.

Community Relations, Communications and Training Department

- 2 CFAC meetings
- 1 Client Rights Committee meeting
- 1 Train-the-Trainer for Adult Mental Health First Aid
- 2 Crisis Intervention Team (CIT) trainings for Emergency Management Services personnel (one was at the statewide conference)
- 10 provider trainings sessions
- 2 Provider Forums
- 15 community education events

Internal Monitoring Quarterly Report: Brief overview by department below:

CM/UM: IRRs including PREST IRRs. Random sample of authorization denials that were overturned on appeal to identify trends/patterns was completed by Dr Carraway. Overturns were results of receipt of additional information, no trends or patterns identified. A sample of Service Reduction letters to consumers/guardians were reviewed with only three letters relating to inpatient care were forwarded to the CM/UM Director for further review.

Network: Sanctions: two requested; one was appealed and upheld.

Call Center: Random sample of emergent clients were reviewed to ensure they are seen within two hours of STR. 100% compliance of those reviewed.

Care Coordination: All reviews were completed, utilizing new tools and calculation process. All areas need improvement in utilization of integrated care scripts.

QM: Errors in the QM database and complaint documentation in Alpha were discussed with managers and corrected.

Human Resources: To be discussed in Clinical Financial Risk Management when issues occur. Human Resources staff audits were completed and submitted to QM Director.

Information Technology: Reports will be presented at QMC each quarter.

Respectfully submitted by:

Carol Robertson

Carol Robertson, Quality Management Director

1/31/17
Date

Quality Improvement Projects Analysis

Customer Services:

Improving access to behavioral health information and services for Hispanic members by improving content available to members of this population seeking such services. (DMA) Measures for the 2nd Quarter. Paid Claims – 5,055 out of 144,338 Claims were for Hispanics (3.50%). This exceeded the Baseline of 3.10% by 0.4% and the Measurable Goal of 3.25% by 0.25%. The Measurable Goal has been met or exceeded. This QIP will be recommended for closure when a new QIP is identified and approved.

- **Improve member's access to care by ensuring follow through with routine and urgent scheduled appointments. (DMH)** Measures for the 2nd. Urgent – 88% (30 out of 34) of Urgent Callers kept their appointment within 48 hours. This exceeded both the Statewide Performance Goal and the Sandhills Center Measurable Goal by 6%. This QIP will be recommended for closure when a new QIP is identified and approved.

Network:

- **Enhance Network Provider Directory. Improve the accuracy of provider information in the Network Provider Directory. (DMH)** This QIP continues to meet both the Zip +4 and Phone number goals. Monthly reports will continue to be generated for Credentialing staff to review and update Alpha. It is recommended for closure once a replacement QIP has been identified and approved

- **Shaping the Network to improve and increase provider choice and ensure members access to quality services. (DMA)** Measures for the 2nd Quarter are as follows: The average number of Medicaid Contracted Provider who did not bill during this quarter is 66. The goal is to decrease this number to 57. This was the first quarter that the measure was below the baseline by 1. This quarter we were over the Measurable Goal by 9. Although the measurable goal was not met this quarter, the project is headed in the right direction as the trend shows a continuous decrease from previous quarters.

- **Decrease the length of time it takes for providers to return their signed contracts and/or contract amendments to Network Development. (DMA)** This QIP is closed and will continue to be tracked until February 2017.

Utilization Management:

- **Increase the number of members authorized for Psychosocial Rehabilitation Services with correct diagnosis or sufficient clinical information. (DMA)** This QIP was started in January 2015 and has not achieved three consecutive quarters of meeting the goal.

- **Maximize the benefit of Child Mental Health Level III (DMA)** The timeline for this QIP is February 2017 or until the UM/UR Unit achieves three consecutive quarters of meeting the stated goal. For this period, 77.8% or 21 out of 27 children received outpatient treatment. This did not meet the goal to decrease the number of providers billing unmanaged outpatient treatment for children in Level III to 15% or less. UM will continue to work towards increasing the number done through EPDST and decreasing the number through unmanaged visits.

- **Assure consistent connection to community services following Facility Based Crisis Services. (DMH)** The timeline for this QIP is May 2017 or until the UM/UR Unit achieves three consecutive quarters of meeting the stated goal. There are two measures for this project. The Overall baseline is 59% with a goal

of 70%. The Lowest performing provider is being monitored. The baseline is 20% with a goal of 35%. As expected the results this quarter show a positive increase from the previous quarter. Training and technical assistance should continue to have a positive impact.

- **Increasing Percentage of Authorized Services Used by Providers. (DMH)** This QIP is closed and will continue to be monitored until February 2017 for 90837 (individual) and until August 2017 for 90853 (group).

Care Coordination:

- **Increase timely completion and submission of Quality of Life Surveys. (DMA)** This QIP's timeline is December 2017 or three consecutive quarters of meeting the stated goal. Note that this was the first measurement since the QIP has been in place. Improvement as compared to the baseline is already being shown as new processes have been put in place. Measures for the 4th Quarter (October – December 2016 – calendar year) are as follows:
  - 34 Quality of Live Surveys were received
  - 21 (62%) were completed timely and correctly
  - 13 (38%) were not completed in a timely manner or correctly