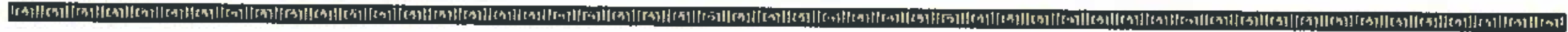


Sandhills Center LME-MCO

Quality Management Committee Executive Summary

April - June 2017

8/21

Quality Management Committee
Executive Summary
Time Period Covered April-June 2017
4th Quarter FY 16-17

The Quality Management Committee (QMC) met face-to-face three times for regular meetings during the 4th quarter of this fiscal year. New and revised Policies and Procedures were reviewed and approved. This Executive Summary includes highlights of the 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. A full quarterly summary report is posted on Sharepoint and available upon request to all.

Complaints, Incident Reporting and Quality of Care Concerns

Quarterly Complaints Report

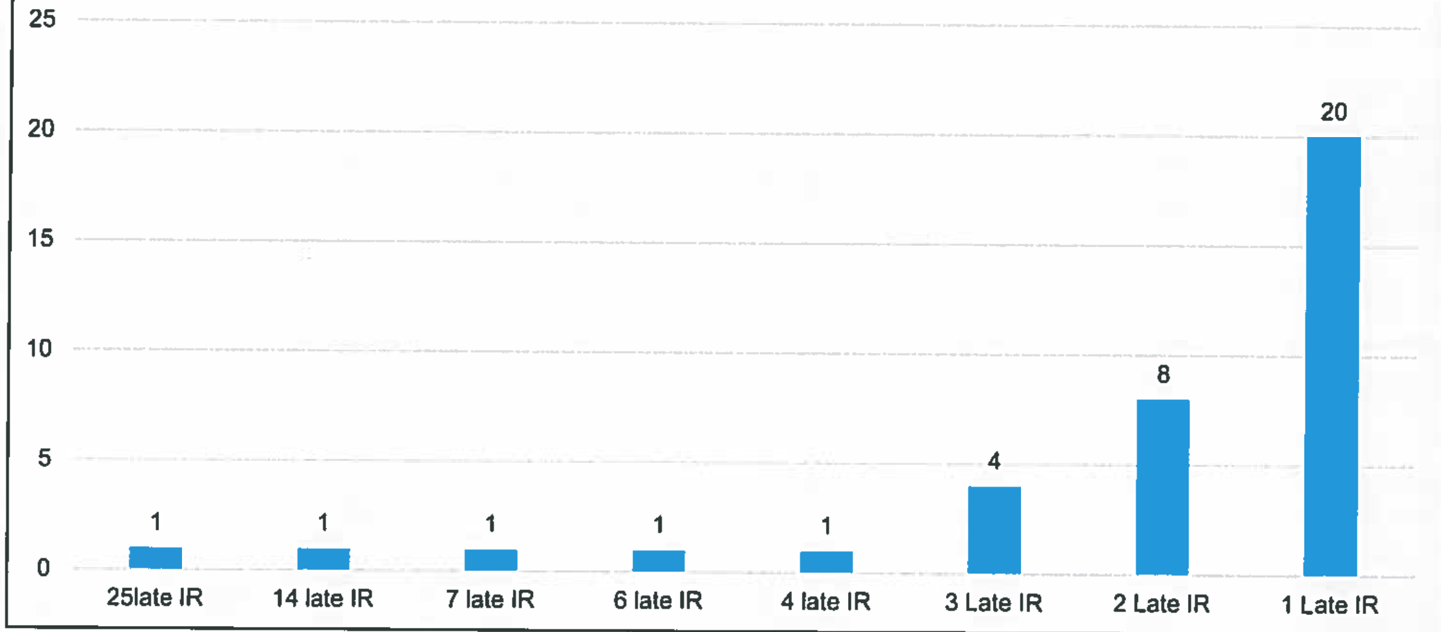
The number of complaints (78) decreased from the third quarter. All complaints about Sandhills Center were referred to HR Director for review and response. Of the 78 complaints, Sandhills Center had 13 complaints. All complaints were resolved within 30 days. Of note, eight cases were referred to the Medical Director for review of health and safety concerns and 13 to Program Integrity. Graphs are available in the quarterly summary.

Quarterly Level II/III Incident Reports

Brief description of the Report: The report shows the Level II and III Incident results. Graphs are available in the quarterly summary.

There was a slight increase in the number of Incident Reports in the 4th quarter from the 3rd quarter; detailed graphs are available in the quarterly summary. All incidents reports are tracked for trends which show:

- Highest number of incidents relate to consumer behaviors.
- Abuse/neglect/exploitation reports are reviewed for health and safety and to ensure proper authorities have been notified.
- The highest number of these are received from IDD residential facilities and staff is alleged perpetrator.
- Falls account for highest number of injury reports.
- The majority of Suspension and Expulsion incident reports were submitted by Substance Abuse providers.
- All suicide attempts and suicides are sent out for independent psychiatric review and letters are sent to Medical Directors of agencies or prescribers, if there is no Medical Director. Largest age groups are females ages 13-17. There were two suicides in the quarter. Provider training has been held to address suicide risk.



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. The highest percentage of late incident reports per provider for the 4th Quarter FY 16-17was 29.17%, 38.89%, & 83.33%. The total late incident percentage was 19.33%.

Providers who have late incident report submissions receive a Plan of Correction. Timely submission was addressed at the February Provider Forums

Quality of Care Concerns Report 4th Quarter FY 16 – 17

Analysis and Trends: Sixty-nine (69) QOCs were submitted this quarter. Twenty-one percent of those received this quarter were due to services not provided true to the model. Clinical records were requested and reviewed for determination of recoupment. Referrals based on documentation increased for the quarter. All clinical concerns continue to be reviewed by both an external review body and an internal psychiatrist, with letters mailed to Medical Directors or prescribers, with recommendations.

Agencies with multiple concerns are contacted via phone or face-to-face meetings to discuss concerns. Two of those meetings occurred this quarter and others are scheduled. These will be tracked to see if this approach brings about change.

Appeals: During the 4th 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 Leadership 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 CIR Committee met three times this quarter and reviewed 102 Level II and III incidents. Most notable was the number of suicide attempts of children under the age of 18 with 15 incident reports and 14 suicide attempt incident reports for adults over 18. There were two suicide incident reports reviewed; one was an adult and one was a teenager.

A provider was staffed for the large number of suicide attempt incident reports submitted since 2015. A telephone conference with the provider and the Clinical Leadership Team was recommended by SHC Medical Director.

Access to and Monitoring of Services: No access to services concerns were brought to QMC this quarter.

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

CM/UM Appeals: During the 4th quarter, there were 48 Medicaid appeals and three IPRS appeals. The majority of the appeals during the 4th quarter were for child services.

Community Care of North Carolina The Medical Director maintains oversite of monthly teleconference calls attended by the three networks and Sandhills Center staff. Information-sharing occurs during these calls as well as clarity around making appropriate referrals to both systems. The MH/SA Care Coordination Clinical Director participates on a CCNC quarterly Substance Abuse/Pregnancy Collaborative. This has resulted in obtaining real time technical assistance regarding access to services for the targeted population.

Integrated Care Project/Evidence Based Practice accomplishments and future goals are listed in the quarterly summary. Highlights are:

- The 4th Integrated Care newsletter, *Living with Asthma,* was published this quarter in addition to creating the scripts used by the Sandhills Center Care Coordination staff. This information was also shared at the Provider Forum.
- The 5th newsletter was approved, with a focus on Side Effects of Psychiatric Medications Manifested as Medical Conditions.
- SHC continues to participate in weekly CMT/SHC project meetings and the minutes are shared with the work group.
- A suicide prevention tool was developed to assist providers in being proactive.
- Developed guidelines that were approved by Integrated Care Workgroup and QMC for enhanced management of follow-up treatment for members who received Emergency Department services.

SHC is actively participating in the Statewide initiative to resolve the Opioid Epidemic through staff training through workshops, developing a newsletter on this topic, and holding discussions with top Integrated Care providers, who are making successful strides in their Suboxone treatment programs.

Community Relations, Communications and Training April - June 2017

Area of Focus: Ensure strong consumer involvement in the work of Sandhills Center

- Intervention: # of CFAC meetings held during the quarter
  - Outcome for period: 3
- Intervention: # of Client Rights Committee meetings held during quarter
  - Outcome for period: 1

Area of Focus: Educate the community about behavioral health issues

- Intervention: # of CIT trainings
  - Outcome for period: 5 trainings; graduated 69 first responders
- Intervention: # of Mental Health First Aid trainings
  - Outcome for period: 16 trainings; graduated 285
- Intervention: # of community education events, excluding CIT & MHFA
  - Outcome for period: 11 events; reached 1484 individuals

Area of Focus: Maintain accuracy of information available through Sandhills Center web site

- Intervention: # of updates made to the web site
  - Outcome for period: processed 51 web change requests, including notices pertaining to Finance/claims, newly released Requests for Proposals, updated Member Handbook, Board of Directors meeting minutes

Quarterly Internal Monitoring was not complete at the time of this report. The data will be reported on at the August QMC meeting.

Quality Improvement Projects Analysis   Full reports and graphs are included in QM Quarterly Summary

Customer Services:

ACTIVE:

1. **Improving access to behavioral health information and services for Hispanic members by improving content available to members of this population seeking such services.** (DMA)
   a. Timeframe for this QIP is June 2016
   b. Measures for the 4th Quarter (Apr-Jun) FY 2016-2017:
      i. Paid Claims – 5,242 out of 142,745 Claims were for Hispanics (3.67%). This exceeded the Baseline of 3.10% by 0.57% and the Measurable Goal of 3.25% by 0.42%.
   c. The timeframe for this QIP is June 2016, since the Measurable Goal has been met or exceeded, this QIP will be recommended for closure when a new QIP is identified and approved.

2. **Increase number and percentage of members with routine appointments who keep their appointment within 14 calendar days of contacting with the Call Center.**
   a. Background - During the last six quarters Sandhills Center has failed to meet the state standard (75%) for kept routine appointments. Failure to attend an initial appointment may result in the member's problem worsening, symptoms increasing, and the loss of opportunity for early lower intensity intervention. Increased use of emergency department, mobile crisis, and other intensive services is also a possibility.
   b. Measures for the 4th Quarter (Oct – Dec 2016) are as follows:
      i. 22 out of 48 Routine Appointments made were kept (46%)
      ii. Note that this was the first measurement since the QIP has been in place.
   c. Timeline – April 2018.

CLOSED: Monitoring for 1 year.

1. **Improve member's access to care by ensuring follow through with routine and urgent scheduled appointments.** (DMH)
   a. Background: This QIP was approved by QMC over 3 ½ years ago (June 26, 2012). The original timeframe was through January 2013 and then revised to December 31, 2015. We consistently were not meeting the statewide performance goal or our measurable goals each quarter for one or both of the measures (Urgent and Routine). In February 2016 both the Customer Services Committee and QMC approved a revision to remove Routine tracking and focus on Urgent appointments. The goal was amended to be consistent with the State Performance Measure of 82%. Three consecutive quarters must be met for closure.
   b. Measures for the 4th Quarter (Apr, May, Jun) 2016/17 are as follows:

i. Urgent – 86% (25 out of 29) of Urgent Callers kept their appointment within 48 hours, this exceeded both the Statewide Performance Goal and the Sandhills Center Measurable Goal by 4%

c. This QIP was approved for closure April 2017. It will be monitored until April 2018.

Network:

ACTIVE:

1. **Enhance Network Provider Directory. Improve the accuracy of provider information in the Network Provider Directory.** (Non-Clinical DMH)
   a. The timeline for this QIP was 18 months, completing on October 31, 2016.
   b. In June, Missing Zip +4 = 0.7% (21 out of 2705) of Provider address had a missing Zip +4. 99.3% were correct which was above our Baseline by 4.3% and our Sandhills Center Measurable Goal by 2.3%.
   c. For Missing Phone Numbers = 0.2% (5 out of 2705) of Provider phone numbers were missing. 99.8% were correct which was above our Baseline by 33.8% and our Sandhills Center Measurable Goal by 2.8%.
   d. 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.
   e. This QIP is recommended for closure once a replacement QIP has been identified and approved.

2. **Shaping the Network to improve and increase provider choice and ensure members access to quality services.** (Non-Clinical DMA)
   a. This QIP was approved in Network Committee on Jan. 12, 2016. QMC approved on Jan. 26, 2016 and DMA approved on April 19, 2016.
   b. The timeline for this QIP was 1 year, Apr. 2017 or until achieves 3 consecutive quarters of meeting the goal.
   c. Measures for the 4th Quarter FY 2016/17 (Apr-Jun) are as follows:
      i. The average number of Medicaid Contracted Provider who did not bill during this quarter is 65. The goal is to decrease this number to 57. This was the second quarter that the measure was below the baseline by 2. This quarter we were over the Measurable Goal by 8. 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.

CLOSED: Monitoring for 1 year – currently no closed QIP's.

New QIP:

1. **Increase the Evidenced Based Best Practices employed by our provider network, and the increase the documentation supporting the use of those practices.**
   a. Background - The Evidence Based Practice (EBP) program is a SHC initiative designed to ensure best practice therapeutic interventions are being utilized, as well as to promote the integration of behavioral health with primary care/prescribing physicians, and increase the overall behavioral health expertise of our provider network. The EBP assessment tools utilized to gather data are specifically tailored to 7 diagnoses; ADHD, Post-Traumatic Stress Disorder (PTSD), Bipolar Disorder, Autism Spectrum Disorder, Suicide Prevention, Alcohol and Other Drug Dependence Disorder, and Major Depressive Disorder. Network Provider Monitoring's (NPM) Qualified Professionals (QPs) complete all required monitoring reviews per DMA Network Provider Monitoring tracks trends, and analyzes the review results, and reports these results to both Network, and QM Committees through a quarterly summary report. During data evaluation, the Clinical Monitoring Manager observed a trend of low number of "Yes" answers for the following questions "Is there evidence of coordination of care with other services/providers or prescribing providers?" on both the Bipolar Disorder, and PTSD tools, These questions represent inadequate documentation of coordination of care between service

providers. Results are concerning as both are diagnosis that, if not appropriately treated, often require higher levels of care within the service continuum. The purpose of this project is to increase the documented frequency of the above questions within SHC's Bipolar disorder and PTSD population, thereby ensuring that Sandhills Center members are receiving the most effective therapeutic treatment available, and increasing the probability of favorable treatment outcomes.

b. Goal - is to increase number of PTSD and Bipolar Disorder providers documenting coordination of care efforts by 10%. Upon completion of this QIP, Network Monitors will be able to mark "Yes" next to the corresponding identified questions during EBP reviews for at least 75% of PTSD treatment providers, and 86% of Bipolar Disorder treatment providers.
c. Timing - August 2018, or until 3 consecutive quarters of meeting the stated goal.

Utilization Management:

ACTIVE:

1. **Increase the number of members authorized for Psychosocial Rehabilitation Services with correct diagnosis or sufficient clinical information.** (DMA)
   a. This QIP's timeline is October 2015 or until the UM/UR Unit achieves 3 consecutive quarters of meeting the stated goal.
   b. The Jan to Mar 2017 period which had 180 authorizations the data indicates that of the 70% random sample of approved PSR authorizations (126), that 126 or 100% were approved appropriately. This quarter our measurements were above our baseline measurement and our goal. This data reflects a significant improvement from the previous quarter.
   c. This was the second quarter our goal was met; this QIP needs to remain open.
   d. This QIP was started in January 2015 and has not achieved 3 consecutive quarters of meeting the goal.

2. **Maximize the benefit of Child Mental Health Level III** (DMA)
   a. This QIP was approved by QMC in February and DMA in April 2016.
   b. The timeline for this QIP is February 2017 or until the UM/UR Unit achieves 3 consecutive quarters of meeting the stated goal. Since DMA approved this in April, the timeline needs to be updated to April 2017 or until 3 consecutive quarters are met.
   c. For this period 100% or 17 out of 17 children received outpatient treatment as follows:
      i. Incorrectly
         1. 5 received outpatient therapy via unmanaged sessions
         2. 0 were authorized but EPSDT was not selected
      ii. Correctly
         1. 12 (71%) were authorized and EPSDT was selected

      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 (n=2.5 15% of 17). However it is important to note that the number receiving outpatient services separate from Level III continues to decrease from the previous periods.

3. **Assure consistent connection to community services following Facility Based Crisis Services.** (DMH)
   a. This QIP was approved by QMC in August 2016.
   b. The timeline for this QIP is May 2017 or until the UM/UR Unit achieves 3 consecutive quarters of meeting the stated goal.
   c. 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%;

i. Overall - For the time period of Apr through Jun 2017, the overall number of members using Facility Based Crisis Services during this period was 153. Out of 153, 92 or 60% successfully connected to a community provider within 30 days of discharge. This is 10 below the goal of 70%.

ii. Lowest – For the same time period, the lowest performing provider had a total of 55 of which 11 or 20% were successfully connected. This is 15 below the goal of 35%.

d. Training and technical assistance should continue to have a positive impact.

CLOSED: Monitoring for 1 year – currently no closed QIP's.

Care Coordination:

1. **Increase timely completion and submission of Quality of Life Surveys.** (DMA)
   a. This QIP's timeline is December 2017 or 3 consecutive quarters of meeting the stated goal.
   b. Measures for the 2nd Quarter (Apr – Jun 2017) are as follows:
      - 25 Quality of Live Surveys were received during this quarter
      - 20 (80%) were completed timely and correctly
      - 5 (20%) were not completed in a timely manner or correctly
   c. This is the first quarter that the measurable goal of 80% has been met.

Quality Management:

1. **Assure prescribers are screening for metabolic syndrome in children and adolescents (1-17 Years of Age) who have been prescribed two or more antipsychotics within the past 12 months.**
   a. This project was initiated as a result of a pilot project at DMA related to reducing the number of children and adolescents who were prescribed two or more antipsychotics in a 12 month period. Further collaboration with two other LME-MCOs led to a further review of the number of children and adolescents who had metabolic screening performed.

      Data was pulled from Relias (CMT Care Management Technologies) targeting Quality Indicator 940 (Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) (1 – 17 Years of Age)) who have been prescribed at least 2 but not necessarily concurrent antipsychotic prescriptions in the prior 12 months and are missing one or both of the following labs: 1-glucose or an A1C or 2-lipid panel.
      This QI indicator is consistent with the Hedis measure and with Evidence Based Best Clinical Practices. 45 % of children who have been prescribed 2 or more antipsychotics were identified in addition to 12 % of the prescribers who serviced 6 or more.
      The purpose of this project is to improve quality of care and collaboration between prescribers.
   b. Need to meet with Carol to create chart.

Respectfully submitted by:

Carol Robertson, Quality Management Director   8/15/17 Date

Utilization Management Committee

Executive Summary

Committee Chair: Sabrina Russell-Holloman, LCSW **Date of Summary: 7/14/2017**
Meeting Date: May 16, 2017
Date of Summary to QM Committee: 7/14/2017

Committee progress towards purpose and objectives

- Continue to maintain over 85% consistency standards for IRR. Clinical vignettes completed quarterly to monitor reviewer consistency.
- Ongoing meetings with Medical Director and Care Coordination Director to discuss plan for Mental Health/ Intellectual Developmental Disability high risk/high need members. UM attending weekly clinical case staffing with Medical Director and Care Coordination MH/SA Clinical Director. Appropriate service recommendations are implemented to promote improved member outcomes.
- UM continues to participate in the Integrated Care workgroup. Providers have increased coordination of care with physical health providers.
- UM participated in DMA/DMH meeting to discuss possible changes to the NC Innovations Waiver.
- UM continues to provide education to members and providers regarding the Intensive Review Process. UM continues to see an increase in appeals for Innovation services.
- UM participated in DMA EPSDT Training. This training is intended to ensure that UM staff review all child service requests under EPSDT.
- UM participated in Statewide training on Individual Placement Support, Critical Time Intervention and ACTT/TCLI.
- UM participated in the Clinical Monitoring portion of the Block Grant audit.
- UM submitted required documentation for desktop review for EQR.
- UM participated in DMH webinar on Plan of Safe Care for infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a Fetal Alcohol Spectrum Disorder.

Significant Reports and Data Reviewed
Certification/Tracking Reports

- Unable to Process
- PSR Utilization
- PRTF Utilization
- Facility Based Crisis Step Down
- Summary Count of Requests by Status
- IPRS and Medicaid Request Completion Timelines
- PREST Delegation Monitoring
- Inter Rater Reliability
- Peer Review tracking
- Summary Count of requests by Care Manager
- DMA/DMH Monthly Data

Committee Highlights

Top Significant Accomplishments

Adherence with contract requirements.
UM Department has maintained a 99% standard for reviewing routine and expedited requests within contract timeframes.
CM/UM Appeals: During the 4th quarter, there were 48 Medicaid appeals and 3 IPRS appeals. The majority of the appeals during the 4th quarter were for child services.

UM has submitted 2017/2018 UM Plan to DMA for review and approval.

PREST IRR Completion
IRR conducted in April 2017. Results were 93% consistency with PREST physicians. Dr. Carraway will discuss inconsistent decisions with PREST Medical Director.

Quality Improvement Projects
The QIP related to increasing the number of members authorized for PSR with the correct diagnosis and clinical information data was reviewed for 1/1/17 to 3/31/17. The data indicates that 100% were approved appropriately. This quarter our measurements continue to be above our baseline measurement and our goal. This data reflects a significant improvement from the previous quarter of 88%.

The QIP related to Maximizing Benefit of Level III services for the quarter 7/1/16 to 9/30/16 indicates 29% received outpatient therapy via unmanaged sessions. 71% were authorized and EPSDT was selected. 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 (n=2.5 15% of 17). However, it is important to note that the number receiving outpatient services separate from Level III continues to decrease from the previous periods. The QIP also notes that all children authorized for individual therapy were approved via EPSDT.

The QIP Assure consistent connection to community services following Facility Based Crisis Services reveals out of 153, 92 or 60% successfully connected to a community provider within 30 days of discharge. This is 10% below the goal of 70%. For the same time period, the lowest performing provider had a total of 55 of which 11 or 20% were successfully connected. This is 15% below the goal of 35%. The overall goal of ensuring connection to services continues to show improvement. This quarter the lowest performing provider also improved their discharge planning from 17% to 20%.

Policy and Procedures
UM reviewed and updated policies and procedures related to Medicaid Appeals to address federal changes regarding timeframes. Changes were made to HUM

Staff Training
CM/UM staff participated in best practice and evidenced based training related to ethics, Parent Child Interaction Therapy, Psychopharmacology for Adults and Children, Autism Spectrum Disorder: Behavior Plans for Children and Adolescents, Clinical Treatment for Major Depression Disorders and Using Harm Reduction in the Treatment of Substance Use Disorders. This training will be used to enhance the clinical skills and knowledge of reviewers completing the initial review.

Other Notable Accomplishments

Staffing of the CM/UM Department
UM Department is fully staffed. New staff have been trained on job duties and departmental expectations.

Provider Communication/Training
UM provided departmental overview and updates to providers at the Provider Forum.

Identified Areas of Need and Possible Solutions

Reports to project utilization of services.
UM currently reviewing DMA quarterly reports to determine options for projecting utilization.

Additional Comments:

Add any additional comments if needed. None

Prepared by: Sabrina Russell-Holloman, MSW, LCSW Utilization Management Director
CM/UM Committee Chair

Customer Service Committee

Executive Summary

Date of Summary to QM Committee: 7/25/17

Quarterly Customer Service Committee Meeting Date: 5/10/17

Committee progress towards purpose and objectives

- Mystery Shopper Call Rating: Mike reported that the first 20 calls (initiated March 2017) have been completed this quarter (March only) to the random list of providers from our provider list. Calls are being made to request a routine appointment to see if providers will provide an appointment within 14 business days.
- Theresa Clark, Project Manager- 2016 NC DHHS Provider Satisfaction Survey All of the green arrows are where Sandhills Center did extremely well in the Satisfaction Survey. Question 29 asked if the provider had questions and wanted to be contacted.
  (January-March) Fiscal Year 2016-2017. Gene presented the following information to the committee: LME/MCO Report of Access, Triage, Referral for Emergent, Urgent and Routine Care: Number of Calls Requesting Services: 28 Medicaid, 74 Non-Medicaid 102 Total: Routine Care Needed: 55% received their services in a timely manner, Urgent
  91% of calls received timely services, Emergent Care Needed: 100% of calls received timely services.
  HCC – Emergent Call Case Review
  There were no outliers to be reviewed by Dr. Carraway.

Inter-rater Reliability Report:

Date of Report: 04/05/17, Period covered: 01/01/16-03/31/17
Results: Number of STRs Reviewed: 26, Inter-Rater Reliability: 85%
22 of the 26 STRs passed with a rating of 85% or better in inter-rater reliability
Average of IRR agreement: 86%, Summary of Review Finding:

Health Call Center –January- March 2017 Cardinal Innovations Call Rollover Report

Month:	January	February	March
Volume:	23	20	19
Time to answer (seconds):	.05	.05	.05
Abandoned calls:	0%	03%	15.8%*
Calls answered within 30 seconds:	100%	97%	84.2%*

Comments:
*Corrective Action plan submitted by Cardinal Innovations for these items.

Mike Markoff – Customer Service Coordinator: Call Center Performance Report Sandhills Center Health Call Center –Jan-March 2017 Report:

Month:	Jan	Feb	March
Volume	**2942**	**2680**	**3003**
Time (seconds)	5 seconds	6 seconds	5 seconds
Abandoned:	120 @ 3.04 %	82 @ 2.27%	73 @ 1.84%
Within 30 seconds	100 %	100 %	100 %
De-queued Calls:	83 @ 2.1 %	56 @ 1.55 %	54 @ 1.36 %

All DMA, DMH and URAC standards for access were met for this quarter. 120 abandoned calls in January were due to the snow and low staff numbers.

Quarterly Interpreter Tracking Report 2017: Jan 14, Feb 10, March 14

QIP Projects: Theresa Clark reported that no new data was available.

Carol Robertson, Quality Management Director
3rd Quarter (January – March) Complaint Report- Fiscal Year 2016-2017 Sandhills Center Quarterly Complaint Report (3rd Quarter):

Complaints have increased from the 2nd quarter. The increase may be the result of providers' receiving the same complaint multiple times by different complainants. The largest numbers of complaints are against providers. The number of complaints against Sandhills Center increased this quarter as a result of a change in Innovations Budget Planning; different complainants. Thirty 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.

Sandhills Center Quarterly Incident Report (3rd Quarter):
There was an increase in number of Incident Reports in the 3rd quarter from 2ndn 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 increased from the previous quarter. Restrictive Intervention reports increased from the previous quarter. Unplanned Absence and Aggressive Behavior were the highest incident report types.

The next Service Committee will be held on August 9, 2017 in Building 3 at 9:30 AM.

Significant Reports and Data Reviewed

Reviewed and analyzed data from the following reports:

- Call Log Summary
- Summary of SHC STR Data
- Cardinal Innovations performance: HCC Phone Data Audit Tool Summary Referred to (Jan-March 2017)
- Reviewed QIPs monthly –
- Reviewed quarterly complaint and incident reports for (Jan-March 2017)
- Quarterly Interpreter Report - (Jan-March 2017)
- March 2017 Mystery Shopper Report
- Quarterly Interpreter Report

Committee Highlights

Accomplishments

Identified Accomplishment	Factors That Supported Success
No Complaint Appeals were received this quarter.	As evidenced by Complaint Appeal Tracking forms.
Reviewed monthly reporting of the Quality of Data regarding phone logs	Occurring monthly.

Primary rollover for Cardinal Innovations reviewed.	Occurring monthly.
Reviewed call center performance data. All within state standards.	Well within DMA and URAC standards.
Customer Service minor revisions to Handbook included updating contact information/websites/phone numbers/addresses.	Received printed Handbooks. Revised version on SHC webpage. Being distributed on an ongoing basis. New Handbook presented during Provider Orientation.

Identified Areas of Need and Possible Solutions

Item/Area of Need Identified	Recommended Solutions
Ongoing monitoring of QIP projects. Developing new QIP.	Monitor closed QIP projects for 1 year.
Continue to monitor URAC Standard Performance Indicators and contract standards.	All required monthly reports to be completed on an ongoing basis.
Revise Kiosk Form/report	Mike, Gene and Theresa to meet.
Handbook approval.	All revisions to be approved by EQR and DMA on an ongoing basis.

Additional Comments: None.

Prepared by: Gene McRae, Customer Service Director and Mike Markoff, Customer Service Coordinator.

Health Network Committee

4th Quarter Executive Summary 2016-17

Committee Chair: Bonita Porter, MSW, LCSW **Date of Summary:** July 11, 2017
Summary Prepared by: Bonita H. Porter, Provider Network Operations Director
Monthly Meeting Date: Second Tuesday each month
Date of Summary to QM Committee: July 24, 2017

Purpose
Network Committee meets in order to review and report on the progress and projects of ongoing activities within our department so as to both inform and be informed by other Sandhills Center Departments. The ongoing Network Operations focus is to offer to our members a Network of providers that best serve their needs.
The Network Operations Department primary ongoing tasks include identifying service gaps and addressing as needed, managing provider contracts, screening provider requests, credentialing and re-credentialing network providers, monitoring network provider performance and delivering sanctions as needed.
Within each of these areas there are additional periodic projects to improve or enhance our program quality and to inform and support our network of providers such as the Gaps Analysis, Evidence Based Practice technical assistance, and various efforts to promote, identify and further develop Integrated Care in our community.

Q4 had one provider termination/sanction in May and one dispute/appeal also in May.

Re-credentialing rates averaged for the quarter was 92%.
Delegated credentialing by participating hospital 100% in compliance and this hospital met all requirements in annual review. Two additional hospitals are interested in pursuing delegated credentialing.

Completed Network projects include the annual Gaps Analysis and Network Development Plan , responded to nearly 100 provider requests to join or add sites or services to the SHC Network in Q4, Updated Provider Manual and Orientation, Annual Perception of Care Survey, RFP and award for Specialized Consultative Services, Block Grant Audit, Revised Network P&Ps per EQR recommendations and pending signing of new DMA contract and completion/closure of the QIP to decrease time it takes providers to return signed contracts.

Ongoing and Active Network Projects include the development of a Clinically Focused QIP, Shaping the Network QIP, EBP Reviews and technical assistance when warranted, RFP for B3 Child MH/SA Respite, Provider Help Desk Q&A Summaries, B3 Service Guide Updates, FY 2017-18 contract renewals and provider training development.

Efforts to continue regarding:

Expanded Opioid Treatment offerings within the network: SHC Medical Director and key staff have met with two in-network providers with aim of improving treatment outcomes and accessibility to opioid treatment for our members. Network continues to investigate and refer suitable new provider requests to offer this service to our clinical leadership.

Increase in reported suicides: Using EBP review tool to monitor providers assessing and addressing SI with members, training on suicide assessment and prevention.

Prepared by: Committee Chair

NETWORK LEADERSHIP COUNCIL (NLC) EXECUTIVE SUMMARY

Date of Summary:	July 6, 2017
Committee Chair:	Jan Herring, BS, QP - RHA Health Services, Inc.
Co-Chair:	Bonita Porter, Director of Network Operations with SHC
Summary Prepared by:	Tana K. Wirtz, Network Development
Monthly Meeting Dates:	April 13, 2017; May 11, 2017, and June 8, 2017
Date of Summary to QM Committee:	July 24, 2017

April/May/June Meetings – Significant Reports and Data Presented

Council Membership

- A new Council member was introduced: Steve Hess, Chief Program Officer, from Family Service of the Piedmont, Inc. (FSP). FSP is a multi-service non-profit provider located in Guilford and in Randolph counties. In addition to behavioral health services for Sandhills Center members, FSP has victim services, consumer credit counseling, rapid re-housing shelter of victims of domestic violence and victim of sexual assault, and some in-home parenting skills education.

Provider Training Review of FY 2016-17 and Planning for FY2017-18

- Anne Gable, SHC Training Coordinator, facilitated the discussion and solicited feedback from the Council. Suggestions included training on Autism Spectrum Disorders, Harm Reduction, and Applied Suicide Intervention Skills.
    - Next steps: Continue to solicit feedback on needed trainings and finalize training schedule for FY17-18. Applied Suicide Intervention Skills training already scheduled in response to on-going review of suicide trends within SHC catchment area.

SHC Finance Presentation

- Hannah Brown, Finance Director, presented a financial overview comparison of March 2016 and 2017. Projected budget totals remain fairly consistent. Largest change between 2016 and 2017 was for one-time pension expenses. Denial claims remain consistent with 2-3% of claims being denied. The top reasons for Medicaid denials were: service not authorized and claim received after billing period. For State funds, it was service not authorized and patient does not have valid target pop for DX submitted.
- Effective July 1, 2017, major changes in provider enrollment in NC Tracks. Also on July 1st, 2017 per the JCB # 240 LME-MCOs will no longer enroll new Medicaid providers and transfer enrollment information through the Provider Upload Process including new sites and new information for existing providers. All new providers and new information must go through NC Tracks first. Hannah B. noted to council members that SHC is aware of the delays with NC Tracks and will help assist providers. This transition is also a major change for LME-MCOs due to reporting of encounter data which could result in financial penalties for encounter claim denials.
    - Next steps: NC Tracks information to be presented at Annual Orientation sessions of Provider Forum.
    - Internal work group formed to implement change and educate providers about new NC Tracks guidelines and responsibilities.
- Question asked about denied claims for LIPs where unmanaged visits have been exceeded and whether or not number of unmanaged visits could be tracked internally by SHC and providers notified.
    - Next steps: Discussion with Finance and Claims regarding a tracking mechanism for unmanaged visits. Response: The unmanaged visit history is stored within the patient tile on Alpha. A couple of years ago, all MCOs on Alpha conducted discussions to determine if there was a way to display this information on the provider side of Alpha. However, it was determined that this would not be possible to do, as this would let a provider see historical visits that may have been provided by another provider, which is not

permissible. I have asked Claims to revisit this topic with Alpha to see if perhaps we could determine another way to have this information accessible to providers. Though there is a strong interest is seeing this through, this will by no means be a quick project if even possible due to system limitations.

ECHO Survey Analysis

- Results from the ECHO (Experience of Care and Health Outcomes) Survey, where members evaluate providers, were reviewed. SHC scored highest on 5 of 43 questions; lowest on 6 of 43, and above average on 19 of 43. Adult survey results indicated that improvement was needed on 7 questions: example, how much were you helped by the counseling or treatment you got; how other did treatment provider explain things in a way you could understand? Child survey results showed improvement was needed on 6 questions. Examples: How much was your child helped by treatment, how often did your child get an appointment as soon as you wanted?
  - Next steps: Results posted on website; reviewed at internal committees and during Provider Forums; work group formed to develop and then implement recommendations to improve provider performance.
- Provider satisfaction survey results also presented. Out of 23 questions SHC scored the highest on 17; the only LME/MCO to have scored the highest on more than three (3) questions; SHC did not receive any minimum score; the only LME/MCO to score above average on every question; 19 results were statistically higher than 2016 NC overall results; Also, we had no results that were statistically lower. SHC score was 95.3% for the questions that rates overall LME/MCO satisfaction.

CFAC Update – *Consumer and Family Advisory Committee*

- SWOT (strengths, weaknesses, opportunities, threats) survey completed and results to be compiled. Stakeholder Breakfasts were held in Anson County, Lee, and Montgomery counties during 4th quarter.
- CFAC seeking a representative from Anson County for substance abuse.
- Anne Gable, SHC Training Coordinator presented at April CFAC and requested input on training needs for FY17-18. Theresa Clark, Project Coordinator presented ECHO and Provider Satisfaction survey results to CFAC members.

Customer Services Update

- As suggested by URAC and EQR, a "Mystery Shopper" project began in March 2017. Each quarter 20 outpatient providers are called anonymously and asked whether or not they offer outpatient and if the caller can schedule an appointment. Providers not meeting the 14-day standard for routine appointments are referred to Network Operations for monitoring and technical assistance.
- A QIP to improve routine appointment attendance is being routed for internal and external (DMA) approval. The goal is that 75% of scheduled routine appointments will be kept by members. The baseline is 44% of members being discharged from a correctional facility have kept their appointments and 76% for other members. For this QIP both groups will be considered jointly.

Utilization Management

- UM remains in compliance with all DMA and DMH standards.
- CABHA regulations are ending and DMS & DMH have received feedback regarding changes to Intensive In-Home and Day Treatment definitions, with an emphasis on clinical oversight and use of evidenced based practices.

Quality Management & Quality of Care (QOC) Concerns

- Late submission of Incident Reports, particularly with Innovations providers, has been an issue.
  - Next steps: Send broadcast email to providers and provide additional training on incident reporting guidelines at upcoming Provider Forums.
- QOCs have increased due to unbundling of services, where LIPs seeing members who are concurrently receiving SAIOP/SACOT services are also seen by outpatient provider. Outpatient services would only be permitted in those situations where highly specialized therapy is indicated for the member. Duplicate billing found with SAIOP or SACOT and outpatient claims.
  - Next steps: Provide additional training on bundled services at upcoming Provider Forums.
  - With regards to duplicate billing, Finance is notifying QM when this occurs and QM is reviewing what is medically necessary and what is a duplication.
- Other QOC issues remain services not being true to model and polypharmacy.

- Comment made that when substance abuse members are referred for medication management, the medication management provider sets up referred member for therapy. When this is identified in a review, SHC will pay for medication management but deny claim for therapy.
  - Next steps: Inform providers about this duplicate billing situation. Encourage more collaboration between providers.

Community Care of NC Update

- Community Care of Sandhills continues to work with primary care physicians. Most recent partner is 1st Health of the Carolinas who enrolled their primary care, family care, cardiology and behavioral health practices. Partnership is also continuing with Daymark and their 10 counties within the area.
- DMA is developing algorithms for prescribing certain categories of medications, including mediations for ADHD and opioids. During a "Pay & Report" period, pharmacies are getting a "flag" if someone comes in to fill a psychotic med that fits in an identified category. The prescription will be filled and reported to DMA for payment. Mid-July 2017 prescriptions outside the established algorithms will not be filled unless overridden by physician/clinician.
  - Next steps: Inform patients of these changes and keep NLC informed.

Care Coordination

- Monthly teleconferences with CCNC continues and SHC MH/SA Clinical Director continues to meet quarterly with CCNC of Greater Piedmont.

Operations Reports

- March, April and May reports were presented and reviewed by committee; all report findings in compliance with DMA and DMH standards.
- Legislative update as federal, state and local levels presented.

Network Operations Updates

- Provider Help Desk Questions and Answers for February, March and April 2017 were reviewed by committee to determine any trends or training needs.
  - Next steps: none noted.
- Routine Monitoring for 3rd quarter presented. Use of Evidence Based Practice (EBP) assessment tools and follow up technical assistance offered to providers if needed.
- NLC members encouraged to complete the annual NLC Self-Assessment form.
- Annual review of SHC Cultural Competence Plan reviewed by NLC and approved.

Additional Comments:

Prepared by: ______________________________

Committee Chair