Sandhills Center
LME-MCO

Quality Management Committee
Executive Summary

January-March 2017

Quality Management Committee
Executive Summary
3rd Quarter FY 16-17
Time Period Covered January-March 2017

The Quality Management Committee (QMC) met face-to-face three times for regular meetings during the 3rd quarter of this fiscal year. New and revised Policies and Procedures were reviewed and approved, as was completion of the annual review of all policies and procedures. 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

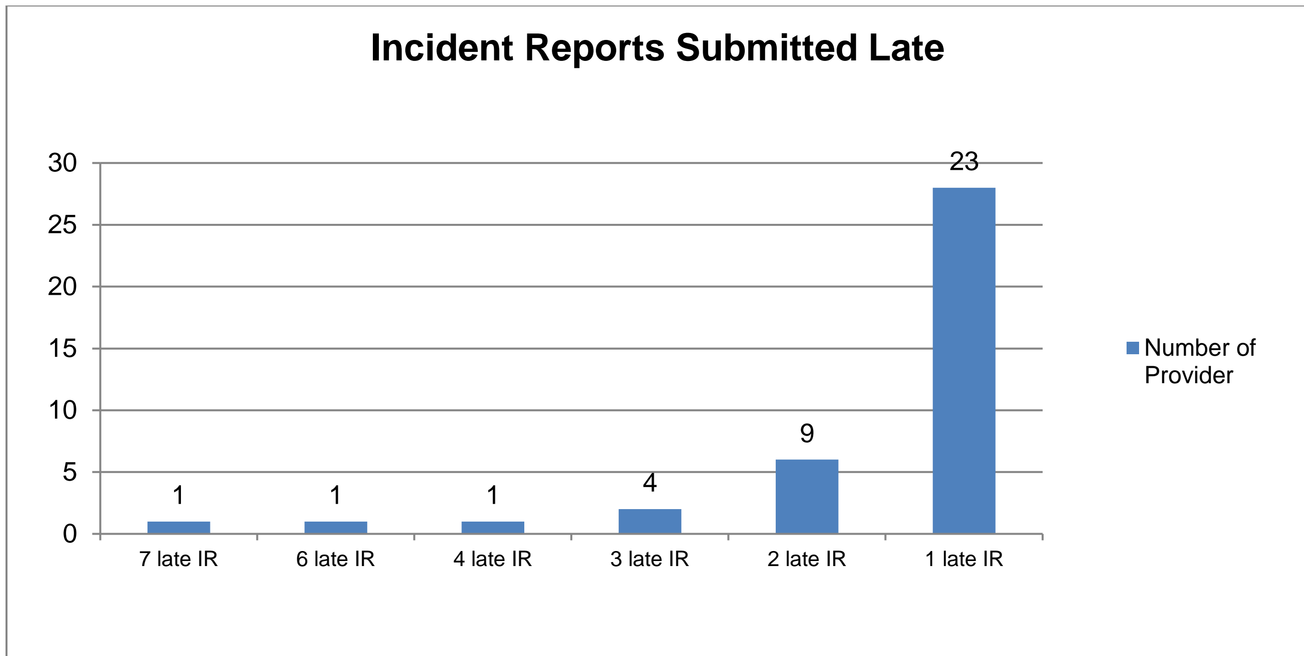
The number of complaints (98) increased from the second quarterly, primarily due to Innovations budget letters. All complaints about Sandhills Center staff were referred to Human Resources Director for review and response. Complaints outside of Sandhills Center staff were about providers and all complaints were investigated and resolved within 30 days. Of note, 10 cases were referred to the Medical Director for review of health and safety concerns, 19 to Program Integrity and seven to the licensure board. 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 and detailed graphs are available in the full quarterly summary.

There was a slight increase in the number of Incident Reports in the 3rd quarter when compared with the 2nd quarter. All incidents reports are tracked for trends:

- Highest number of incidents relate to consumer behaviors.
- Abuse/neglect/exploitation (a/n/e) reports are reviewed for health and safety and to ensure proper authorities have been notified.
- Highest number of a/n/e incidents is 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 agency Medical Directors or prescribers, if the agency has no Medical Director.
- Referencing suicide attempts and suicides, most are by females, ages 14-16 and males, ages 21-44. There was one suicide 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. 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 this provider's IRs were late).

Plans of corrections are being sent monthly to providers who have late submission. Timely submission was addressed at the February Provider Forums.

Quality of Care Concerns Report

Analysis and Trends: One hundred three QOCs were submitted this quarter. Forty percent of those received this quarter were due to duplication of services and the majority of these were submitted by the Finance Department. Clinical records were requested and reviewed for determination of recoupment. Referrals based on documentation decreased for the quarter; however, decrease may be due to a change in reporting polypharmacy concerns. All clinical concerns continue to be reviewed by both an external review body and an internal psychiatrist, with letters with recommendations mailed to Medical Directors or prescribers.

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

Appeals: During the 3rd 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 CIR Committee met three times this quarter and reviewed 64 Level II and III incidents. Most notable was the number of suicide attempts of children under the age of 17, with ADHD as the prominent diagnosis. The diagnosis was questioned and Sandhills Center's Associate Medical Director was asked to review diagnoses and medications to determine whether this population is being overmedicated or misdiagnosed. This issue was brought to the Clinical Leadership Team and recommendation was made for further provider training. In addition, a conference call was made with one physician regarding his prescribing practices.

The Committee also looked at the number of expulsions from services and the reasons for expulsion. An effort will be made to encourage our larger providers to include substance abuse treatment in their array of services.

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: 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: There were 40 Medicaid appeals and five State Dollar appeals. Most continue to be about PSR and IIH. There was an increase, however, in Innovations appeals, due to resource allocations.

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

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

- 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.
- Monthly Internal Integrated Care meetings continue to focus on project status updates and other pertinent information.
- A Suicide Prevention tool was developed to assist providers remain proactive.
- Network staff and Integrated Care clinicians are working very closely together on evidence-based practices and have developed a CM/UM Hedis Measures assessment tool for staff use.
- A Sex Offender Treatment guide, a free and reduced cost medical clinic guide, and a quick reference on the effects of opioids on pregnant women, were developed and posted on our website.

Community Relations, Communications and Training Department:

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: 2 trainings; graduated 48 first responders

•Intervention: # of Mental Health First Aid trainings

- ✓ Outcome for period: 2 trainings; graduated 21

•Intervention: # of community education events

- ✓ Outcome for period: 7 events; reached 843 individuals

Area of Focus: Maintain accuracy of information available through Sandhills Center website

•Intervention: # of updates made to the web site

- ✓ Outcome for period: processed 57 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 Report: was completed within each department and/or in collaboration with Quality Management. The complete report is included in quarterly summary.

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 were identified.

Network: Sanctions: Five sanctions, none appealed. Data Integrity for NC TOPPS: four errors found and corrective action taken. NC SNAP data integrity audit: 12 errors found and corrective action taken.

Call Center: No issues identified with random sample of emergent STRs; IRR outliers have corrective action plans to review with Medical Director. Call Center supervisors will continue to monitor.

Care Coordination: MH/SA IRR review not completed due to significant differences in QM results and Care Coordination department results. In-depth review in process, therefore, results are pending. Innovations reviews improved from last quarter; non-Innovations and Transition to Community Living (TCL) still need to work on documentation. It was recommended that they also review their questions to see if more need to be added.

Review of ISPs for person-centered language improved, resulting in only nine errors for Innovations and approximately 50% for non-Innovations.

Review of PCPs from Transition Coordinators, to ensure Supported Employment is included when desired, was lower than last quarter; only five of 12 reviewed met criteria.

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

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

Finance: Review of utilization of credit card receipts for 16 TCL consumers show card receipts do not balance due to clerical errors.

Respectfully submitted by:

____________________________________ ________

Carol Robertson, Quality Management Director Date

Quality Improvement Projects (QIP)Analysis:

Full reports and graphs are included in QM Quarterly Summary

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)** 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)** This QIP will be recommended for closure when a new QIP is identified and approved.

- **New QIP: Increase number and percentage of members with routine appointments who keep their appointment within 14 calendar days of contacting the Call Center.** Interim goal of 66% set, with a timeline of one year.

Network:

- **Enhance Network Provider Directory. Improve the accuracy of provider information in the Network Provider Directory. (DMH)** It is recommended for closure when 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)** The goal is to decrease this number to 57. This was the second quarter that the measure was below the baseline by two. This quarter we were over the Measurable Goal by eight. 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.

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. This is the first quarter goal was met.

- **Maximize the benefit of Child Mental Health Level III. (DMA)** The timeline for this QIP is February 2017 or until the CM/UM achieves three consecutive quarters of meeting the stated goal. The goal was not met this quarter but is improving.

- **Assure consistent connection to community services following Facility Based Crisis Services. (DMH).** 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.

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 Life Surveys were received.
  - 21 (62%) were completed timely and correctly.
  - 13 (38%) were not completed in a timely manner or correctly.

Utilization Management Committee

Executive Summary

Committee Chair: Sabrina Russell-Holloman, LCSW **Date of Summary: 4/19/2017**
Meeting Date: February 21, 2017
Date of Summary to QM Committee: 4/19/2017

Committee progress towards purpose and objectives

- Continue to maintain over 85% consistency standards for IRR. Clinical vignettes completed quarterly to monitor reviewer consistency. Reviewers are 100% consistent in decisions.
- 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. UM staff utilizing Integrated Care scripts with providers. Providers have increased coordination of care with physical health providers.
- UM participated in DMA/DMH meeting to discuss possible changes to Intensive In Home and Day Treatment service definition. UM provided feedback regarding service delivery oversight.
- UM is currently monitoring SB 161 for changes to the appeals timeframes. UM has started reviewing documents that will require revisions for implementation.
- UM continues to provide education to members and providers regarding the Intensive Review Process. As a result, UM has seen an increase in appeals for Innovation services.

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 3rd quarter, there were 40 Medicaid appeals and 5 IPRS appeals. There has been an increase in Innovations denials and appeals based on the Resource Allocation Model. UM continues to educate members and providers regarding the Intensive Review Process and the need to request services they feel are medically necessary.

PREST IRR Completion
IRR conducted in January 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 10/1/16 to 12/31/16. The data indicates that 88% 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 of 54%.
The QIP related to Maximizing Benefit of Level III services for the quarter 4/1/16 to 6/30/16 indicates 62.9% received outpatient therapy via unmanaged sessions or were authorized but EPSDT was not selected. 37.1% 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=4.05 15% of 27). 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 Assure consistent connection to community services following Facility Based Crisis Services reveals out of 142, 84 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 52 of which 9 or 17% were successfully connected. This is 18% below the goal of 35%.
As expected the results this quarter show a positive increase from the previous quarter.

Policy and Procedures
UM completed annual Policy and Procedure Review. Changes were made to HUM 1 Review Criteria Requirements Policy, HUM 30 Prospective and Concurrent Review Determinations Procedure and HUM 42 Certification Submission and Review Process Procedure. The changes made were to add the Support Intensity Scale as a part of the initial review and updated the Person Centered Profile.

Staff Training
CM/UM staff participated in best practice and evidenced based training related to working military families, pregnancy and substance use, trauma and ethics, treatment of PTSD and clinical service documentation. 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. Recent recruitment efforts have enabled Department to hire candidates with extensive Mental Health and Substance abuse experience as well as managed care experience.

Provider Communication/Training
UM informed providers of changes made to the staffing ratio for Intensive In Home Clinical Coverage Policy.

Identified Areas of Need and Possible Solutions

Reports to project utilization of services.
UM met with Business Intelligence staff to highlight need and request assistance. Business Intelligence staff feels reports can be generated based on Data Warehouse.

Additional Comments:

Add any additional comments if needed. None

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

Approved by:______________________________
QM Committee Chair/Regulatory Compliance Officer

Executive Summary- Customer Services Department
Period: January 2017-March 2017

Policy and procedure:
During this quarter all policies and procedures (HCC and CS) were reviewed and updated, if needed.
Issues noted: Annual review of policies, procedures and revision, if needed.
Action taken: The following policies and procedures were updated: HCC 6, CS 5, CS 5a, CS 17a.
Health Call Center (clinical) scripts were also reviewed.

Access:
Issues noted: The number and percentage of members keeping routine appointments has fallen below the state standard of 75% for the last four quarters.
Action taken: A Quality Improvement Plan has been developed to focus on improving this area. Interventions include: text message reminders, member scheduling that considers child care, transportation or other barriers, first available appointments offered, motivational interviewing techniques, and next day follow-up for missed appointments. Effectiveness will be monitored monthly.

Other:
- Mystery shopper provider access availability process begun (CCME suggestion).
- All access standards met for this quarter, no action taken.

Member Eligibility and Enrollment:
Issues noted: During the last three quarters, newly enrolled members frequently had errors in their assigned benefit plan/target population. This error impacts member service planning, authorization, and provider reimbursement.
Action taken: Collaboration with Finance department to reduce the number of errors in this area. Interventions include: technical assistance to providers on benefit plan criteria and enrollment, training to providers on the various target populations and criteria,

Other accreditation or regulatory issues:
Issues noted and actions:
- Cardinal Innovations primary rollover contract performance review.
- Member Handbook updated in areas of Grievance appeals and changed term “members” to consumers to match the web site.
- Inter-rater reliability review: passed with 85% concurrence in STR disposition.

Health Network Committee

3rd Quarter Executive Summary 2016-17

Committee Chair: Bonita Porter, MSW, LCSW **Date of Summary:** April 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: April 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.

Q3 saw a slight uptick in terminations with a total of five while there have been zero disputes to date. Re-credentialing rates are not static by nature but the average for the quarter was 86%.

Ongoing projects include: Service Gaps Analysis, Shaping the Network efforts, the development of a clinical QIP, response to requests to expand the network, continued technical assistance to providers regarding EBPs and free trainings Through SRAHEC for providers on EBPs.

Significant accomplishments for the quarter include:

DBT Specialized Service Contract was awarded through RFP Process.

Trainings on Effectively Documenting Treatment Provided, EBPS for PTSD, Opioid Effected Pregnancy and DBT were offered through SRAHEC at no cost to providers.

In collaboration with Integrated Care Outreach Clinician developed Resource lists for services for specific populations including Sex Offender Treatment Providers, Low-cost and Free Medical Clinics and Opioid Effected Pregnancy Services.

Updated the B3 Quick Reference Guide.

Further Efforts Continue Regarding:

Service Gaps Analysis.

Improved Integrated Care Service Delivery efforts. By screening prospective new providers on their practices and monitoring existing providers on their documentation of coordinated care and also offering technical assistance as needed.

Expanded Opioid Treatment offerings within the network. SHC Medical Director will follow-up with clinical leadership at our largest providers on Opioid Medication Assisted Treatment efforts as this is a state identified clinical treatment need. At this time none of our top 3 outpatient providers offer this service.

Prepared by: ____________________________________
Committee Chair

Approved by:_________________________________
QM Committee Chair

Network Leadership Council (NLC) Executive Summary

Date of Summary:	April 3, 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:	January 12, 2017, February 9, 2017, March 9, 2017
Date of Summary to QM Committee:	

January/February/March Meetings – Significant Reports and Data Presented

Council Membership
- New vacancy on NLC and applications being solicited.
- New Finance Director, Hannah Brown, introduced.

Access2Care Screening Kiosks
- Access2Care access is tracked and numbers slightly lower over holidays. No individual information collected but visitors to website can access Call Center either by phone or email.

CFAC Update – *Consumer and Family Advisory Committee*
- Stakeholder Breakfast meetings in Harnett, Moore and Hoke Counties.
- Issue: 11,000 individuals on state wide waiting list for Innovations waiver. Individuals on waiting list are able to access other services.
- No IPRS funding cuts planned for this fiscal year.
- CFAC working on their SWOT (Strengths, Weaknesses, Opportunities and Threats) in preparation for developing their Strategic Plan.

Customer Services Update
- Consumer Handbook has been revised and approved by DMA.
- New QIP "Improving Attendance at Routine Appointments," by assisting callers with scheduling routine appointments and by reminding members, sending text messages and asking about barriers such as child care and transportation.

Utilization Management
- UM remains in compliance with all DMA and DMH standards.
- Increase in client appeals due to Innovations moving to resource allocation model. Clients providing additional information and appeals being reviewed.
- DMA moving forward with modifying IIH service definition, with staff ratio changing from 1 to 8 to 1 to 12 in near future; possible rate change as well.
- Request from providers for 6-month authorization period (instead of 3-month) for Individual Placement Supports, and this was approved.

Quality Management & Quality of Care (QOC) Concerns
- Documentation issues continue to be an issue as well as services not being true to model. SHC continues to schedule training.
- Focus is on number of suicide attempts and suicides; most common age range 13 to 17, and 21 to 27; location is home or group home; most common interventions were hospitalization and safety plans; most common diagnoses ADHD, Bipolar, and Schizoid-Effective disorder. QM to review data and focus on inventions and outcomes.
- Integrated Care project is moving forward and Integrated Care Coordinator is reaching out to providers.
- 21 letters regarding polypharmacy concerns were sent to Medical Directors of agencies. SHC providing technical assistance via phone calls and face to face meetings.
- Care Coordination staff trained on use of opioid and pregnancy scripts.

- SHC access standards for Innovations not being met (85% is standard) because incident reports not reported in timely manner. Training and presentation at Provider Forum to advise providers of issue, that 72 hours does not mean 3 business days.
- Some providers billing SA outpatient and SAIOP/SACOT concurrently and this is duplicate billing. Training provided.

Integrated Care News Letter

- Settlement agreement has been reached between Disability Rights and DHHS. Goal is to improve access to services for dually diagnosed minors with complex needs. Lynn Beattie has begun developing an integrated care project, which will measure outcomes.
- New Integrated Care newsletter and script being developed concerning Children with Asthma.

Community Care of NC Update

- After 5 years, SBIRT grant has ended within SHC area. Partners continuing their monthly meetings via conference calls.

Care Coordination

- New Mental Health Licensed Substance Abuse Care Coordinator, Leslie Kidd, has hired and will work out of Asheboro office.

Operations Report for September

- 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 months of October, November, December, and January were reviewed by committee to determine any trends or training needs. Availability of foreign language interpreters for SHC consumers was noted.

Additional Comments:

Prepared by: ___________________________________
Committee Chair

Approved by: ___________________________________
QM Committee Chair