

# Sandhills Center

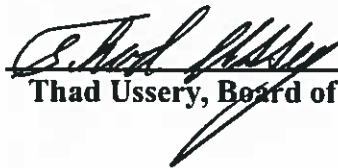
## Quality Management Program/Plan

**FY 2015-2016**

**References:**

**URAC Core Standards 17-24**

**NC Department of Health and Human Services Contract Attachment II 7.1**



**Thad Ussery, Board of Directors Chairperson**



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### ***Mission***

***The mission of Sandhills Center, a Local Management Entity-Managed Care Organization, is to develop, manage and assure that persons in need have access to quality mental health, intellectual/developmental disabilities, and substance abuse services.***

### ***Vision***

***Sandhills Center Local Management Entity-Managed Care Organization will partner with members, their families, service providers, policy makers, and other community stakeholders in creating, managing, and supporting Behavioral Health Services that meet the needs of our consumers.***

### ***Working Principles***

***Sandhills Center Local Management Entity-Managed Care Organization strives to promote:***

- ***Access to a continuum of services to meet the Behavioral Health needs of the citizens of Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph and Richmond Counties of North Carolina***
- ***Active partnerships among members, families, providers and communities***
- ***High quality Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services***
- ***Cost effective delivery of services in the least restrictive environment, appropriate to the needs of members***
- ***A provider network that is culturally competent and respectful in meeting member's needs***
- ***A collaborative approach to problem-solving and resource development***

## **Quality Management Program Introduction, and Purpose (CORE 17, 18)**

Sandhills Center is a Local Management Entity-Managed Care Organization that provides coordination, planning, administration, and monitoring of behavioral health services for persons of nine counties located in the heart of North Carolina. The geographic area encompasses a total population of approximately 1,039,175 people of varying ethnic and socioeconomic groups and includes areas ranging from small urban to extreme rural areas.

Sandhills Center has developed and implemented a comprehensive Quality Management (QM) Program that systematically monitors the quality and effectiveness of its internal systems, as well as ensuring the provision of high quality services delivered by its provider network. It is designed to comply with URAC Standards, DMH/DD/SAS Rules, 42 CFR 438.240 and with the utilization control program required by CMS for DMA's overall Medicaid Program described in 42 CFR 456. Sandhills Center follows the Centers for Medicare and Medicaid (CMS) Quality Framework. The functions of the Quality Framework are design, discovery, remediation, and continuous improvement.

- Design – designing quality assurance and improvement strategies
- Discovery – collecting data and directing participant experience in order to assess the ongoing implementation of the program, identifying strengths
- Remediation – Taking action to remedy specific concerns that arise
- Continuous improvement – utilizing data and quality information to engage in actions that lead to continuous improvement

Additionally, Sandhills Center utilizes the Plan, Do, Check, Act (PDCA) Quality Improvement Model.

- Plan – Analyze the problem, establish a solution plan and set goals
- Do – Implement the solution
- Check – Evaluate the solution
- Act – Monitor for continuous improvement and implement system change

Sandhills Center established a Quality Management (QM) program to ensure quality services to Sandhills Center's members (consumers) and its clients (the Divisions of Medical Assistance and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services). As such, the QM Program Plan addresses the needs of members, its clients and the organization's various internal departments. Primary responsibilities of the QM Program include:

- Ensure mechanisms are in place to measure and monitor Sandhills Center's compliance to its own policies/procedures and key processes
- Ensure all performance measures for the State contract are met and reported as required
- Establish performance standards for internal/external processes including, but not limited to, access to services, satisfaction and complaints
- Implement performance monitoring mechanisms as well as quality improvement activities based on findings
- Act upon data findings
  1. Identify needed areas of improvement; develop process for action to correct deficiencies, and sustain performance.
  2. Establish mechanisms to receive and use stakeholder (client, member, provider, community) feedback on a continuous basis to improve the overall system.

3. Institute quality studies, including formal ongoing Quality Improvement Projects for each URAC accredited program, including the studies that are approved by the Division of Medical Assistance as required by the contract.
4. Ensure data driven decision making in determining action and developing strategies.

The purpose of the QM program is to promote objective monitoring, and evaluation of internal/external processes, services, and outcomes. Quality improvement activities are implemented based upon the findings. The scope of the QM Program includes all Sandhills Center programs and departments, clients, members, families, community stakeholders, contracted network providers. This is done through the following structure and activities:

- Establishment of a data driven culture;
- Connection that brings an entire organization together through interdepartmental representation on teams and committees;
- Consistent method of communication and information-sharing within the organization, with the provider network and with members/enrollees;
- Forum to review, evaluate and analyze patterns and trends through the use of data;
- Mechanism for problem solving;
- Method for persons served to express satisfaction or lack thereof;
- Mechanism for analysis of service delivery and a method of systematically addressing processes for improvement.

Sandhills Center employs staff to support the day-to-day operations of the QM program. Staff includes a QM Director, Complaint and Incident Manager, Complaint and Incident Specialist, Monitoring Managers, Monitoring staff, and support staff.

#### **Quality Management Plan (CORE 19)**

The Quality Management Program is guided by the QM Program Plan. The QM Plan is developed by the QM Director with input from Sandhills Center Chief Clinical Officer/Medical Director, Executive Management and QM Program staff. The QM Plan includes essential content related to:

- Quality Management Program Authority and Responsibilities
- Quality Management Program Resources
- Quality Management Program Requirements
- Quality Management Committee Structure
- Quality Management Documentation
- Quality Improvement Projects

In addition to the above content, the Quality Management Program Plan includes relevant annual goals/objectives that establish the priorities for the Quality Management Program for the year. Annual goals/objectives are established based on the mission, vision, and values of the organization. Annual goals/objectives are assessed on an ongoing basis, are data driven, and developed in concert with Sandhills Center, staff, clients, members, stakeholders. The Quality Management Plan can be updated at any time to reflect changes in the books of business system, internal/ external processes, or based on performance monitoring data.

Participants and other stakeholders have an active role in program design, performance appraisal, and quality improvement activities. This plan is instituted for the purpose of ensuring adherence to the Mission and Vision Statement and to the Working Principles upon which they are founded.

## **Quality Management Program Goals and Objectives (CORE 19)**

The following describes the goals/objectives of the Quality Management Program for fiscal year 2015-2016:

1. Continue to ensure involvement of Sandhills Center Committees (Network Leadership Council, Global Continuous Quality Improvement Committee, Clinical Advisory Committee and Consumer and Family Advisory Committee) in the development of topics for Quality Improvement projects.
  - To work collaboratively with Business Intelligence (BI) staff as they ensure QIPs are data driven with clear analysis
2. Ensure involvement of stakeholders and enrollees in development of policies and procedures.
3. Incorporate Internal Monitoring Plan activities into quarterly, bi-annual and annual reports.
  - Work with BI to make all reporting a data driven process where possible; create random sample selection of staff documentation for review to meet requirement of Internal Monitoring Plan; add information into Alpha from the newly revised QM data base to mirror the grievance section. Strategies utilized will be:
  - Work with Information Technology (IT) to explore capability to incorporate Incident Reporting section in Alpha that will pull the providers from the Alpha information and assist in creation of reports provider specific or groups of incidents by category.
  - Incorporate new process in Alpha to include Quality of Care reviews and Routine Monitoring that mirror Grievances and Incidents.
4. Promote use of Evidenced Based Best Practices (EBP) throughout the service delivery system by:
  - Ensuring information is listed on SHC website and that information is accurate and that all links remain active;
  - Incorporating information about EBPs in the QM report at Quarterly Provider Forums.
5. Transition the agency's reporting methodology toward less written summaries and more data analysis and trending on a bi- annual basis (ongoing) Strategies include:
  - Identifying all sources of data to be utilized for specific programs;
  - Establishing baselines;
  - Ensuring sample sizes are appropriate and meet required practice standards for sampling;
  - Establishing methodology to contrast and compare varying time frames;
  - Focusing committee discussions on data analysis and trending of program information.

## **Monitoring Core Processes and Outcomes (CORE 19)**

The Quality Management Program (QM) is comprised of staff responsible for the monitoring (both internal and external) activities of Sandhills Center. These activities include but are not limited to:

- Quality indicator development and monitoring to identify practices that do not meet standards;
- Data collection, analyses and trends;
- Health and Safety – receipt, review and follow-up to incident reports submitted from providers in the network;
- Performance Profile Status (Routine)Monitoring;
- Investigative Reviews for Incidents/Complaints/quality of care concerns;
- Recommend appropriate action to correct deficiencies and monitoring of corrective action plans by providers;

- Provide performance feedback to providers including detailed discussions of clinical standards and LME-MCO expectations;
- Development/adoption of clinically appropriate practice parameters, protocols/guidelines to enable providers to meet expectations;
- Internal review of all sections within Sandhills Center for inter-rater-reliability and compliance to policies and procedures, report findings quarterly to QMC;
- Quality Improvement Projects and initiatives;
- Network management and provider relations activities;
- Satisfaction surveys (member and provider);
- Availability and access to care;
- Use of services;
- Effectiveness of care;
- Health Plan Stability (Network Capacity);
- Complaints and grievances;
- Member rights and responsibilities;
- Cultural competency;
- Clinical and administrative denials and appeals;
- Marketing and communication oversight; and
- Adherence to reporting requirements to the Board of Directors and the Chief Executive Officer on quality management activities and quality management projects.

The Sandhills Center Quality Management program is intended to ensure that the structure and processes in place lead to desired outcomes for members, our clients (NC Division of MH/DD/SAS and Division of Medical Assistance), and network service providers.

#### **Oversight and Responsibility of the Quality Management Program (CORE 19 a & c)**

The Sandhills Center Board of Directors has ultimate authority and responsibility for quality management of the organization. As such, the Board delegates this authority and responsibility to the Sandhills Center CEO and to the Quality Management Committee. The Quality Management Director is a member of senior management and has the day-to-day operational responsibility for the Quality Management Program. The Quality Management Director reports to the Regulatory Compliance Officer works in concert with the Sandhills Center Chief Clinical Officer/Medical Director, who has accountability and oversight for the clinical operations of the organization.

The Chief Clinical Officer/Medical Director and QM Director co-chair the Quality Management Committee (QMC). The Chief Clinical Officer/Medical Director ensures that:

- Results from quality management care/service activities have been thoroughly analyzed by appropriate staff/committees;
- Opportunities for improvement have been identified and approved interventions have been implemented;
- The review/resolution of clinical quality of care issues.

A quarterly report of all quality management activities, including statistical reporting measures, satisfaction survey results, incident and complaint analyses and quality improvement projects, is provided to the Board of Directors for feedback.

Annually, the QM Director prepares a formal evaluation of Quality Management Program's annual goals/objectives, the evaluation of the overall effectiveness of the previous year's Quality Management

Program, and a new Quality Management Plan. This is presented both to the Quality Management Committee and to the Board of Directors for approval.

### **QM Committee Structure and Composition (CORE 20)**

Sandhills Center's QM Committee is the main conduit of change for the organization. It is at this committee that all implementation for improvement is directed. The Committee is granted authority by the Board of Directors, and the Chief Executive Officer. The committee is co-chaired by the Chief Clinical Officer/Medical Director and the Quality Management Director. Membership is as follows: Sandhills Center CEO, Sandhills Center Chief Operating Officer, Business Intelligence/Waiver Contract Manager, Care Management/Utilization Management Director, Health Network Director, Customer Services Director, Customer Services Coordinator, Finance Director, Information Technology Director, Regulatory Compliance Officer, Human Resources Director and a Consumer/Family Representative. Other staff serving as non-voting members includes the QM Administrative Assistant and the Regulatory Compliance Manager. The QM Committee meets at least quarterly on the fourth Tuesday. Approved minutes of all QMC meetings are maintained by the QM Administrative Assistant. Provider input is received from the Global Continuous Quality Improvement Committee (GCQIC). The GCQIC is comprised of providers representing each service contracted with Sandhills Center and is co-chaired by providers.

### **QM Committee Purpose (CORE 20)**

The purpose of the QM Committee is to oversee and improve the internal/ external performance and quality of the Sandhills Service Management system (operations, components, functions, processes, practices). The system is monitored through the collection, analyses, trending, reporting, review and further discussion of data. All noted deficiencies in performance, as well as opportunities for improvement, are identified and improved through the design, assignment, implementation, tracking and ongoing evaluation of quality improvement activities.

The Sandhills Center QM Committee provides a forum for problem-solving and systematically addressing processes for improvement as well as providing feedback.

### **QM Committee Responsibilities (CORE 19, 20)**

Responsibilities of the QM Committee include, but are not limited to the following:

- Review of CM/UM, Health Network and Customer Services Committee and executive summaries. This includes review of aggregate trend reports and analysis of clinical/service indicators.
- Identification of quality indicators, measures and activities as required by the contract between Department of Health and Human Services (DHHS) and Sandhills Center and based on previous or current QM Plan goals/objectives.
- Establishment of performance thresholds and benchmarks for all internal/external quality indicators;
- Ensuring quality improvement efforts are prioritized, resources are appropriate and resolution occurs;
- Approves Quality Improvement Projects and monitors progress towards goal;
- Review of Policies and Procedures;
- Review of the QM Plan annually;
- Review of the effectiveness of the QM Program annually;



- Review for decision making data analyzed from investigative monitoring, incident reporting, DHHS required monitoring activities and complaints (members and providers);
- Review of outcomes;
- Review of service availability and access to care;
- Review of member and provider satisfaction surveys for improvement opportunities;
- Review of provider sanctions, limitations or terminations applied by Network or Regulatory Compliance;
- Review/approve Sandhills Center marketing material and website links;
- Review of aggregate report for all appeals;
- Ensuring a quarterly report of quality improvement activities is provided to the Consumer and Family Advisory Committee, Network Leadership Council and to the County Commissioners of the nine counties;
- Review of Credentialing Committee activities as reported through the Network Executive Summary;
- Ensuring staff, consumers and providers receive information annually describing the effectiveness of the quality improvement activities.

### **Quality Management Committee and Program QM Structure (CORE 20)**

The QM Committee has ultimate accountability for the oversight and effectiveness of the QM Program. In order to facilitate the coordination of all Sandhills Center quality management activities including providing oversight, direction and consultation to the Program QM Committees, a committee structure is designed to:

- Facilitate the development/implementation of an effective/efficient infrastructure for service management, formal oversight and decision-making;
- Reflect a committee structure common within the Local Management Entity-Managed Care Organization environment;
- Provide a mechanism that allows Sandhills Center to comply with Divisions of MH/DD/SAS, DMA and URAC standards.

The Committee Structure consists of four (4) major committees:

- Sandhills Center Quality Management Committee
- Care Management (CM)/Utilization Management (UM) Committee
- Health Network Committee
- Customer Services Committee

The Program Committees are responsible for oversight of the day-to-day operations of the Quality Management Program. They also communicate their activities and findings back to the Sandhills Center Quality Management Committee.

### **Care Management/Utilization Management Committee Description and Purpose**

The role of this committee is to oversee, and monitor the Sandhills utilization management structure, process, as well as related activities, to ensure members have prompt access to all relevant covered services according to member need, choice, medical necessity, and established or emerging best practices. Through the review and analyses of single member, population-specific and aggregate data, the UM Committee monitors and evaluates information to ensure all members receive culturally competent, medically necessary services that are aligned with evidence-based best practice guidelines. The committee also ensures that services are delivered at the most appropriate intensity, frequency and

duration that yields the desired outcomes, as identified by the member, service provider, Sandhills Center, NC Division of MH/DD/SAS and the NC Division of Medical Assistance.

CM/UM Committee activities include but are not limited to the following:

- Selection of quality indicators for UM;
- Establish indicators as well as needed reports for all internal/external UM quality indicators, in conjunction with QM;
- Establish performance benchmarks for systemic improvement;
- Monitor use of clinically appropriate protocols/guidelines used by Network providers to enable providers to meet established standards;
- Review/update/approve UM decision making and management criteria for services;
- Review/update/ approve benefit plans that are within clinically appropriate practice parameters;
- Review data related to prospective/ concurrent/retrospective reviews;
- Review data to detect over/under utilization of services;
- Identify opportunities for improvement and conduct Quality Improvement Projects based on data analysis;
- Assess quality and appropriateness of care furnished to consumers, inclusive of all demographic groups, care settings or types of services; and
- Recognize the need for corrective action and initiate strategies to maintain the effectiveness of the UM Program.

#### **Health Network Committee Purpose and Description**

The role of this committee is to oversee and monitor the development, and management of the Sandhills provider system structure to ensure the presence of an adequate number and mix of qualified, competent, credentialed, well-oriented, trained providers who meet the behavioral health services needs of Sandhills Center members. Through the establishment of provider participation credentialing criteria, monitoring, and review/analyses of data, this committee assures providers deliver quality services which are person-centered, and meet the needs and preferences of Sandhills Center's members.

Health Network Committee activities include but are not limited to the following:

- Establish indicators and needed reports for all Health Network quality indicators, in conjunction with QM;
- Establish performance benchmarks for systemic improvement;
- Establish provider participation and credentialing criteria;
- Establish method and process for monitoring accessibility of services, appointment availability and wait times;
- Review internal performance for identification, recruitment, processing, credentialing;
- Evaluating network sufficiency, including service access, availability and adequacy on an ongoing basis; identifying strategies to develop additional services when gaps are identified;
- Orientation and monitoring of providers;
- Review/analyze findings of provider monitoring activities; and
- Identify opportunities for improvement; conduct Quality Improvement Projects based on data analysis.

#### **Health Network Sub-Committee: Network Leadership Council (NLC)**

The Network Leadership Council provides a mechanism to ensure provider input, participation in decision-making related to building as well as maintaining a diverse provider network that meets the

requirements of the State. The Network Leadership Council serves as a fair and impartial representative of services among providers within the Sandhills Center provider network. The NLC facilitates open exchange of ideas, shared values/ goals/visions to promote collaboration and mutual accountability among providers. The NLC also strives to achieve best practices to empower members within our community to achieve their personal goals.

Membership consists of network providers, Sandhills Center staff, representatives from the Consumer and Family Advisory Committee (CFAC) and the Community Care of North Carolina (CCNC). Provider members are active, contracted partners in the Sandhills Center provider network. Provider representation directly reflects the network composite and may include individuals in either managerial/leadership and/or clinical roles.

Specific activities include:

- Review of and recommendations for the annual provider communication plan, including provider manual, provider website, provider training topics, and activities;
- Provide input on topics for quality improvement projects, barriers to improvement and action plans to reduce or remove such barriers;
- Review of results of quality improvement projects, initiatives and data related to utilization, performance;
- Review of quality management activities selected by Sandhills Center leadership, and Committees co-chairs;
- Provide input regarding the Sandhills Center Service Needs, Gaps and Provider Capacity Strategic Plan;
- Review of and recommendations for the use of emerging best practices;
- Assist in the development, approval and annual review of the Sandhills Center Cultural Competency Plan;
- Review Provider Satisfaction Survey results and make recommendations to address areas of concern;
- Review reports/data on provider related performance and quality management activities; provide input/recommendations;
- Review and approval of the Provider Code of Ethics;
- Conduct an annual self-assessment process and evaluation;
- Offer recommendations for provider monitoring and quality indicators;
- Review provider network performance against stated goals.

### **Clinical Advisory Committee (CAC)**

The Clinical Advisory Committee is the forum for discussion/approval of clinical treatment practices and community standards of care that are used in the Sandhills Center provider network, including review of credentialing and provider disputes. Issues may be forwarded to the Network Leadership Council for information purposes or for additional input following review approval by the CAC.

Members of the Clinical Advisory Committee include network provider representatives that have no role in Sandhills Center's management, Sandhills Center Chief Clinical Officer/Medical Director and Sandhills Center staff. The Chief Clinical Officer/Medical Director is responsible for oversight of clinical aspects of the credentialing program in cooperation with the Clinical Advisory Committee.

CAC membership is comprised of active practicing licensed clinicians that mirror the network composition in addition to Sandhills Center LME-MCO employees, licensed non-network healthcare practitioners residing within the LME-MCO's geographic area, and Sandhills Center licensed clinical

leadership staff. The Chairperson of the committee is the Sandhills Center Medical Director/Chief Clinical Officer. Meetings are convened at least quarterly and/or as needed.

The Clinical Advisory Committee is a rotating membership composed of licensed independent practitioners—MD’s, practicing psychologists, LCSW’s, LCAS’s, and PLC’s—who are representative of our provider network with regards to discipline, specialty, clinical competencies, geographic locations, and agency size. Additionally, this committee has representatives from the LME-MCO’s CCNC Network and members who are academic experts in the mental health field. These experts are not members of the provider network, but they reside within the Sandhills Center LME-MCO geographic area.

#### **Sandhills Center Clinical Advisory Committee Scope of Responsibilities & Duties:**

- Review of Evidenced based clinical practice guidelines in conjunction with recommendations from Sandhills Center Integrated Care partners;
- Review clinical decision support tools/utilization management criteria;
- Review of Customer Services clinical triage and referral processes;
- Identification of training needs of providers;
- Evaluation of service utilization as related to clinical guidelines;
- Evaluate data from Quality Management audits, Gaps Analysis and other data tools as resources for monitoring and effective clinical guidelines implementation;
- Review of credentialing program and function as Credentialing Committee;
- Function as provider dispute/appeals committee.
- This Committee will be the primary gate keeper for consideration of new/innovative services and rate changes for services that adhere to clinical practice continuums of services and emerging best practices. Recommendations regarding such will be provided to the Sandhills Center Medical Director who will ultimately decide which rate changes and new/innovative services will be forwarded to the CEO for consideration.

**Credentialing Subcommittee:** Ensures that the Credentialing Sub Committee membership is broad enough that appropriate clinical peer input with knowledge of service specific standards of care is available when reviewing credentialing applications and Provider Dispute/Appeals related to professional conduct or competence.

The Credentialing Subcommittee is composed only of non Sandhills Center members of the CAC who hold active and unrestricted licensure in their field and these members are the only ones casting votes on credentialing matters. The Sandhills Center Medical Director chairs the subcommittee. In the case of a tie vote, the Sandhills Center Medical Director casts the deciding vote.

#### **Credentialing/Re-Credentialing Functions:**

- Review overall direction of the credentialing program, including review and approval of credentialing policies/procedures;
- Review and approval of credentialing criteria for services;
- Review and approval and/or disapproval of providers requesting enrollment in the network through credentialing/re-credentialing enrollment procedures:
  - a. The Credentialing Subcommittee has delegated authority to the Chief Clinical Officer/Medical Director to approve “clean” credentialing applications” as defined as: Credentialing applications with no open actions from any regulatory body/law enforcement agency and credentialing applications with no closed/resolved actions from any regulatory body/law enforcement agency within the last 3 years. The previous definition also applies

to matters of re-credentialing in addition to having no negative entries in the provider profile system.

- b. The definition of an “unclean” application for credentialing & re-credentialing is any application with adverse actions of three (3) or younger & completed QM issues. Unclean credentialing & re-credentialing applications are discussed monthly by the Clinical Advisory Committee & minutes documented. The credentialing subcommittee is composed only of non-Sandhills Center member of the CAC who hold active and unrestricted licensure in their field and these members are the only ones casting votes on credentialing matters. The Chief Clinical Officer/Medical Director chairs the subcommittee and in the case of a tie vote, the Sandhills Center Chief Clinical Officer/Medical Director casts the deciding vote.
- Evaluate the effectiveness of the credentialing program.

#### **Provider Dispute/Appeals Functions:**

- Review and approval of provider disputes/appeals policies/procedures;
- Review of provider disputes and appeals related to professional conduct or competence;
- Complete annual assessment of provider dispute resolution activities.

#### **Customer Services Committee Purpose and Description**

The role of this committee is to oversee and monitor the quality of services and care delivered to Sandhills members to assure full member/family participation in the service design as well as delivery. Data from Customer Services is reviewed/analyzed to identify and improve internal/external structures and processes. Such data may include volume/type of member calls, member requests, member screening, clinical triage, member complaints/grievances, member satisfaction and outcome data.

Further responsibilities of this committee include but are not limited to the following:

- Identify/define quality indicators, measures and activities as required by contract between NC Divisions of MH/DD/SAS, DMA, and Sandhills Center, based on previous/current member services activities;
- Review and approval of Member Handbook;
- Establish performance thresholds and benchmarks for all internal/external quality indicators for member services; review data based on these benchmarks;
- Review for discussion/additional decision making data analyses from incident reporting, and targeted monitoring;
- Identify opportunities for improvement; conduct Quality Improvement Projects based on data analysis.

#### **Critical Incidents/Issues Committee**

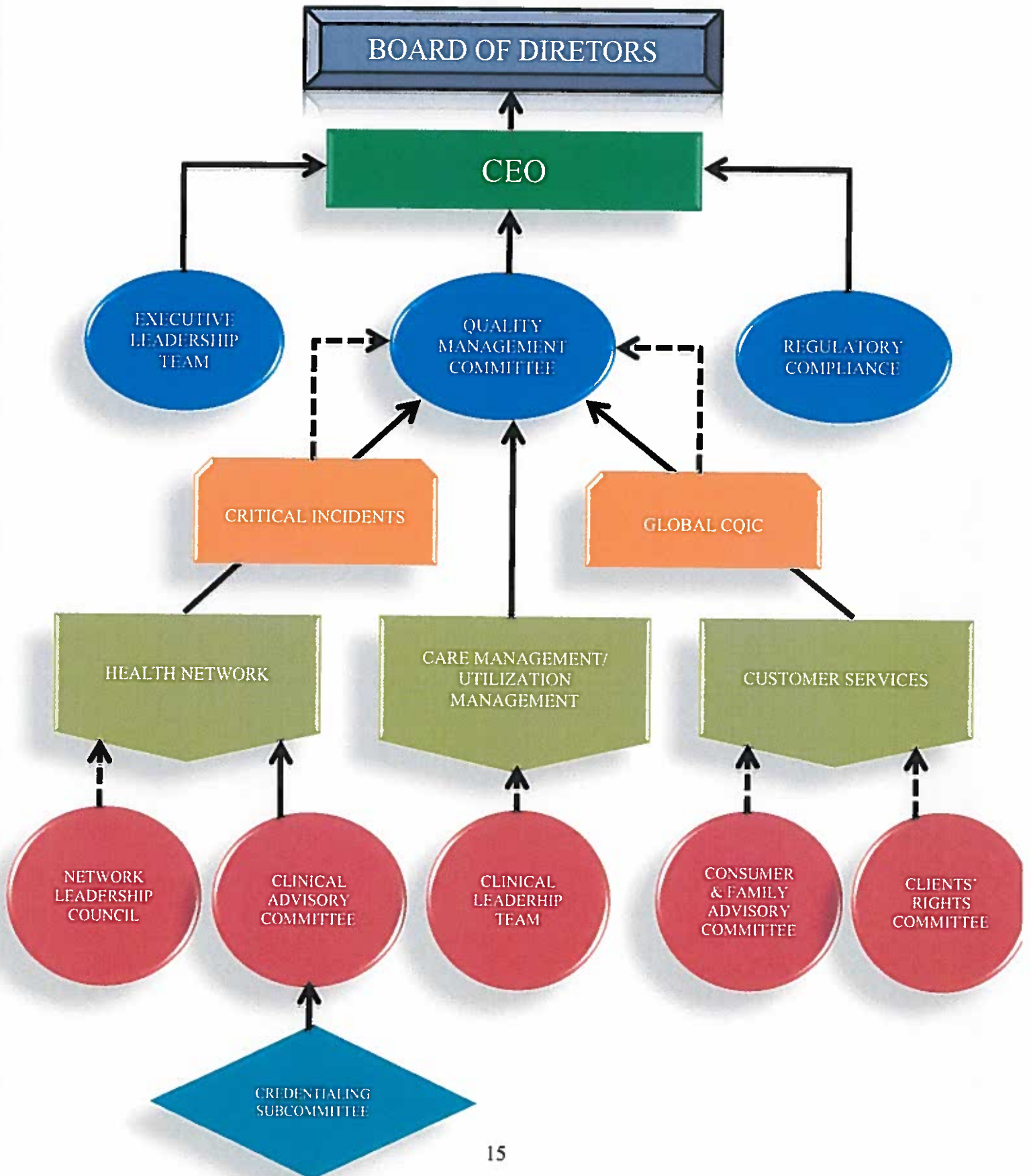
The role of this committee is to review all incidents/issues that meet high risk criteria. The committee is chaired by the Chief Clinical Officer/Medical Director. It includes staff representation from the Health Network Program, Care Management/Utilization Management, Care/Coordination; Customer Services, Regulatory Compliance and QM Monitoring. The committee reviews each incident/issue to ensure appropriate action has been taken. The committee also looks at trends related to incidents and complaints to determine if systemic improvement is warranted.

#### **QM Subcommittee: Global Continuous Quality Improvement Committee**

The role of this committee is to provide feedback to the Quality Management Committee regarding Quality Improvement Projects, quality of care concerns and results of monitoring activities as they relate to quality of care issues

The Committee is made up of providers contracted with Sandhills Center LME-MCO, meets at least quarterly, and is co-chaired by providers. Attention to provider types and specialties is included, so that equal representation is maintained.

## Operational Committees (see chart below)



## **General Documentation and Distribution Requirements for Committees**

All committees and related subcommittees maintain meeting minutes and task logs which are recorded in a prescribed format. This information is distributed to the individual committee chairs as well as the QM Committee Chairs within seven (7) working days following each committee meeting. In addition, the CM/UM, Health Network and Customer Services committees prepare and submit quarterly executive summaries of data analyses, as well as required action(s) to the QM Committee at least five (5) working days prior to the QM Committee meetings. The previous QM Committee's meeting minutes are distributed to members for review, corrections and action within three (3) working days of the proceeding meeting. All Program QM Committee reports are incorporated into the QM Committee for review.

Quality Management outcomes, reports, recommendations, and actions are made available to staff through executive/ management meetings, interdepartmental communication, shared electronic website, email, newsletters and formal reports.

### **Confidentiality**

All QM Committee Members and Program QM Committee Members adhere to Confidentiality requirements. Members sign a confidentiality agreement upon hire and each time confidentiality requirements change. Ongoing training is provided to Committee members.

Staff engaged in QM activities maintains the confidentiality of information used in such activities, except when specifically required, reference to providers or members is redacted to safeguard the member/provider's identity.

All members or providers who participate on the Sandhills Center committees must also demonstrate their understanding of the Confidentiality Requirements by signing a Confidentiality agreement prior to Committee participation.

### **Quality Management Documentation: (CORE 21 a)**

The Sandhills Center QM program is based on continuous collection and analysis of data. Quality Initiatives are identified based on the ongoing compilation of data and analysis specific to member services/care. Priority will be established based on evaluation of highest risk/highest need for members/enrollees. In addition, topics with the greatest potential increase in performance may also gain priority. Data sources include, but are not limited to, authorizations, claims, member/enrollee surveys, provider satisfaction surveys, NC TOPPS data, grievances and appeals, incidents, provider monitoring, etc.

Communication of quality management activities to staff and management is an important part of Sandhills Center's QM Program. Minutes from the Program QM Committees in addition to the Quality Management Committee reflect the activities related to the key indicators oversight, tracking and trending.

Information is shared with staff via the Program QM Committees as well as the Quality Management Committee through posting of Minutes on the electronic Document Management system, committee meetings and staff meetings.



### Quality/Performance Measures (CORE 21b & c)

Sandhills Center develops and monitors clinical/service quality measures regarding a broad spectrum of issues that encompass all functional areas within Sandhills Center. The QM program establishes quality measures as part of the measurement/evaluation process, utilizing paid claims data, internal databases, survey data and Hedis measures when available. Quality indicators have an established baseline measure. Re-measurement will occur at designated intervals, but at least annually, to measure performance. Valid statistical techniques are utilized to ensure appropriate evaluation (data collection methodology, sampling, etc.).

Each of the QM Program Committees (Health Network, Care Management/Utilization Management, and Customer Services) identifies and defines applicable performance indicators, consistent with their roles/responsibilities outlined in the QM plan. Refer to table below for examples. Sandhills Center also complies with the performance standards outlined in the contract between Sandhills and the DHHS. The Quality Management program monitors and tracks LME-MCO compliance with quality of care/service measures regarding Effectiveness of Care, Access/Availability, Enrollee and Provider Satisfaction, Use of Services, Network Capacity, Enrollee Health & Safety as well as other measures specified in the DHHS contracts.

Performance on these items is reviewed at the QM Committee meetings and is also included in the quarterly QM Committee Executive Summary. Below are examples of some of the indicators measured. Other performance measures are monitored based on DHHS contracts in the areas of Effectiveness of Care; Provider Satisfaction; Plan Descriptive Information, Use of Services; Compliance with Waiver Assurances i.e. Level of Care, Qualified Providers, Service Plan Development), Health Plan Stability, Plan Description Information and Health and Safety.

Health Network	Utilization Management	Customer Services
# of Providers not accepting new referrals	Timely Certification Decisions	Time to Answer incoming calls; Abandonment & Blockage rates
Timely Provider Selection Process	Quality and Appropriateness of Services	Screening Triage Referral Severity Level
Access and availability to Service	Appeals	Customer Satisfaction

The following methods may be used to assess Sandhills Center's program availability and accessibility to the client and members.

- Analysis and trending of information on appointment availability obtained during monitoring;
- Follow up to members who have requested referral through the Health Call Center;
- Annual Geo Access and Network analysis;
- Evaluation of complaints/grievances related to availability, access to care and member satisfaction surveys;
- North Carolina Division of MH/DD/SA (client) access to provider data and member satisfaction;
- Analysis and trending of information related to Health Call Center telephone statistics.

Sandhills Center's programs/departments monitor its client's satisfaction related to contract performance standards.

## **Monitoring of Performance Measures (CORE 21 d, e f, g, h)**

Monitoring/tracking/ reporting on performance measures are completed by the effective use of the Quality Management Program Committee structure along with the Quality Management Plan. Monitoring is the evaluation of clinical/service indicators against performance goals. Monitoring activities of Sandhills Center include, but are not limited to, the following:

- Provider medical records audits;
- Performance Profile Status Monitoring using standardized tools;
- Investigative monitoring;
- Member/Enrollee satisfaction surveys;
- Provider satisfaction surveys;
- Data to determine over/under utilization of services;
- Data to determine quality and appropriateness of care;
- Provider performance with identified measures;
- LME-MCO performance with identified measures;
- Access to services;
- Complaints and grievances.

Compliance with these performance indicators is measured at each monthly committee meeting with the supporting data being reviewed and analyzed by the committees. Based on review of the data, any indicators that measure outside the acceptable range are noted and assigned as a task for research and resolution. On a quarterly basis, each of the QM Program Committees prepares an Executive Summary that is presented to the QM Committee as the oversight body. The Executive Summary includes the analysis of data reports and the identification of any trends/patterns, as well as assigned tasks and/or opportunities for improvement.

Sandhills Center recognizes the following methods used in identifying and introducing quality issues with contracted providers into the QM Program:

- The Health Network Committee, Network Leadership Council, Global Continuous Quality Improvement Committee and Clinical Advisory Committee;
- Monitoring activities;
- The risk to the health and safety of enrollees;
- Types and number of provider incident reports submitted; and/or
- Concerns and grievances registered by enrollees or their families.

When provider performance does not meet desired expectations, the need for corrective action is communicated to the provider. Technical assistance/training may also be conducted with the provider in an effort to correct and prevent a recurrence of the issue. Quality Management staff may also collaborate with other LME-MCO staff in the correction and improvement process. Monitoring also occurs to assure providers have implemented the corrective action.

## **Feedback Loops**

Systematic data collection/analysis occurs to promote ongoing monitoring and assessment of progress towards desired expectations. Key data elements are measured and re-measured on an ongoing basis but at least annually. Measurements are results driven and aid in determining if strategies for improvement are successful or if barriers to improvement exist. Meaningful ongoing measurement provides the formative information that helps shape performance improvement. Outcomes reporting occurs at specific intervals (and as needed) through the Sandhills Center committee structure to ensure progress towards measurable goals and consistent follow-up.

Stakeholders have an active role in the design, performance appraisal and activities of the QM Program through the Program Subcommittees, CFAC, as well as the Board of Directors. Sandhills Center provides ongoing feedback to providers, stakeholders and members that include performance, outcomes, reports, recommendations and actions as part of its QM process. Such feedback continually flows back to the Program Directors through management meetings and then to staff through interdepartmental communications, staff meetings, agency-shared website, email communications, or formal reports. The QM structure provides the mechanism for QM activities to also be continually shared with the LME-MCO Board of Directors, Network Leadership Council, Consumer Family & Advisory Committee, Client Rights Committee, Global CQI Committee, providers, stakeholders and members/enrollees.

### **Quality Improvement Projects (QIPs) (CORE 22, 23, 24)**

Quality improvement projects exemplify the process of continuous quality improvement, allowing Sandhills Center to refine and maintain quality services. Development and implementation of quality initiatives include using data from multiple sources that focus on clinical or non-clinical areas. Additionally, member safety is a topic that is always in the forefront for programs interacting with members/enrollees. Each program, at any given time, maintains at least two quality improvement projects. Overall, at least one project for Sandhills Center focuses on error reduction and/or performance improvement related to the services provided or member safety. Additionally, at least one project focuses on members, relates to specified key indicators of quality and involves a senior clinical staff member in judgment about clinical performance if the project is clinical in nature. Sandhills Center maintains Quality Improvement Projects (QIP) in accordance with URAC standards and DHHS contract requirements.

All Sandhills Center Quality Improvement Projects contain the following elements:

- Project start date;
- Performance issue identified and what data indicated there was a problem;
- Data supporting the project selection;
- Identified quantifiable baseline measures for the indicator and relevance to members/enrollees served;
- Goals associated with the measure;
- Improvement strategies and dates these were implemented;
- Establish projected time frames for meeting goals for quality improvement;
- Re-measure at least annually;
- Periodic progress measurements and documented discussions;
- Identified barriers;
- Changes in improvement strategies and brief description of changes;
- Conduct an analysis if the performance goals are not met; and
- Project end date.

Each program recommends proposed Quality Improvement Projects via their Committee based on analyses of data collected. Topics for Quality Improvement Projects may also be identified by Consumer and Family Advisory Committee (CFAC) or the Client Right's Committee (CRC). The status of established initiatives is also shared with these committees for input/identification of further strategies, interventions, or barriers to improvements. If the data supports and demonstrates the need for a QIP, the potential project is forwarded to the QM Committee for approval. QIPs demonstrate improvement by achieving a benchmark level of performance improvement suggesting evidence that change is sustainable over one year and that favorable behavioral outcomes as well as member satisfaction can be expected. Findings from QIPs are used to analyze the delivery of services, quality of care, over/ under utilization of services, disease management strategies, and outcomes of care.

QM Committee minutes document the approval of all Quality Improvement Projects Updates. The status of each QIP is presented to the Committee at least quarterly, but more often as indicated. Each QIP is tracked for 12 months after completion to ensure sustained improvement.

### **Quality Management Program Evaluation**

The effectiveness of the Quality Management Program, including the QM Program/Plan annual goals/objectives, is reviewed and evaluated annually by the Quality Management Committee. The evaluation consists of a comprehensive analysis of the accomplishments of goals, analyses/ trending of performance indicators, committees' activities and the results of quality improvement activities. The evaluation assesses the overall effectiveness including the system-wide monitoring activities (internal policies/procedures, core processes and outcomes-oriented data related to improving quality of care/service delivered) as well as progress towards improving member safety and influencing network-wide clinical practices. Barriers to achieving desired goals are identified with recommendations made to address those barriers.

As a result of this evaluation, there may be activities that need to be carried over into the next year as well as the identification of new activities. The annual evaluation may also lead to identification of educational/training needs, establishment, and/or revision of policies and procedures, or alteration of organizational operations.

Once the annual QM Program evaluation is complete, the findings and recommendations are presented to the Board of Directors, along with the new QM Program Plan and updated/new annual goals and objectives.