2019-2020

Quality Management Plan & Program Description

PARTNERS BEHAVIORAL HEALTH MANAGEMENT
901 S. New Hope Road, Gastonia, North Carolina 28054

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I. ORGANIZATIONAL OVERVIEW

Partners Behavioral Health Management (Partners BHM) is dedicated to assuring the highest quality services are rendered by those providers who receive oversight by Partners BHM. Partners BHM covers the economically and culturally diverse region of Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Rutherford, Surry, and Yadkin counties of North Carolina. Partners BHM's mission is as follows:

> *"Our mission is to manage a behavioral health care system funded by federal, state, and local taxpayer dollars. We ensure all individuals who are eligible for our programs have access to quality providers and effective services. We improve lives and strengthen our communities by focusing on positive outcomes and proper use of funds entrusted to us."*

The Quality Management Program of Partners BHM is designed to ensure the Local Management Entity (LME)/Managed Care Organization (MCO) and its core functions include all qualified provider network services which are delivered in a manner consistent with the State Plan, the DMH/DMA contracts, national accreditation standards, and Partners' mission, philosophy, values and working principles. These core functions meet or exceed the standards and statutory requirements under which the LME/MCO operates.

The Quality Management Program promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement activities based upon findings. The Quality Management Program is designed to continually and consistently assess and analyze system performance data which will subsequently guide performance improvement to better support the consumer population served. The Quality Management Program balances three components: quality assurance, quality improvement and quality data. Quality Management activities yield data from multiple sources which, after analysis, is integrated and utilized for planning and guiding administrative and operational processes. The ultimate measure of the Quality Management Program's success is the achievement of safe, best practice services and desired individual outcomes for our consumers.

As the LME/MCO, Partners BHM oversees and manages consumer-centered local services for behavioral issues or illness, intellectual and developmental disabilities, and substance use. These services include but may not be limited to Member Services with a 24/7/365 Access to Care call center, Provider Network, Care Coordination, and Utilization Management Services. The Partners BHM Quality Management Plan & Program Description (QMPD), formerly titled the Quality Assurance/Quality Improvement (QA/QI) Plan and Program Description, helps to ensure Partners BHM

meets its regulatory and contractual responsibilities through continuous and systematic measurement and improvement of program systems and processes.

II. STATEMENT OF FUNCTION AND OBJECTIVES

The Quality Management (QM) Program is the vehicle through which Partners BHM analyzes and responds to data collected by its consumer health information system, claims data, operational performance monitoring, and other program measurement processes. The objective of the QM Program is to systematically use performance information and data to drive improved consumer outcomes, training, and support. The functional structure of the program not only guides and supports business decisions but creates a system of continual integrity and readiness for external review agents such as the Department of Health and Human Services (DHHS), Department of Health Service Regulation (DHSR- which is a regulatory oversight agency for state), Intra-departmental Monitoring Team (IMT), External Quality Review (EQR) oversight national accrediting bodies and other agents.

The QM Plan & Program Description is a guide which promotes objective and systematic measurement, monitoring and evaluation of services, and implementation of quality improvement activities based upon findings. The QM Plan & Program Description defines the quality structure and process of the program, as well as the role and responsibilities of the Quality Improvement Committee (QIC) and its sub-committees. **[NCQA QI 1. A.1]** The overarching function of the Quality Management Program is to ensure the following objectives:

- Consumers are free from abuse, neglect, and exploitation, and care is provided in a safe and therapeutic manner.
- Consumers have access to quality services to meet their clinical needs.
- Individuals benefit from the services they receive.
- Public resources are used appropriately, effectively, and efficiently.
- Consumers in the service system are empowered to improve their individual outcomes.
- Providers in the network are encouraged to focus on quality measures and are held accountable for their actions.
- Comprehensive, open stakeholder involvement is welcomed.
- Reasonable and accurate feedback is shared with the provider network.
- A universal quality culture for respect, collaboration, and focused improvement is widespread across the network to meet those cultural and linguistic needs.
- Support for state leaders, policy makers, and legislators who focus on system improvements is communicated to consumers and providers.

III. STRUCTURE OF THE QUALITY MANAGEMENT PROGRAM **[NCQA QI 1. A.1]**

A. AUTHORITY AND RESPONSIBILITY

The ultimate authority for the Partners BHM QM Program is its Board of Directors. The Board of Directors delegates this authority to the QIC through the Chief Executive Officer (CEO), and the CEO assigns clinical oversight to the Chief Medical Officer (CMO)/designee. **[NCQA QI 1. A.2]** The QIC is responsible for guiding the QM Program, including the annual review and approval of the QMPD. The Board is kept up-to-date on quality improvement initiatives, at least annually, through reported updates and Board review of the annual Quality Management (QM) Program Evaluation. The clinical operation of the QM Program is overseen by the Chief Medical Officer (CMO), who is a board-certified M.D.

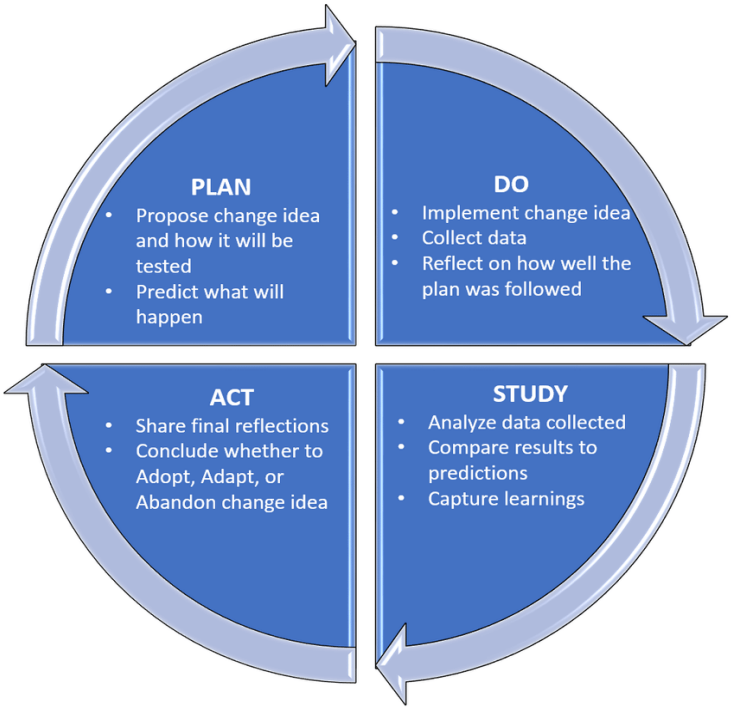
The QIC, which is granted authority by the Partners BHM Board of Directors, is responsible for the management of the QM Program **[NCQA QI 1. A.1]**. This committee meets no less than quarterly with the purpose of improving services by monitoring processes, implementing interventions, and evaluating the effectiveness of those interventions. The QIC maintains records of the committee meetings through documented minutes, regarding the committee's findings, recommendations and actions which are reviewed and approved by the QIC. The committee membership includes senior clinical staff, Operations Team members, and staff representatives of the organization, as well as representatives from the provider network and consumer/family members.

Partners BHM is fortunate to have active participation on QIC and other committees by both providers and members of the Consumer Family Advisory Committee (CFAC). The Provider Council, Global CQI Committee and CFAC appoint liaisons from its membership to serve on the QIC. **[NCQA QI 1. A.3 & 4]** Each provider and/or CFAC member serving on the QIC and/or its sub-committees shall comply with all state and federal rules, guidelines, and mandates related to conflicts of interest and confidentiality, but not limited to Partners' Conflict of Interest Disclosure and Attestation Policy and Procedure (4.18) and Partners' Confidentiality Policy and Procedure (4.01). All committee members shall, at a minimum, upon appointment and as changes occur, complete a disclosure statement. Disclosure statements shall be filed with the Chief Compliance Officer or designee.

The Director of the Quality Management Department has the authority and responsibility for the overall operation and implementation of the Quality Management Program and is responsible for overseeing the implementation of the Quality Management Plan which includes the following: **[NCQA QI 1. A.1]**

- Annual review and approval of the QM Plan & Program Description
- Chair and support of the QIC in conducting activities
- Tracking identified opportunities for improvement through the ongoing analysis of data, the implementation of plans of corrections (POC), and the completion of root cause analyses (RCA's)
- Facilitating quality projects and interventions
- Providing on-going monitoring for compliance with national accreditation standards, state, and external quality review mandates
- Providing quality related training to employees, committee members, and service providers of Partners BHM
- Reporting the activities of the Quality Management Program to the governing board

B. CONTINUOUS QUALITY IMPROVEMENT (CQI) MODEL



Partners BHM integrates a quality improvement philosophy and model which is based on PDSA (Plan, Do, Study, Act) and the use of "SMART" goals (specific, measurable, attainable, relevant, and time-specific) for quality related improvement projects. The PDSA principles include *Planning* improvements and development of tools and resources for identified change; *Doing* which is actual implementation of the improvement strategies; *Studying* to determine if those strategies made any significant transformation; and finally, *acting* on outcomes and measurements of those elements implemented with planning of next value-based action steps. A process for implementing appropriate remedial action for continuous quality improvement includes the following elements:

- A structured and systematic approach to identify quality improvement opportunities
- A common language for problem solving techniques
- Facilitation of communication among committees and groups
- Managing and reporting of key data elements and outcomes which provides supports for value-based contracting (VBC) which leads to an increase in the credibility of data

C. RESOURCES **[NCQA QI 1. A.]**

Partners BHM employs staff and uses other resources to provide the necessary support in the day-to-day operations of the QM Program. At Partners BHM, all employees, contractors, and providers are "quality-driven" and take part in the implementation of the QM Program. Key personnel positions crucial to the QM oversight process are consistently evaluated for sufficiency and reviewed with Human Resources as indicated.

Partners BHM embraces a culture where quality is the responsibility of everyone and aims to continuously improve service delivery through monitoring and analyzing data, evaluating and modifying practices, and developing initiatives to measure and improve within the organization as well as within the provider network.

The Information Technology department provides a technology framework for increasing overall productivity, efficiency, and performance. Data enables the agency to monitor, coordinate, and improve operations as well as evaluate areas of need and potential areas for improvement.

The QM Improvement and Assurance Teams are responsible for quality improvement projects, facilitation and analysis of applicable satisfaction surveys, internal monitoring of accreditation standards, and various other tasks.

The QM Monitoring Team includes Consumer Rights Officers and QM Monitoring Specialists. The Consumer Rights Officers monitor incident reports, sentinel events, and safety issues which may arise in the provision of care. QM Monitoring Specialists conduct routine provider monitoring that may include office customer service issues such as quality of practitioner office space and other identified areas including, but not limited to, "for cause" audits and other audits as requested or required for services delivered in the Provider Network.

The QM Data Team is responsible for data analysis and data management, which includes measuring outlined performance indicators in the core functional areas to assure compliance with DMH and DMA contract requirements, as well as accreditation standards. The data unit generates reports, analyzes data, and identifies significant trends and patterns for various internal quality measures. When applicable, data reports are submitted to the Executive Leadership Team (ELT), Cross Functional Teams, and/or the QIC. Organizational decisions and recommendations are made by these groups based on the data provided.

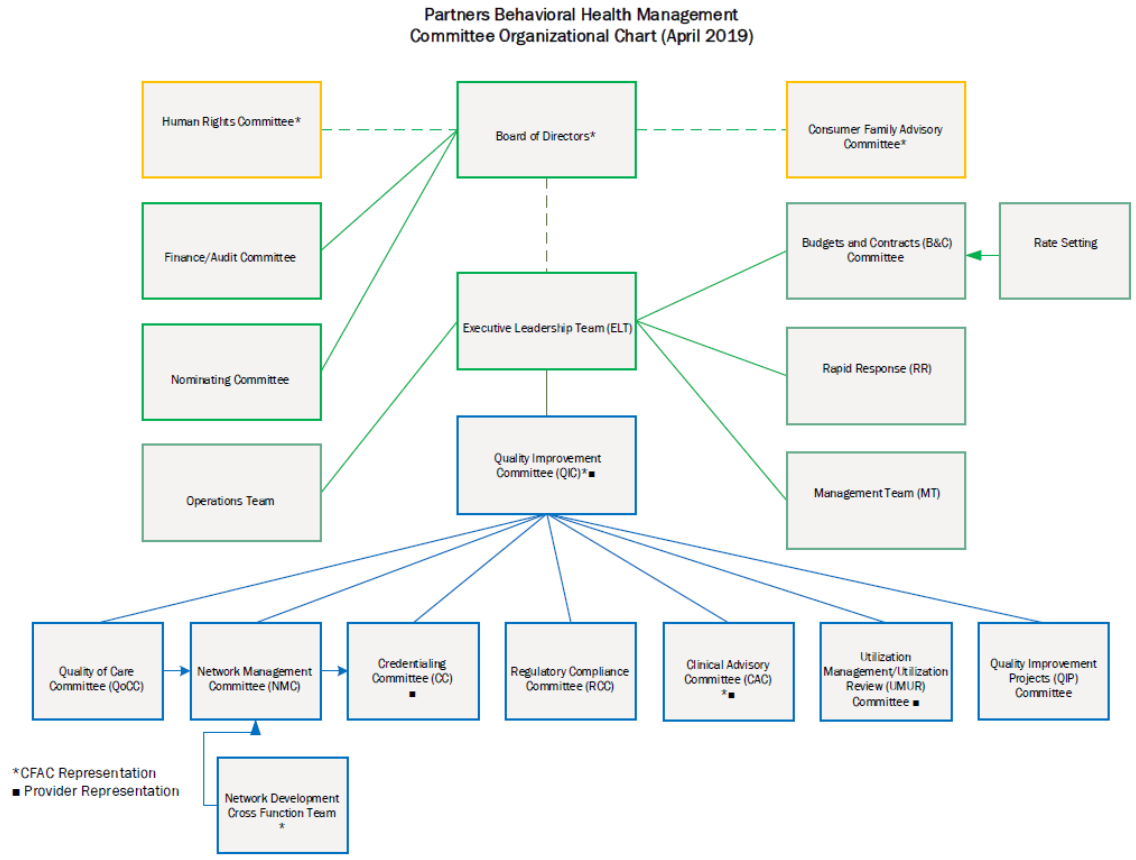
The Compliance Team is responsible for the oversight of the internal compliance activities within the organization, including risk management. The team reports on levels of compliance or non-compliance which may be discovered because of monitoring and auditing activities, and the success of efforts to improve compliance, which may include training, education, and recommendations for corrective actions.

The Chief Medical Officer (CMO) **[NCQA QI 1. A.2]** is the senior clinical staff person responsible for providing guidance to the clinical operational aspects of Partners BHM and to provide oversight to all QIC activities**.** This individual is responsible for the oversight of the clinical decision-making aspects of the program and has periodic consultation with practitioners in the field. The CMO is also responsible for ensuring the organization utilizes qualified clinicians who are accountable to the organization for decisions affecting consumers. He/she provides regular supervision and clinical support to clinical departments of Partners BHM. The CMO oversees peer review activities as well as provides quality review and quality assurance oversight for Partners BHM clinical actions. The CMO holds an active, current, and unrestricted medical license in the state of North Carolina, as well as board certification in psychiatry. **[NCQA QI 1. A.2].**

The CMO has a minimum of five years post-graduate experience in direct patient care and possesses the qualifications to perform clinical oversight of Partners BHM clinical services. The Chief Medical Officer, or his/her designee, participates in the QIC, Clinical Advisory Committee (CAC), Utilization Management Utilization Review Committee (UMUR), Quality of Care Committee (QoCC) (which includes incident/sentinel event review), Network Management Committee (NMC), Credentialing Committee (CC), and the Quality Improvement Projects (QIP) Committee.

D. COMMITTEE STRUCTURE **[NCQA QI 1. A.3]**

The structure of the QIC and its sub-committees are shown in the Committee Organizational Chart below:



1. Quality Improvement Committee (QIC)

The QIC is responsible for, but not limited to, performing the following activities:

- Provide guidance to staff on QI priorities and projects

- Makes policy recommendations and decisions related to QI Program objectives
- Clinical Practice Guidelines (CPG's) annual review and approval
- Review and approve Quality Improvement Projects (QIPs)
- Routinely monitor progress and outcomes of QIPs
- Evaluate the effectiveness of the QM Plan & Program Description annually by review and approval
- Monitor and document key quantifiable performance measures and use those measures to establish acceptable levels of performance, including a baseline and at least an annual re-measurement. These key performance measures include, but are not limited to
    - Access to Services
    - Complaints and Grievances
    - Consumer and Provider Satisfaction
    - Service Planning and Quality
    - Provider Quantity and Quality
    - Consumer Health and Safety
    - Consumer Rights and Responsibilities
    - Outcomes and System Performance
    - CMS and Division of Health and Human Services (DHHS) contractual quality measures across all MCO functions
- Implement written corrective action plans to improve or correct identified problems or meet acceptable levels of performance
- Monitor accreditation, regulatory, and contractual (DMA/DMH) compliance
- Review various satisfaction survey reports and approve action plans to improve overall performance

The QIC also utilizes sub-committees and workgroups to fulfill its role. Each committee or workgroup is identified on the committee organizational chart. In addition, each committee or workgroup is chaired by a Partners BHM staff person and has an associated charter. The charter provides additional detailed information related to the committee including its purpose, structure, meeting schedule, membership, and responsibilities.

The QIC Membership is composed of a cross-functional team of representatives from (i) various units within Partners BHM, (ii) the Provider community, **[NCQA QI 1. A.4]** and (iii) the Consumer and Family Advisory Committee. All members are voting members unless identified as non-voting or designee.

2. Regulatory Compliance Committee (RCC)

   The purpose of the Regulatory Compliance Program is to prevent and/or detect operational non-compliance within the organization. The purpose of the RCC is to establish a mechanism to monitor, trend, and make recommendations for the improvement/enhancement of the overall organizational compliance efforts and internal controls, specifically in the following areas: HIPAA Privacy, HIPAA Security, Program Integrity (PI), and Healthcare Fraud, Waste, and Financial Abuse (FWA) The Regulatory Compliance Committee meets at least quarterly and provides oversight for an effective Compliance Program. The membership of the committee is composed of a cross-functional team of representatives from various units within the organization and has the following responsibilities:

   - Monitor, analyze, and report on trends in data related to HIPAA Privacy, Security, and FWA
   - Make recommendations on agency systemic action, as appropriate in the following areas:
     - Staff training recommendations to Human Resources (HR)
     - Provider training recommendations to the Network Management Department Chair and Training Coordinator
     - Agency Policy and Procedure and/or form recommendations
     - Departmental Policy and Procedure, form, internal control, and/or other department specific recommendations to the department director
     - System alert/edit recommendations to IT
   - Reviews and approves the Regulatory Compliance Program Description/Plan, at a minimum, on an annual basis and submits to the appropriate approving authority
   - Coordinate and reviews periodic agency compliance risk assessment

3. Quality of Care Committee (QoCC) (includes incident/sentinel event review)

   The QoCC meets monthly, and membership is composed of a cross-functional team of representatives from various units within the organization. The QoCC reviews all incidents, adverse events, systemic concerns related to health, safety, and quality of care within the Partners BHM network which involve consumers, providers, and/or services. Event response and patterns are tracked and analyzed for appropriateness of action. This cross-departmental

committee reviews findings, provides recommendations, and develops strategies to assist providers in improving their delivery of services to Partners BHM's consumers. This Committee makes recommendations to the NMC for potential action. The QoCC also performs the following functions:

- Reviews reports of death, Level III incidents (committee is notified within 24 hours of a Level III incident), and/or quality of care issues as identified
- Review of Division of Health Services Regulation (DHSR) reports and Innovations Level I incidents (failure to provide back-up staffing) for discussion, recommendation, and/or follow-up
- Develops and makes recommendations (related to complaints or present findings of safety or systemic concerns, trends, patterns, lack of provider response, and/or isolated events such as: attitude, customer service issues, billing/financial, quality of service sites) to departments within the organization for any sanctions and/or other applicable responses
- Makes recommendations to enhance or improve the care for Partners BHM consumers
- Makes recommendations for Quality Improvement Projects (QIPs) to the QIC **NCQA QI 1. A.1 & A.3]**
- Develops, facilitates, and/or coordinates safety or quality of care training and education for providers and MCO staff as deemed appropriate (note: this should be coordinated with Partners BHM Training Coordinator)
- Reviews quality of care trends and identifies sentinel event trends or other adverse or potentially adverse occurrences

At any time, events may trigger a more in-depth review of provider processes and action may be requested of a provider (e.g., Root Cause Analysis, Plan of Correction, etc.)

4. Clinical Advisory Committee (CAC)

The CAC meets no less than quarterly, and membership is composed of a cross-functional team of representatives from various units within the organization. The purpose of the CAC is to provide input into the MCO's clinical program; to examine and approve clinical review criteria used by the MCO staff, and to review and approve clinical content material communicated to consumers and stakeholders. This group serves to promote evidence-based

practices for all populations served within the network. The main responsibilities of the CAC are as follows:

- Examine and approve clinical review criteria used by MCO staff
- Conduct bi-annual review of posted and publicized Partners CPG's
- Review and approve clinical content material for communication to consumers and stakeholders (note: following appropriate agency subsequent approval criteria for such materials)
- Develop, maintain, evaluate, and approve recommended and required clinical best practices and evidence- based practices for services delivered by network providers
- Recommend, conduct, and facilitate training for MCO staff, providers, and others related to clinical practices (note: coordinate training through the Partners BHM Training Coordinator)
- Review requests for Service Definition/Clinical Service Requirements clarification and/or interpretation and follow-up on these requests as appropriate (note: this includes, but is not limited to, the development of Partners BHM positions and communication and/or coordination of education/training internal and/or external stakeholders)

5. Credentialing Committee (CC)

The CC meets monthly and membership is composed of a cross-functional team of representatives from various units within the organization. This committee also includes, but is not limited to, the CMO (Chair), Credentialing Specialists, and at least three licensed clinicians from within the Partners BHM provider network representing different NC clinical licensing boards. The committee serves as a fair and impartial representation of all providers within the Network. The objectives of this committee are as follows:

- Approves, declines, and/or provisionally approves providers for entry into the Network
- Reviews and renders a decision related to de-credentialing of providers who have been terminated from the Network
- Completes re-credentialing of providers, as required
- Collaborates closely with the Provider Network Management Committee related to Provider status within the Network
- Assures Provider credentialing processes are in compliance with all applicable rules, regulations, accreditation standards, and DMA as well as the NC DMH/DD/SAS contractual requirements

- Prepares the annual report for the MCO Board, CEO, and Management Team on the number of applicants reviewed and accepted, the enrollment by geographic area, and the areas of clinical expertise

6. Network Management Committee (NMC)

   This committee is responsible for ongoing monitoring of the Provider Network, including Medicaid, IPRS, and non-UCR providers. The committee works with cross-departmental staff on service development when gaps are identified. The committee meets monthly, and membership is composed of a cross-functional team of representatives from various units within the organization. Committee responsibilities include, but are not limited to the following functions:

   - Receives provider sanction recommendations for consideration based on investigative findings, trends, incidents, and/or internal committee and/or departmental referrals.
   - Renders decisions relating to provider sanctions using the Provider Sanctions Grid as a resource for the types of sanctions for consideration.
   - Provides recommendations and committee action reporting to Credentialing Committee and QIC
   - Oversees Provider selection activities; network development; network performance feedback; and clinical/operational expectations
   - Ensures network capacity and diversity
   - Utilizes input from the Provider Forum and Provider Council groups
   - Reports to the QIC for oversight and tracking of provider performance, peer review analysis, and recommendations for corrective action, remediation, or sanctions, as warranted
   - Ensures bi-directional communication between CC and NMC. Action taken against a provider in one committee needs to be communicated timely to the other committee to assure consideration of appropriate and timely action, if necessary

7. Utilization Management/Utilization Review (UMUR) Committee

   This purpose of the UMUR Committee is to assure appropriate utilization of IPRS, Medicaid, and non-UCR funded services. Membership is composed of a cross-functional team of representatives from various units within the

organization. This committee also includes provider representation. Responsibilities of the committee include but are not limited to

- Review of various utilization measures such as policy adherence, performance indicators, denials, denial rates, utilization patterns, length of stay data, approval rates, call activity, and turn-around times
- Recommends and develops action plans based on review findings, as appropriate
- Collaborates with appropriate units and/or committees within the organization related to Benefit Plan adjustment
- Makes recommendations based on service utilization trends, i.e., Contracts and Budgets Committee for fiscal impact of benefit plan adjustments and Provider Network Committee for service gaps

8. Quality Improvement Projects Committee (QIP)

The purpose of the QIP Committee is to establish a means to develop, monitor, and manage QIPs within the organization which have been approved for implementation. At any given time, Partners BHM will maintain no less than two quality improvement projects, per the URAC accreditation program, which address opportunities for error reduction or performance improvement related to the services covered by the accreditation. A single QIP may be applicable to two accreditations, if it addresses the functions covered by both accredited units. Additional QIPs will be implemented as necessary to meet the DMH/DMA contract requirements for the number and scope of clinical or non-clinical QIPs. Membership is composed of a cross-functional team of representatives from various units within the organization. This committee also serves to do the following:

- Develop and recommend QIPs for submission and approval by the CMO and endorsed by the QIC
- Monitor, trend, and report on QIP progress, achievements, measures, and barriers
- Develop and implement action plans to address barriers and challenges related to QIPs
- Serve as departmental liaisons related to QIP activity

9. **Cultural and Linguistic Diversity: [NCQA QI 1. A.6]** Partners BHM is committed to providing the best behavioral health services to our members taking into account cultural and linguistic needs. The principals of the Practice Guidelines guide our approach to diversity including: person-first approach to care, community inclusion, partnership and collaboration, a person and family directed approach, and incorporating peer culture, support and leadership. This approach takes into account diversity and patient choice. The cultural and linguistic needs of our members are assessed annually through the Population Needs Assessment and provider network gap analysis in the following
    - Conducting ongoing gap analysis in service utilization including:
        - Penetration Rates identifying service access rates by ethnic groups and putting into a cluster analysis
        - Ethnic Disparities by geographic location
        - Ethnic Disparities in service utilization
    - Conducting data analysis that focuses on several variables including race, gender, age, eligibility category, and language to gain insight into the long-standing disparities in the health status of people of diverse backgrounds
    - Monitoring the provision of interpretation and translation services to ensure effective communication with Non-English-speaking populations
    - Monitoring the provision of alternative communication for individuals who are deaf or hard of hearing including American Sign Language and providing alternative methods of phone communication including Text Telephone Typewriter (TTY) and/or Telecommunication relay services.
    - Results of the Population Needs Assessment and Provider Network GAP Analysis will be used to improve services offered to members and to make capacity changes in the Provider Network.

10. Complex Care Management Programs

    Partner's BHM focuses on patients who are in high risk residential setting and focuses on getting them discharged into the community and maintaining them in these settings. In order to ensure these patients, stay in the community Partners' BHM has a number of mechanisms to manage high volume/high risk services that include but are not limited to the following:
    - Enacting care management protocols such as increasing the frequency of Clinical Management Supervisor and physician reviews of cases, as needed, when adverse patterns and trends are noted
    - Implementing targeted Case Management teams, outpatient services, and other community supports as clinically indicated.
    - Connecting individuals with drug and alcohol diagnoses to substance abuse treatment either from the crisis center or upon stabilization after acute inpatient admission

- Re-training of care management staff on the continuum of behavioral health services

11. Network Development Cross Function Team

    This team is a sub-committee of the NMC and a secondary sub-committee of QIC. Membership is composed of a cross-functional team of representatives from various units within the organization. This committee also includes representatives from the Consumer and Family Advisory Committee (CFAC). The committee provides ongoing monitoring for the gap analysis/needs assessment and ensures network development projects align with the gap analysis/needs assessment. The team also makes recommendations for prioritization of service expansion and network development and ensures the development is coordinated and aligns with goals for the network. The committee acts in the following capacity:

    - Works with the network development staff to prioritize network expansion, development, and training needs
    - Provides recommendations for service expansion to the NMC
    - Aligns network development planning with clinical team input and recommendations
    - Ensures network capacity, diversity and that linguistic and cultural needs are taken into consideration
    - Utilizes input from the cross departmental staff and provider council and/or provider specialty groups

12. Summary of Committees with Clinical Functions and Practitioner Involvement **[NCQA QI 1. A.4]**

    Partners BHM is committed to improving the quality of its operational processes that requires clinical subject matter expertise. Partners BHM embeds clinicians and practitioners in many committees to ensure a strong clinical perspective is a consistent and active part of its quality improvement initiatives. The following committees have significant clinician / practitioner involvement:

    - Clinical Advisory Committee
    - Network Management Committee
    - Quality Improvement Committee
    - Quality Improvement Projects Committee

- Quality of Care Committee
- Utilization Management/Utilization Review Committee

The clinicians and practitioners that serve as active, voting members on these committees includes the following professions:

- Medical Doctors (MDs)
- Licensed Clinical Social Workers (LCSWs)
- Registered Nurses (RNs)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselors (LPCs)
- Medical Assistants (MAs)
- Licensed Clinical Addictions Specialist (LCASs)

Partners BHM leverages this clinical expertise to perform a variety of clinical functions including, but not limited to the following:

- Advise the clinical program operations
- Examine and approve clinical criteria
- Review and approve clinical content published to stakeholders
- Perform network peer review analysis and recommend corrective actions
- Monitor / manage / investigate provider network sanctions and/or potential quality incidents
- Engage practitioners in QI program activities
- Develop, monitor, and manage Quality Improvement Projects (QIPs)
- Oversee all clinical aspects of Utilization Management policies, procedures, processes to ensure policy adherence, evaluate denial/approval rates, and track turnaround times

13. Role of the Chief Medical Officer and Associate Medical Director

Partners BHM's Chief Medical Officer (CMO) is a physician with a minimum of five years of clinical practice experience and two years in a leadership position in a clinical environment such as an Associate Medical Director. The CMO provides clinical leadership and oversight of the QI program. The CMO is focused on clinical strategy and clinical operations within the organization. The CMO is involved in the development, implementation, ongoing monitoring and evaluation of key quality improvement initiatives that Partner's BHM develops during the year. They work closely with the QI

department staff in the implementation of these programs. Partners BHM's CMO/or designee serves as chair over the following four committees:

- Clinical Advisory Committee
- Quality Improvement Projects Committee
- Quality of Care Committee
- Utilization Management/Utilization Review Committee

The Associate Medical Director plays an important role in the peer review and credentialing processes. He/she conducts peer review of quality of care issues. He/she also reviews professional history occurrences for physician credentialing. He/she presents cases to the CAC for review and, if indicated, follow-up action. He/she reviews and approves "clean" credentialing files.

The Associate Medical Director works with the Director of Compliance to ensure compliance with federal and state standards/requirements and participates in the Compliance Committee.

IV. RESPONSIBILITIES OF THE QUALITY MANAGEMENT PROGRAM

A. PROGRAM SCOPE & STRUCTURE **[NCQA QI 1. A.1]**

The scope and content of the Quality Management Program is designed to continuously monitor, evaluate, and improve the care, safety, and services provided to consumers. The Quality Management Program is comprehensive as it addresses the Centers for Medicare & Medicaid Services (CMS) Quality Framework focusing on the seven dimensions of home and community-based service delivery listed below.

Consumer/Enrollee Access: Partners BHM ensures consumers/enrollees have access to home and community- based services within their communities by offering a choice of providers.

Consumer/Enrollee Centered Service Planning and Delivery: Partners BHM ensures services and supports are implemented in accordance with unique needs of the consumer/ by completion of a Person-Centered Plan.

Provider Capacity and Capabilities: Partners BHM ensures there are sufficient providers within the community by monitoring the need for services, surveying the community, and completing the annual needs assessment.

Consumer/Enrollee Safeguards: Partners BHM helps assure consumer/enrollee safeguards are in place in homes and communities, while considering the

consumers' informed and expressed choices. Partners BHM ensures the rights of the consumers/enrollees through education and by providing information on freedom of choice.

Consumer/Enrollee Rights and Responsibilities: Partners BHM provides a statement of rights and responsibilities to all individuals when they initiate services through Partners BHM's network. In addition, an annual mailing to all Partners BHM's consumers includes the Consumer/Enrollee handbook.

Consumer/Enrollee Outcomes and Satisfaction: Partners BHM monitors and assists with the assurance of consumer/enrollee satisfaction with their services and achievement of desired outcomes. Partners BHM collects, on a minimum of an annual basis, consumer/enrollee satisfaction surveys to measure satisfaction. Partners BHM collects, ensures compliance with, and monitors the North Carolina Treatment Outcomes and Program Performance Systems (NC-TOPPS) for measured outcomes.

System Performance: Partners BHM's system supports its consumers/enrollees in an efficient and effective manner. Partners BHM is continuously striving to improve quality. QIPs are ongoing within Partners BHM to improve internal as well as external quality. Partners BHM embraces the CMS Quality Framework and ensures these quality principles and practices exist throughout the organization. Partners BHM instills this Quality Framework by designing, executing, and monitoring outcomes.

To operate these dimensions into a system that can be managed and tracked, QM categorizes 6 areas for oversight by QIC: [NCQA QI 1.A]
Patient Safety; Access to Care; Patient Satisfaction; Quality of Care; Provider Satisfaction; Cultural & linguistics; Systemic Performance.

B. QA/QI WITHIN PARTNERS BHM AND THE PROVIDER NETWORK

Partners BHM is committed to Continuous Quality Improvement (CQI) across departments. Departments are periodically evaluated to identify compliance with various performance standards and to assure quality driven processes. Each department within Partners BHM provides written documentation of the objectives and approaches utilized in departmental quality management activities.

If departments fail to meet specific performance or safety requirements, a Corrective Action Plan (CAP) may be issued. In addition, elements of quality assurance are managed within departments. For example, applicable clinical departments, such as Utilization Management and Access to Care, have identified

the ongoing need to review and evaluate inter-rater reliability. Those internal quality checks are conducted by and/or reviewed with the CMO or designee with process details outlined in operational plans or program descriptions. The QM Department offers technical assistance/training to staff as needed, including but not limited to, CQI processes, QIPs, QI goal writing, and other related topics. Additional quality improvement activities across Partners BHM departments include ongoing supervision meetings for clinical staff with the CMO including formal review of all cases of concern. Lastly, when requested and through facilitation of the Global CQI, Partners BHM QM staff meets with provider staff interested in the further development of their own QA/QI processes.

The Legal Department facilitates the approval process for Partners' Policies and Procedures and Program Descriptions and Plans as these processes move from identified departmental review, through the appropriate committees, and are approved through Management Team. Policies and other processes are also presented to the LME/MCO Board of Directors for approval and/or reporting. Instructions for the development of Policies, Procedures, Plans and Program Descriptions are located on the Partners BHM Resource Center. The QIC Organizational Chart of Committees, QIC Sub-Committee Charters, and Committee Guidelines are located on the Resource Center as well.

C. QUALITY PERFORMANCE INDICATORS AND REPORTING

The Quality Management Program conforms to key performance indicators established by the North Carolina Department of Health & Human Services (DHHS) and its Division of Medical Assistance (DMA), North Carolina Division of Mental Health/Developmental Disability/Substance Abuse Services (DMH/DD/SAS). These indicators do not reflect the entire scope of the organization or the entire service array but were chosen by DHHS because they have a direct impact on consumer care and reflect accepted standards of care, fair and reliable measures, and readily available data sources. In addition, the indicators provide a mechanism to obtain information about client (DMH/DD/SAS) satisfaction with services provided by Partners BHM. Both the indicators and targets mirror the requirements of the LME/MCOs' Performance Contract with the NC DHHS. Raw data used to determine performance measures are compiled by each individual LME/MCO and submitted to DMA and DMH/DD/SAS. Each division compares this raw data with the established performance indicator standards, and DMA and DMH/DD/SAS publish the performance indicator reports.

In support of Partners BHM's work as a MCO, the QM Department has developed a detailed, working document of all DMA/DMH reports and Partners' internal reports titled the Master Report Listing. For most reports and measures, there will be cross-departmental activity to assure the validity of the data collected. Performance reports, both reported externally and internally, are reviewed through the QIC. Lastly, the QM Department works to communicate outcomes, identify opportunities for improvement in processes, and collect, track, trend, and analyze data to assure the mission of Partners BHM is implemented at every level of the organization.

A central function of the QM Program is to assure all contractual obligations of the LME/MCO are appropriately prioritized, both for DMA and DMH/DD/SAS. These benchmarks of the LME/MCO functions are overseen and addressed globally as a role of the QM Department, though the responsibility for performance, reporting, and interventions are the responsibility of the individual departments. Specifically, each department has identified key LME/MCO functions, staffing, and performance expectations. The reporting responsibilities/timelines/content to meet the DMA and DMH/DD/SAS contracts are accomplished within the LME/MCO day-to-day operations.

1. Departments review their performance against the measures set forth in contract expectations. The frequency of reports allows the department to measure and meet the standards of performance, check the validity of the information captured in those reports, and make ongoing adjustments in anticipation of the formal reporting requirements set forth by the DMA/DMH contracts. By using this ongoing assessment, Partners BHM can identify any proactive interventions needed to meet the defined minimum performance levels on contractual standardized quality measures, as well as adjust the scores in affected reports. The formal reporting tools as outlined in the contracts are supplemented by internally-developed dashboards and specialty reports which isolate the primary contributors to meeting the business expectations and performance standards.

    a. The QM Department reviews the timeliness and results of report submissions, such as Access to Care-Emergent, Urgent and Routine Standards along with comparative outcomes. Per DMA and DMH/DD/SAS contract requirements, the department assures production of management reports regarding consumer trends, local service system trends, LME/MCO operations, access to care and service patterns, and costs for prohibitive cost/substantial risk

individuals and Medicaid recipients with unstable medical and MH/DD/SA diagnoses.

b. Performance Improvement Projects (PIPs), also known as QIPs, are ongoing, addressing both clinical and non-clinical areas. These projects may result as responses to specific areas of needed improvement within the LME/MCO, or as noted per contract, those areas affecting significant aspects of care expected to have favorable effects on behavioral health outcomes and consumer satisfaction, and/or areas addressed proactively. QIPs are implemented and followed with the CMO's involvement so both interventions and outcomes have the communication loop completed when reviewing effectiveness.

2. Mechanisms to detect both over and underutilization of services are dispersed throughout the organization. Utilization Management/Clinical Services has a policy and procedure (Policy 13.06, Detecting Over and Under Utilization) in place, with a detailed outline of the parameters, by which this is monitored.

3. Tracking and trending are possible at the individual service level or aggregate. On a more global level, service utilization is tied with claims data and trends. Historical usage can be compared with current rates of utilization within or across services, per providers or groups of providers, etc. As the normed levels of service utilization are established, along with the acceptable variance range, the outliers of over/under utilization will be evident through reporting review during clinical departmental staffing, QIC review, and ELT dashboard review.

4. Quality and appropriateness of care will be assessed at several levels:
    a. Consumer plans of care and individual outcomes will be reviewed either in Care Coordination, UM, or both.
    b. The effectiveness and quality of treatment offered by providers will be reviewed through QIC and its sub-committees based on monitoring, targeted review, contracting relationships, credentialing, and grievance and incident reports, etc.
    c. Financial parameters per contract, per contract group (service related), and within the Provider Network will give indicators of quality and appropriateness of care as linked with consumer and clinical outcomes and through the LME/MCOs aggregate performance in treatment outcomes.

d. Providers are responsible for following the Clinical Practice Guidelines adopted by Partners BHM. Compliance expectations and requirements for these guidelines are reflected in Partners' Practice Guidelines Policy (13.09) and the Provider Operations Manual, including notification to the provider stating adherence to these guidelines will be monitored. Provider compliance may be monitored in the following ways:
    1) Focused audits completed via Utilization Reviewer and others as appropriate and applicable.
    2) Routine review of Service Authorization Requests (identifying any areas of concern)
    3) Peer Review activities
    4) QOC Committee activities
    5) CAC activities
    6) Medical record audits by the QM Department Monitoring Team
    7) Program Integrity monitoring, if indicated
e. Consumer safety is monitored through grievance and incident management and provider monitoring.
f. The subcommittee structure reporting to the QIC will allow an inherent means of oversight to general provider compliance issues with Clinical Practice guidelines. Each committee representing the monitoring functions above will address any applicable compliance issues as identified. Data on individual providers with Clinical Practice Guideline compliance issues will be collected and monitored over time for improvement and reviewed at the QIC level.

5. The LME/MCO is comprehensive in its planning for and review of populations served. The quality assurance and improvement structure consist of committees with interdepartmental representation and often provider and consumer/family participation, therefore, multiple viewpoints are considered. Reports and tracking/trending capability allows the review of all appropriate discrete variables (e.g., a certain population with a certain service) based on the element reviewed. This full scope of demographic groups, care settings, and types of services is overtly addressed in the report design, so information can be searched as needed with no exclusions.

6. The QM Department has the primary responsibility for provider review including monitoring, plans of correction, provider performance measurement, and review of specific items such as accessibility and treatment practices. Partners BHM has established communication routes with providers through

forums, webinars, email correspondence, and via the website. This provides an easy, varied means of communicating both the contractual obligations and expectations to the providers along with clinical standards. Beyond QM's role, provider accountability may be documented through grievances, incident reporting and review, QoCC case reviews, and Program Integrity reviews.

a. Provider performance through medical record audits may be conducted through post-payment reviews, grievance or incident investigations, DHHS record review protocols within monitoring, Program Integrity investigations, claims review, QoCC review, or clinical case staffing. Medical record audits, unless conducted as part of the network monitoring protocol, are primarily initiated in response to a precipitating event, rather than through scheduled random audits.
    - Reporting requirements for the DOJ/Transition to Community Living Initiative (TCLI) are managed through joint efforts of the following departments within the LME/MCO: Consumer Relations, MHSU Care Coordination, and Quality Management. Processes are in place to review the thoroughness, accuracy, and timeliness of data collected.
    - Requirements associated with the Substance Use Prevention and Treatment and Mental Health Services Block Grant responsibilities and reporting are addressed in applicable provider contracts with primary compliance oversight by Partners' Quality Management Department. The QM Department also ensures reports are submitted as required.
b. In summary, the integration of departmental oversight functions and independent committee reviews culminating in QIC oversight allows for an inclusive system of quality improvement and assurance. The following actions further support a formal structure:

    - Clinical team supervision meetings (Access to Care, UM, Care Coordination) under the CMO's and Chief Clinical Officer's leadership allow a conduit for assessing the quality and appropriateness of care to consumers across demographic groups, care settings, and types of service. Access to care, established clinical practice guidelines, and results of medical record audits as related to provider performance are addressed in consideration of care provided and outcomes expected.

- Communication of findings and/or recommendations with Network Management so providers are aware and equipped with all necessary tools for service effectiveness.
- The quality expectations and oversight, both within the LME/MCO and within the network, make vital links for systemic success in consumer care. (DMA Contract 7.1.4 d, e, g, i, j)

D. QUALITY IMPROVEMENT PROJECTS

Partners BHM's QIC identifies areas for improvement from its ongoing monitoring of key performance measures. When an opportunity is identified, is approved by the CMO, and the QIC determines a formal quality management process is warranted, QIC will then select it as a QIP.

1. Quality Management Process Model

Once a QIP is selected, the QIP Committee is tasked to develop, implement, and monitor the QIP. The committee utilizes the PDSA (Plan, Do, Study, Act) process improvement model, as outlined in the graph on page four, to manage the QIP and ensure goals are met and maintained.

2. QI Projects Structure

The QIC ensures at least one of the selected QIPs, per URAC-accredited program (HCC, HUM, HNM), addresses consumer safety for the population served. Partners BHM maintains at least two quality improvement projects (QIP) per accreditation program. Additionally, specifications and focus areas for QIPs are delineated and followed as set forth by NC Division of MH/DD/SAS and DMA. The QIP Committee includes the CMO, as his/her input is crucial for clinical QIPs. The QIP Committee Chair is responsible for gathering, documenting, and reporting to the QIC all the following factors for each selected QIP:

- A measurable goal or "SMART" (specific, measurable, attainable, relevant, and time-specific) goal
- A design and implementation strategy to improve performance
- Projected time frames for meeting goals
- A report of measurement of the QIP performance at least annually

- Document changes or improvements relative to the baseline measurement [Core 21(e)]
- A barrier analysis if the performance goals are not met

3. Communication of Quality Management Program Activities

   Partners BHM recognizes the need to involve the whole organization in quality improvement and assurance. To promote quality throughout the organization, the progress of these QIPs, as well as other Quality Management activities, is routinely communicated to all staff through emails, shared drive postings, and via Partners internal newsletter, *In-the-Loop*. Members of the QIC are provided with regular updates on QIP performance.

   The meeting minutes of all committees in the Quality Management Program are regularly posted to ensure Partners' staff members have access to information presented and decisions made in those committees. Committee Charters, Committee Guidelines and the QIC Committee Organizational Chart are companion documents to the QMPD.

   Consumer and provider satisfaction surveys are conducted, with feedback results communicated to stakeholders and incorporated into the LME/MCO's quality improvement and assurance process.

E. OTHER QUALITY MANAGEMENT DEPARTMENT ACTIVITIES

1. NC Treatment Outcomes and Program Performance System (NC-TOPPS) oversight: Routine monitoring of updates needed by providers for NC-TOPPS submissions, including communication with providers for performance improvement. NC-TOPPS results are communicated routinely to Providers via NC-TOPPS Report Cards. Information is also shared with Provider Network and other pertinent units of the LME/MCO.
2. The NC Division of Health Service Regulation tracking: Ongoing tracking of all DHSR reports provided to the LME/MCO, including monitoring of timelines for MCO departmental follow-up, if required; includes notification to the Provider Network, Care Coordination, Contracts and Consumer Rights Officer, as indicated.

3. Grievances: The Legal Department has responsibility for Grievances. Ancillary review of grievance data and annual reporting is completed through internal audits and reporting to QIC.
4. Corrective Action Plans (CAP): QM Department staff assists, as needed, those departments who are assigned a CAP by QIC or external review.
5. Policies and Procedures oversight: QM staff will assist the Legal Department (managing unit) and other departments as applicable in their decision to develop policies, procedures, or program descriptions and or departmental work-plans. Policies require board approval and are reviewed and managed by the Legal Department.
6. Level I Failure to Provide Back-Up Staffing: QM staff review, track, and trend Level I Failure to Provide Back-Up Staffing reports as required by the NC Innovations Waiver H.
7. Other activities, reports, and monitoring functions required of the LME/MCO: These include all items on DMA Contract Section 7 (Quality Assurance and Quality Improvement).

F. ANCILLARY COMMITTEES

Partners BHM has additional external led committees which serve to promote quality assurance for consumers, providers, and within the Partners BHM organization.

1. Human Rights Committee (HRC)

   The Human Rights Committee is comprised of board representation and consumer/family members representing all disability groups. A Partners BHM Consumer Rights Officer serves as a liaison to the committee. This committee meets bimonthly. The primary responsibility of the committee is to ensure the protection of consumers' rights by

   - Reviewing complaints and grievances regarding potential client rights violation
   - Reviewing consumer appeals
   - Reviewing concerns regarding the use of restrictive interventions by network providers
   - Reviewing concerns regarding confidentiality
   - Reviewing concerns regarding consumer incident reports

2. Global Continuous Quality Improvement Committee (GCQI)

Partners BHM's providers lead the GCQI formed through the Provider Council. This committee is composed of provider representatives and a Partners BHM staff liaison and meets quarterly. The purpose of this committee is to promote improvements and processes within provider agencies which lead to greater consumer satisfaction with services and choice among providers who use best practice models of treatment throughout the catchment area. The main objectives of this committee are to

- Review quality concerns developing in the network
- Assess training needs of the network related to quality
- Participate in the selection of Partners BHM QIPs and the formulation of project goals
- Aggregate trends of network performance and review/ address in this committee
- May appoint members to QIC
- Allow for avenues in which providers can learn from each other

3. Provider Council

The Provider Council meets monthly and represents the provider community. This Council represents the interests and needs of providers and identifies strategic issues impacting the performance of the network. Responsibilities include efforts to promote standardization and consistency throughout the system. This council may appoint members to QIC. The council also advises Partners BHM changes in the system impacting consumers and providers. The council membership includes network providers representing diverse services and consumer/family members. It is a provider led committee.

V. SATISFACTION SURVEYS

A. COMMUNCATION OF SURVEY RESULTS **[NCQA QI 6]**

Partners Quality Management department is committed to sharing information with our consumers, families, and providers about our quality assurance initiatives. Partners BHM shares results of satisfaction surveys with consumers, families, and providers by sharing with various committees and information outlets to include GCQI, Consumer Family Advisory Committee (CFAC), the Provider Council, as well as on the Provider Website

Once complete, results of the survey are returned to the MCO. Partners BHM conducts an analysis of the survey results and completes a comparison to previous annual survey data across multiple years. All survey results are fed into the Annual QM Evaluation which is reviewed by the QIC, Operations Team, ELT, and Partners' governing board. The QIC is expected to identify and address systemic issues affecting Partners BHM and/or its Provider Network through corrective actions or quality improvement projects. Members of ELT and Operations sit on the QIC.

1. Provider Satisfaction Survey

An annual Provider Satisfaction Survey is conducted by the Division of Medical Assistance (DMA). DMA contracts with an External Quality Review Organization (EQRO) to conduct this survey each year to assess provider satisfaction.

2. ECHO (Experience of Care and Health Outcomes)

DMA also conducts an annual satisfaction survey for randomly selected Mental Health and Substance Use Disorder Medicaid consumers. DMA contracts with an External Quality Review Organization (EQRO) to conduct this survey each year to assess consumer satisfaction with services.

3. Perception of Care Survey

The NC Division of MH/DD/SAS conducts a Perception of Care survey on an annual basis to assess consumers perception of care of services received from network providers. A designated number of Mental Health and Substance Use Disorder consumers are selected to participate in the survey. Once the designated number of surveys are completed, the surveys are returned to NC DMH/DD/SAS for analysis.

4. National Core Indicators Survey

National Core Indicators is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI) and the MCO. The purpose of the survey is to gather a standard set of performance and outcome measures for IDD consumers that can be used to track performance over time, to compare results across states, and to establish national benchmarks.

5. Consumer Satisfaction Survey
   This survey is disseminated annually and assesses across all disabilities served by Partners BHM.

VI. ORGANIZATIONAL QUALITY ACTIVITIES

The Organizational Quality Activities Plan or OQAP and the Annual QI Workplan catalogs new and continuing quality improvement activities initiated by Partners BHM. The plan includes goals and objectives based on the strengths, weaknesses and initiatives identified in the previous year. The work plan **[NCQA QI 1. A.5]** is a mechanism for tracking quality management activities. The OQAP is reviewed and revised as needed and is monitored throughout the year to assess the progress of activities.

VII. QUALITY MANAGEMENT PROGRAM EVALUATION **[NCQA QI 1. B]**

This annual report presents an evaluative summary of the Quality Management Program activities accomplished, discovered, mediated, or improved during a specific state fiscal year. The Annual QM Evaluation is reviewed by the QIC, ELT, and Partners' governing board. Challenges, systemic issues, and improvements are discussed, and performance plans or QIPs are developed to address issues.

VIII. ACCREDITATION

Partners BHM maintains URAC accreditation for the following programs:

- Health Utilization Management
- Health Call Center
- Health Network

The Quality Management Department (QM) in collaboration with other organizational departments is responsible for ensuring Partners BHM maintains ongoing compliance with all accreditation standards relevant to these programs. Quality Management is also responsible for accreditation activities, including the completion of the reaccreditation application every three (3) years, conducting monitoring reviews, and completing all relevant URAC documentation.

XI. STATEMENT OF APPROVAL

The Quality Improvement Committee to include Partners' Chief Medical Officer approves this Plan/Program Description.