



**FIVE COUNTY MENTAL HEALTH
AUTHORITY**

LOCAL BUSINESS PLAN

2007-2010

Final Plan – February 26, 2007

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PREFACE

This document is the Local Business Plan as developed and adopted by the Five County Mental Health Authority. It is the culmination of work derived from feedback gathered at Five Community Forums and staff input. Please read this material keeping in mind that it is a “living document” and a work in progress. Although Five County Mental Health Authority has articulated a beginning set of strategic objectives, it is understood that we will add to this list during the course of the next three years. In addition we will annually review the appropriateness of the document and make changes as needed. Significant stakeholder involvement will be solicited to make adjustments to the plan. This plan can be reviewed on the agency web page at fivecountymha.org.

We would like to thank the many citizens, community partners, agency staff and stakeholders who volunteered their time to participate in the planning and the development of this document. Without their assistance and great insight this product would not have been possible.

CHAPTER I

GOVERNANCE AND ADMINISTRATION

1. Mission: The mission of the Governance and Administration function is to provide overall leadership and direction to the agency and to develop and maintain good relationships with community and employees.
2. Current Operations:

Five County Mental Health Authority (FCMHA) is the local political subdivision of State government responsible for the mental health, developmental disability and substance abuse system of care in Franklin, Granville, Halifax, Vance and Warren counties of North Carolina. The July 1, 2006 estimated population is 231, 356 with a landmass of over twenty-four hundred (2400) square miles. The counties are rural although both Granville and Franklin counties are experiencing rapid growth due to their close proximity to the Raleigh and Durham metropolitan areas.

An Area Board of seventeen (17) members governs the organization currently although the by-laws call for a fifteen-member board. The Board is a voluntary board responsible for public policy. The By-Laws require equal representation from each county with one member being a county commissioner appointed by the commissioners of each county. The five county commissioners then appoint all other members in compliance with North Carolina general statute. The Board meets at least eight (8) times per year and all meetings are advertised and held in compliance with North Carolina Open Meeting Laws. The Board receives a packet approximately one week prior to the scheduled meeting containing the minutes from the previous meeting, the agenda for the upcoming meeting and any relevant material that will be needed for discussion or review. The Board has an adopted set of By-Laws that require a Board Chair, Vice-Chair and Secretary. Each year the Chair appoints a Nominating Committee, consisting of one member from each county, that presents a slate of officers to the Board at the November Board meeting. The Board elects new officers that begin their term on January 1 of each year. Officers serve a one-year term and may be re-elected as allowed by the By-Laws. The Secretary to the Board is typically an agency employee and not a member of the Board. The Board By-Laws require board committees that consist of Personnel, Finance, Quality Management and Human Rights. The Board Chair appoints members to each of these committees at the beginning of each calendar year. Members serve a one-year term and may be reappointed multiple times to the same committee. These committees typically will meet in the months that the Board meets and are held prior to the Board meeting. Committee members discuss relevant issues and make recommendations regarding policy to the full Board. All issues that arise are sent to the most appropriate committee for

discussion with recommendations to come back to the full Board for action. Each committee has a designated chair and an agency staff liaison. The agency staff liaison assists the committee chair in developing the meeting agenda, gathering information and answering questions from members. The Area Director serves as an ex-officio member on all Board committees. All new members of the Board receive initial orientation training with on-going training as part of regular board meetings.

The Area Board hires an Area Director to serve as the Chief Executive Officer of the agency who is responsible for the implementation of Board policy. The Area Director serves at the pleasure of the Board and does not maintain a written contract. The Area Director and Board, through the Board Chair, annually develop a set of performance standards and goals for each fiscal year. The results of this performance are reviewed at mid-year and end of year. The Director serves as the liaison to each county government. Counties are kept abreast of issues through the Area Director interaction with each County Manager. County Managers are provided quarterly reports, receive the Area Board meeting packet and meet face to face with the Area Director on a routine basis. On occasion the Area Director makes a presentation to each set of County Commissioners.

The Area Board and agency staff value stakeholders' opinion therefore FCMHA conducts community forums at least once a year and often twice per year to solicit input regarding the success and effectiveness of the agency and the system at large. Annually the Area Board and staff create a list of Organizational Goals to be accomplished by the agency as well as a set of Strategic Objectives that drive the direction and actions of the agency. The results are reported back to stakeholders and the Area Board. At each Area Board meeting the Consumer and Family Advisory Committee (CFAC) Chairperson reports on CFAC activities and meetings. There are multiple Area Board members who are also CFAC participants.

The Governance and Administration unit includes the Human Resource and Public Affairs activities. This component of the unit consists of a Human Resource Director, a Public Affairs Officer, two switchboard/reception support staff, one and a half human resource assistant positions and one general support position.

The Human Resource function oversees all employee personnel activities, manages non-service contracts/Memoranda of Agreements, ensures processing of requests for release of information regarding former consumers, maintains agency administrative files, maintains agency policy and procedure manuals, coordinates agency training activities for employees, providers and community, and triages all incoming agency calls.

The Public Affairs position is responsible for many of the activities that fall under community collaboration in the LME cost model. The Public Affairs Officer writes press releases and monthly articles for each county newspaper, publishes a quarterly newsletter, coordinates monthly radio spots and a radio talk show, maintains, updates and provides educational events related to the Network of Care web site, works collaboratively with local newspapers and radio organizations to facilitate the distribution of MH/DD/SA items of interest to the general public, designs and distributes MH/DD/SA informational brochures to various local business and community partner organizations and engages in Chamber of Commerce activities and other community organization events to promote the distribution of MH/DD/SA service information.

The unit also includes a part-time Clinical Officer that is responsible for the development of new clinical initiatives and for the first level of clinical oversight of activities conducted by other clinical staff.

The unit, under contract, employs a consulting psychiatrist that performs specific functions. Primarily these include the review of any consumer appeals, a review of a sample of utilization reviews decisions and the review of Provider medical/psychiatric practices.

3. Strategic Objectives

During the next three-year period the Governance and Administration unit will focus on the following objectives:

- a. Develop improved methods of quantifying Provider performance available to the Area Board.
Target Date: July 1, 2007
Person Responsible: Area Director
- b. Coordinate the provision of training for Providers on writing of crisis plans.
Target Date: July 1, 2007
Person Responsible: HR Director
- c. Develop and implement a process for the ongoing scanning of records utilized by the agency.
Target Date: July 1, 2007
Person Responsible: HR Director
- d. Develop and implement marketing/public relations strategies aimed at increasing the awareness of the general public regarding MH/DD/SA issues.
Target Date: July 1, 2007

Person Responsible: HR Director, Public Affairs Officer

- e. Reduce the size of the Area Board to fifteen members.
Target Date: December 31, 2007
Person Responsible: Area Director and Area Board Chair
- f. Conduct an analysis and implement any needed changes in the agency organizational structure.
Target Date: December 31, 2007
Person Responsible: Area Director
- g. Comply with North Carolina General Statutes regarding the composition of the Area Board.
Target Date: December 31, 2007
Person Responsible: Area Director and Area Board Chair
- h. Coordinate a series of trainings on crisis intervention for Providers, law enforcement, hospital emergency departments, magistrates, primary care physicians, school personnel and other community partners.
Target Date: January 30, 2008
Person Responsible: HR Director
- i. Maximize the effectiveness of natural support and recovery resources of all individuals through the establishment of a system for liaison between volunteers, consumers, and the area authority.
Target Date: June 30, 2008
Person Responsible: Clinical Director
- j. Increase the integration of mental health services into the general healthcare system by facilitating the co-location of mental health practitioners in primary care offices and building strong cooperation with Community Care of NC.
Target Date: June 30, 2009
Person Responsible: Clinical Director
- k. Increase the number of FCMHA professional staff who meets the designation of Skilled Professional Medical Personnel.
Target Date: June 30, 2009
Person Responsible: HR Director
- l. Conduct at least two Area Board trainings per year.
Target Date: June 30, 2010
Person Responsible: Area Director
- m. Train an additional 30 to 40 law enforcement officers in the Crisis Intervention Team model each year.

Target Date: June 30, 2010
Person Responsible: Clinical Director

FCMHA shall utilize a broad spectrum of stakeholders to assist in the planning process. These include other community agencies, consumers and family members, local government, internal staff advocacy groups, Providers of MH/DD/SA Services and law enforcement.

4. Resource Allocation

The Governance and Administration unit at FCMHA consists of the following positions:

Chief Executive Officer	1.0
Human Resource Director	1.0
Chief Clinical Officer	.5
HR Assistant	1.5
Support to CEO	.5
Switchboard/Reception	2.0
Public Affairs Officer	1.0
Other Support	1.0

The total number of positions is 8.5 as compared to 5.6 in the cost model however the cost model lists Human Resources in the Business Management function and public affairs activities as a part of community collaboration under Service Management. The total cost of the FCMHA function is \$741,108 as compared to the cost model of \$481,413. This is a 54% deviation from the cost model and is attributable to the additional human resource and public affairs positions. These add an additional 4.5 positions to the unit. A second reason for the deviation from the cost model is due to the Clinical Officer being a physician and having a higher salary than the policy analyst in the cost model.

The organizational chart identifies 13.6 positions however this includes three psychiatrists and two nurses who do clinical work. Their costs are not paid from LME funds as their time is contracted out to private providers. Also not included in the above positions is the consulting psychiatrist as those costs are contained in the contract line item under the LME non-personnel costs.

5. Business Rules

a. Enhance the Efficiency and Effectiveness

1. Rule: North Carolina General Statutes 122c-118.1
Provides clarity regarding the composition and responsibility of the Area Board that facilitates the oversight of the local system of care.
2. Rule: North Carolina General Statutes 122c-115.4

Provides clarity of the functions of LME that allow local programs to focus on specific tasks.

b. Inhibit the Efficiency and Effectiveness

1. Rule: A third party shall authorize Medicaid services. A system that was better coordinated with the Division of Medical Assistance (DMA) could result in a higher quality of service to citizens of North Carolina and could reduce state oversight costs. Coordination efforts should address monitoring of private providers, joint review of high cost cases, joint development of strategies to reduce health care costs, the development of the local system of care and the quality and comprehensiveness of the local provider community.

CHAPTER II

BUSINESS MANAGEMENT AND INFORMATION MANAGEMENT

1. Mission: The mission of the Business and Information Management function is to support FCMHA's mission, departments, employees, management and community partners by providing: accurate and timely information; state of the art communication equipment; functional facilities and precise financial and planning services.
2. Current Operations:

The business and information management departments report directly to the Finance Officer, who acts as director of both departments. The business management department is divided into seven separate and distinct areas: accounting, accounts payable, purchasing, payroll, claims adjudication, reimbursement and facilities management. In addition the Information Management department is broken down into four distinct areas: network administration (hardware), helpdesk support (software), reporting and project management.

The accounting segment of the department is responsible for all standard general ledger accounting functions. This also includes producing monthly financial reports to the Area Board, local management entity management, county and State. The department also provides information that is necessary for the planning of the Authority. Revenues are separated by type (federal, State, county governments and other) and, as much as possible, by disability category. Expenses for services are tracked by disability and by department.

All purchases are processed through one general fund account controlled by the accounts payable department. The accounts payable clerk reviews invoices for proper authorization that is controlled by purchase orders, service contracts, expense reports and budget authorizations. Costs are allocated to individual departments for management tracking and budget control. Non-Unit Cost Reimbursement expenditures are separately identified and accounted by the coding in accounts payable.

The purchasing department employs a system that requires purchases over \$100 be requested by generating a purchase request with a purchase order created from this request. The person responsible for this function also monitors the office supply inventory and allocates costs monthly to the various departments. Purchase for services is controlled by annual contracts established by the Provider Services Department.

Payroll is handled "in house". All employees are established in a base department, and any of their time worked outside of the base department is allocated to the visited department. This is tracked in the payroll software. Payroll assists the Human Resources Unit in managing and negotiating benefits for employees. Payroll checks are direct deposited to employees' bank accounts to save on costs.

Claims adjudication receives paper claims submitted by providers. The adjudicator reviews the invoice for accuracy in dollar amount, coding, invoice completeness and authorization. Once the claim is reviewed, it is sent to the reimbursement area for billing through the State reimbursement system or Medicaid system. Denials are completed and sent back to the providers for any claims that cannot be billed. These denials may occur in either the claims adjudication or billing departments.

The reimbursement department is responsible for keying the providers' billing into the computer system and processing the claims through the state billing system. Denials are prepared for any claims that do not meet the computer edits by the reimbursement staff. The reimbursement department reviews any claims that are denied payment through the State reimbursement system. Any internal processing errors are corrected and denials are sent to the providers for the claims that need their attention.

The information system department is responsible for both the computers and phone systems of the agency. The agency has one manager that oversees information systems operations and projects. This position has four direct reports to them: one network administrator, a project manager/report writer, one full time report writer, and one help desk person who also backs up the network administrator.

The network administrator handles all hardware, wiring and interface issues. This includes the telephone system and printers as well as the computer system. Users include all staff and contracted providers who may have access to our system. Currently there are fifteen servers, over sixty personal computers and one telephone system operating at two separate locations. The agency uses Microsoft Office software for general office computing, Unicare's Profiler software to track consumer billing and reporting, and Geneva software for the accounting systems. Reports are in place to track down time in each of these systems.

There is one person who is primarily responsible for the helpdesk response. This person assures that computer issues by staff and providers are promptly addressed. The questions may involve software issues, connectivity issues with the server and printer issues. Response times are monitored and reported on monthly. This person is also responsible for the backup of data in the system.

There are two individuals responsible for implementing new projects and report writing. The project manager is primarily responsible for implementing all new software conversions. This position deals directly with the vendor and manages

the project implementation. The second person is primarily a report writer that will assist in project implementation, but is primarily responsible for generating and distributing reports. Both positions deal with established reports and special report writing upon request. Currently the report writer has primary responsibility to assure that billing and receivable reports and files are accurate and generating properly. The project manager is responsible to see that the CDW information is being generated, tracked and errors corrected.

The department is responsible for providing orientation to new staff and providers on their aspects of the information system. They are each responsible for implementing changes in their part of the system to conform to State reporting requirements.

3. Strategic Objectives:

- a. The finance department will initiate new IPRS summary reports in order to expedite payment to providers using less manpower by the LME.
Target Date: July 1, 2007
Person Responsible: Finance Officer, Accounting Manager, IT Manager
- b. Implement a new report to estimate encumbrances for state funded services for use in the care management department.
Target Date: September 30, 2007
Person Responsible: Finance Officer
- c. Establish maximum daily cash balances outside of investment accounts to improve income from the investment accounts.
Target Date: September 30, 2007
Person Responsible: Finance Officer
- d. Implement electronic receipt of invoices from providers.
Target Date: September 30, 2007
Person Responsible: Finance Officer, IT Manager
- e. Establish an index of reports accessible to LME management and staff. The reports shall be set up in computer file folders accessible to all users on the network.
Target Date: December 31, 2007
Person Responsible: Finance Officer, IT Manager
- f. Implement form and folder security within Profiler to allow providers direct access to their consumer accounts in the LME computer system.
Target Date: December 31, 2007
Person Responsible: Finance Officer, IT Manager

- g. Implement electronic receipt and posting of person centered plans, and crisis information in the Profiler file of the consumer.
Target Date: December 31, 2007
Person Responsible: Finance Officer, IT Manager
- h. The website will be revised to allow better communication and education for providers and the community.
Target Date: December 31, 2007
Person Responsible: Finance Officer, Network Administrator
- i. Set up Email boxes for contract providers on the agency network to assist in communication.
Target Date: December 31, 2007
Person Responsible: Finance Officer, Network Administrator
- j. Initiate electronic direct payment to providers.
Target Date: December 31, 2007
Person Responsible: Finance Officer, Accounting Manager
- k. Input 100% of the person centered plans and crisis plans into the Profiler System.
Target Date: June 30, 2008
Person Responsible: Finance Officer, IT Manager
- l. Increase participation in electronic payment of providers to 100%.
Target Date: June 30, 2008
Person Responsible: Finance Officer, Accounting Manager
- m. Investigate and implement other electronic solutions for exchanging data between providers and the LME.
Target Date: June 30, 2009
Person Responsible: Finance Officer, IT Manager
- n. Increase participation of providers in electronic submission of invoices to over 90%.
Target Date: June 30, 2009
Person Responsible: Finance Officer, IT Manager
- o. Review and make improvements as needed in any of the above objectives as a part of a continuous quality improvement plan.
Target Date: June 30, 2010
Person Responsible: Finance Officer

FCMHA shall utilize a broad spectrum of stakeholders to assist in the planning process. These include other community agencies, consumers and family

members, local government, internal staff advocacy groups, Providers of MH/DD/SA Services and law enforcement.

4. Resource Allocation:

The total positions budgeted to operate the departments of Business Management and Information services are 17.4, which compares to 18.3 in the cost model. One major difference is that the cost model allows for the Human Resource function in this department. Operationally, FCMHA handles these functions in the Governance department.

The total dollar amount allowed in the cost model for these functions is \$1,196,037, which compares to FCMHA cost of \$1,081,178.

5. Business Rules:

a. Most significant business rules that have enhanced effectiveness and efficiency:

1. Rule: Must collaborate with community partners in identifying needs and best practices to develop a comprehensive system of care.
There is communication from the Division of Mental Health in relation to the performance of the LME to peers. This allows the organization to concentrate on designated trouble areas, and obtain assistance from others in improving implemented changes.

b. Most significant business rules that inhibit effectiveness and efficiency.

1. Rule: Shall hire internal applicants to avoid a reduction in force and lose of jobs.
Many of the current staff has been retained throughout the change of reform and are required to perform new duties required by reform. Many of these staff are lacking in computer skills and/or have minimal experience with the software they currently use. In particular, most of the retained staff needs additional training in such software programs as Excel and basic Microsoft products in general. The current level of expertise causes a lot of inefficiency, as staff is trained to perform only a particular function within the software. When errors occur information becomes corrupted or lost. There is constant rework being performed. This barrier can be addressed by increased formal training of staff in the software programs on an ongoing basis.
2. Rule: DMA requires the LME to report all items in CDW.
Vendors are developing software, which is being developed to support the required accounting of mental health reform in North Carolina, as the system is being rolled out. The manner in which North Carolina operates

and reports their use of funds is unique from other state systems. Software that is working for managed care systems in other States must be reprogrammed to fit the reporting needs of the State of North Carolina. This causes delays in implementation and additional programming cost at the local level. This barrier can be reduced by the reduction of the amount of reporting changes coming from the State level.

3. Rule: LME funding is based solely on the cost model.
Limited funding does not allow for separate implementation teams to be hired for computer projects. Currently operations tend to fall behind as staff works in new programs and trainings along with their current work. The situation causes frustration and position turnover as staff is unable to do quality work on two fronts. This barrier could be reduced by allowing for special funding of computer implementations over and above the normal LME allocation.
4. Rule: Must increase the use of computer technology to improve cost efficiency in operations.
The provider networks do not have the computer infrastructure that would allow for easier transmission of data, reports and payments. As we switch to allowing the providers to electronically submit data, many will not have the resources or training to support a consistent application across the network. This barrier could be resolved by requiring a minimum computer capability by providers to be allowed in the network.
5. Rule: Shall comply with federal and state reporting requirements.
Reporting regulations imposed at the federal and state levels are constantly changing. These changes result in additional costs in programming and training of staff. These communications also must be made to the provider network adding an additional burden to the system. The way to impact this barrier is to minimize the amount of change that is occurring and improve the method in which the information is communicated to the providers. The providers ought to be trained and held more responsible for obtaining information, and a communication database for the provider networks should be maintained at the State level to communicate directly with providers.

CHAPTER III

PROVIDER RELATIONS AND DEVELOPMENT

1. Mission: The mission of the Provider Services unit is to develop and support a community of qualified providers that will enhance the mental health and well being of Five County area residents.
2. Current Operations:
 - a. Identification of Mental Health, Developmental Disability, Substance Abuse Community Needs.

The agency actively participates in the design, collection and analysis of county health department needs assessments to ensure that behavioral issues are addressed. The resulting reports are reviewed by the Provider Services unit Director and Provider Relations Specialists. This information is triangulated with systematically gathered and anecdotal information on needs from community partners, and regular reports from the agency screening, triage and referral unit on 'documented unmet demand'. The agency serves a poor, rural, geographically large area that exacerbates the national and statewide lack of incentives for significantly increasing service capacity (provider availability and accessibility). Thus, unmet needs remain fairly constant across time. Additional service needs include Community Support capacity, all levels of substance abuse services, crisis services, psychiatric services, safe and affordable housing especially independent living for mentally ill adults, Hispanic/Latino expertise and group counseling.

- b. Provider Recruitment and Selection.

Securing new providers is largely an opportunistic venture as opposed to planful, managed growth because the regulatory and marketplace barriers and disincentives limit the number of qualified providers. Thus the primary method used to fulfill unmet needs and to increase service capacity involves the expansion of existing provider capacity. Encouraging existing providers to consider adding or expanding services, soliciting new providers by phone or email and responding to unsolicited provider inquiries is a daily occurrence. Prioritizing, coordinating, and communicating the results of these activities amongst unit staff often accounts for a significant portion of the workday. The number of initial contacts with prospective providers is a monthly unit performance indicator.

The agency has successfully divested all of its services within a relatively short period of time and through this process, has developed tested request for proposal policies, procedures and practices. Refinement of these processes has sharpened the agency's understanding and application of effective criteria for provider selection. Alongside technical assistance, staff spends the majority of their time evaluating providers using these criteria:

- Consideration of the scope of services and economies of scale,
- Business acumen including tenure, corporate structure and filing, infrastructure, financial accountability and access to credit, adherence to sound business practices,
- Professional standing - education, experience, (including specific areas of expertise) training, certification, licensure, accreditation, licensure sanctions, malpractice claims/liability history, criminal history, professional liability insurance, references,
- Demonstrated evidence of best practices or a sound plan to enact promising/best/evidence-based practices, and
- Onsite review of service delivery site(s), including assessment of cultural, racial, linguistic, communicative, economic and physical barriers that deter access to service, and ability to fulfill all contractual obligations, including compliance with State defined service definitions and all applicable State and Federal laws, statutes and regulations.

c. Provider Contracting and Endorsement.

The agency has adopted the policy and procedures outlined in the Division of MH/DD/SA Services' Communication Bulletin # 44 and subsequent bulletins to develop provider endorsement training and to guide the contracting and endorsement process. The process with a new provider starts with documenting the date and content of the initial contact. Two Provider Relations Specialists begin the evaluation process during this contact (see criteria, above). They give information on community needs and provider challenges such as local workforce limitations and transportation and geographic accessibility. They impart FCMHA preferences and expectations such as ensuring service capacity and staff qualifications. They clarify how the prospective provider can access information about contractual obligations, and policies, procedures and practices. During subsequent contacts, the Provider Relations Specialists provide consultation and technical assistance on the provider application content and process. If the initial contacts are proving difficult or unsatisfactory by telephone or email, or if there are numerous issues that must be addressed to determine if it is advisable or feasible to continue deliberations, then a face to face meeting(s) will occur with key provider and agency personnel. Once both parties have ascertained an initial "fit", the prospective provider is informed about application timelines and the application approval process. One hundred percent adherence to endorsement timelines is a monthly unit performance indicator. The Provider Relations Specialists perform compliance verification on the submitted application, including qualifications at the organizational and Qualified Professional/licensed professional levels. The lead Provider Relations Specialist then facilitates an onsite pre-endorsement review that is conducted by a Quality Management unit Compliance Officer. The lead Compliance Officer informs Provider Services in writing of the outcome of the review. When and if the provider has been deemed to meet initial qualifications, then a Contract for State funded services and/or an Agreement for Medicaid enhanced benefit services is prepared by the unit Director, supported by the

Contracts Coordinator, in consultation with the Area Director and the Director of Business Management around Attachment A and Attachment C specifications. The provider is informed about mandatory orientation sessions and the Provider Services Administrative Support staff member schedules them for these sessions and tracks attendance. Following the return of a signed Contract/Agreement and attendance at orientation, the provider's information is entered into the agency Provider Directory, our agency software databases and the Network of Care website. All agency personnel and the community of providers are then formally notified of the addition of a new provider. Only then do the screening, triage and referral and Care Management staff begin the referral process with the new provider.

The Provider Services unit is also responsible for responding to independently enrolled providers who are seeking to use FCMHA's Medicaid number to be able to bill for outpatient treatment to children. The unit's Administrative Support staff member manages this process, which includes an abbreviated provider application and a signed Memorandum of Agreement that is updated annually.

The Provider Services Housing Specialist administers the Letter of Support process for residential services. The Director of the unit authors special Memorandums of Agreement such as those governing the Geriatric Specialty Team, Agreements with school systems or with transportation providers.

d. Maintenance of the Community of Providers.

The unique blend of transaction-based and relations-based contracting models that is dictated by regulatory and market forces presents a constant challenge for Provider Services. Unit staff relies on the following provider relations and contracting principles to provide a business environment that puts consumer needs and interests first and helps ensure equitable treatment of providers:

- Timely communications using a variety of methods and media to convey regulatory issues, training opportunities, service expansion initiatives, clear and explicit explanation of contractual rights and obligations, procedures,
- Timely, effective technical assistance, easy access to information and staff needed to answer questions and resolve problems,
- Equitable, responsive and dependable system of arbitration and dispute resolution of provider complaints and grievances,
- Low/no cost, relevant training opportunities,
- Opportunity to partner in designing, implementing service initiatives, and,
- Transparent, objective and equitable performance evaluation.

e. Technical Assistance and Consultation.

Providing technical assistance consumes most of the unit's time on a daily basis. Assisting providers in navigating the State systems and understanding the

numerous contractual obligations represented by state, federal and local directives, regulations, statutes, policies and procedures is a fairly constant activity.

The Provider Services unit acts as a conduit and clearinghouse for all FCMHA policy, procedure, practices and business decisions and all State communications that directly or indirectly effect provider operations. State communications are shared with our providers via email on the same day they are received. Along with FCMHA information, they are posted on our website and explained and discussed at monthly Provider Council meetings. This information is incorporated contractually as appropriate via special performance indicators and/or Operations Manual updates. If there are repeated questions or confusion amongst providers, the unit Director seeks clarification and facilitates voluntary or mandatory provider training, as was done with endorsement and with the new service definitions.

The FCMHA Operations Manual was completely revamped in the fall of 2006. It follows Division of MH/DD/SA Services guidelines and contains many hyperlinks to source documents. The Operations Manual is easily accessible on the FCMHA website. One of the Provider Relations Specialists has a performance appraisal goal related to reviewing and updating the Operations Manual on at least a quarterly basis.

The Provider Services staff makes special provision for prospective and new providers by reserving an open meeting time every Friday morning to discuss the State fund or endorsement application, to highlight contractual obligations and to orient participants to the Operations Manual.

Training opportunities for providers are updated constantly and listed on the agency website. The Directors of Provider Services, Quality Management and Human Resources share an agency strategic plan goal of enhancing provider training, starting with development and refinement of a comprehensive plan. Provider training priorities from the provider perspective have been identified. The Provider Services unit tracks training hours monthly.

New provider orientation has been revamped several times in the past year. The Provider Services presentation has been significantly expanded to address recurrent provider problems and challenges. Recent additions include professional etiquette, practice and caseload management, staff recruitment and retention, and how to subcontract.

Provider monitoring is performed by the Quality Management unit's Compliance Officers. Provider Relations Specialists support monitoring in three ways:

- Inform prospective providers about and subsequently reinforce fulfillment

of obligations which are frequently misunderstood or not fully operationalized, such as clinical staff credentialing and training, insurance coverage, first responder requirements, adherence to best practices,

- Instruct providers how to obtain information about monitoring and other operational issues via the Operations Manual, Provider Council meetings, the FCMHA website and memos and communication bulletins (for changes or additions to FCMHA policy and procedure that may effect providers), and,
- The unit Director has program evaluation, performance measurement and outcome measures expertise and takes an active role in developing special performance indicators with providers, incorporated in Attachment C of the Contract and the Memoranda of Agreement.

3. Strategic Objectives:

- a. Ensure effective communications with prospective providers such that they rate Provider Services good or better in 92% of surveys in the areas of staff reliability, timeliness of response and accuracy and clarity of information.

Target Date: July 31, 2007

Person Responsible: Provider Services Director

Form a primary stakeholder group of newly contracted providers to be used for advising and beta testing survey items over a six-month period.

- b. Increase availability and accessibility of assessment, outpatient counseling and psychiatric services in underserved areas, primarily Warren County and southern Halifax County. This will be accomplished through increased public information and education efforts about existing resources, implementation of telepsychiatry, and increased hours of services within the targeted areas.

Target Date: January 31, 2008

Person Responsible: Provider Services Director

- c. Enhance communications with providers through use of interactive computer technology and updated website format and software to increase ease of access to information, and to improve access to timely and consistent information.

Target Date: January 31, 2008

Person Responsible: Provider Services Director

- d. Facilitate the FCMHA Provider Council becoming a provider-managed

venue by March 2008 as evidenced by providers setting meeting agendas, running meetings and effecting other changes in Council purpose and structure.

Target Date: March 31, 2008

Person Responsible: Provider Services Director

- e. Enhance the training plan for providers to ensure opportunities at least twice a year to receive competency-based instruction in Community Support service delivery, effective supervision of direct support staff, person-centered and crisis planning, promising/best/evidence-based practices and DSM orientation for Qualified Professionals.

Target Date: April 30, 2008

Person Responsible: Provider Services Director

- f. Optimize the number of providers and/or their scope of practice through equitable use of published provider performance criteria.

Target Date: July 31, 2008

Person Responsible: Provider Services Director

- g. Improve community support, targeted case management and residential treatment services by giving incentives to providers to implement competency-based workforce development plans. Providers will achieve a score of at least 88% on their quarterly Provider Report Card.

Target Date: October 31, 2008

Person Responsible: Provider Services Director

A specific stakeholder group for this objective will be the FCMHA Workforce Development Committee which is chaired by one of the Provider Relations Specialists and includes several contracted providers and the Director of the Human Services Technology Program of Vance-Granville Community College.

- h. Develop and support at least two specialized residential treatment centers for youth sex offenders.

Target Date: October 31, 2008

Responsible Party: Provider Services Director

- i. Increase provider capacity such that 'routine' requests for substance abuse, mental health and developmental disability services result in first face-to-face contact occurring within 7 calendar days at least 95% of the time.

Target Date: January 31, 2009

Person Responsible: Provider Services Director

- j. Increase the number of children who receive services (1570 in FY 04-05) having a substance abuse and/or mental illness (estimated to be 9,100) by at least 20 percent from July 2007 to June 2010 through

strengthening communications between prevention and treatment providers, identification and development of children's services within existing contracted provider practices, and active recruitment of qualified children's services providers.

Target Date: June 30, 2010

Person Responsible: Provider Services Director

A specific stakeholder group for this objective will be the FCMHA community Collaborative.

- k. Increase the number of individuals receiving supported housing by eight (8) percent annually.

Target Date: June 30, 2010

Person Responsible: Provider Services Director, Housing Specialist

Specific stakeholder groups for this objective will be the various housing coalitions and committee's reference in the Five County Mental Health Authority Strategic Housing Plan.

- l. Increase the number of individuals receiving supported employment by at least ten (10) percent annually.

Target Date: June 30, 2010

Person Responsible: Provider Services Director

FCMHA shall utilize a broad spectrum of stakeholders to assist in the planning process. These include other community agencies, consumers and family members, local government, internal staff advocacy groups, Providers of MH/DD/SA Services and law enforcement.

4. Resource Allocation:

There are currently 6.0 positions represented by the following to perform the Provider Relations and Development function: The Director of Provider Services, two Provider Relations Specialists, one Contracts Coordinator, one Administrative Support person and one Housing Specialist.

The annualized cost is \$360,050. The cost model calls for 8.40 positions and a total expense of \$692,176.

There is one significant operational variation as the Quality Management unit has the primary responsibility for the provider monitoring function.

5. Business Rules:

- a. Significant business rules which enhance the efficient and effective operations of the Provider Relations and Development function is:

1. Rule: The Contract and Memoranda Of Agreement must be standardized. Actions that could be taken to further enhance this positive rule include creation of a standardized agreement, or a minimum set of requirements/guidelines for agreements that govern the allocation of non-unit cost reimbursement funds with agencies that have no intention or capability of fulfilling all of the current contractual obligations. A second recommended action is to clarify the language in the insurance clause, modify the subcontracting clause to limit LME liability, and make provision for the fact that not all of the “core performance indicators” of Attachment C is applicable to all providers. It is further recommended that the updated Contract and MOA be published no later than mid-April so that LMEs have sufficient time to prepare and providers and their boards have sufficient opportunity for review.
- b. Significant business rules which inhibit the efficient and effective operations of the Provider Relations and Development function are:
1. Rule: Services are earned on a fee for service or non-ucr basis. Lack of adequate and meaningful incentives for provider recruitment of state funded substance abuse services. Actions that could be taken to minimize the impact of this negative rule would involve creation of an SA workforce development fund to support recruitment and expansion of opportunities for SA direct service personnel to become certified or licensed.
 2. Rule: Must contract with any willing and qualified Medicaid provider who does not have a place of business within the LME area and/or only intend to serve one or a very limited number of individuals. The excessive number of Medicaid providers is an ongoing burden in terms of assessing provider accountability and providing technical assistance. Actions that could be taken to minimize the impact of this negative rule are to seek a waiver that would give LMEs the authority to limit who can become a provider.
 3. Rule: Medicaid endorsed providers are not required to serve the state dollar consumer. This necessitates duplicative contracting processes, thus additional expenditure of time and funding. Having the flexibility to serve individuals who frequently switch between Medicaid and needed State funding would make LMEs much more efficient, productive.
 4. Rule: A Qualified Professional definition is based on education and experience. We should enact a competency-based standard to improved quality of care. Actions that could be taken to minimize the impact of this negative rule are to make implementation of the Division’s competency plans a priority for FY 2007-2008.

CHAPTER IV

CARE MANAGEMENT

1. Mission: The mission of the Care Management function is to ensure that consumers have access to services in a timely and simple manner and that they receive the most appropriate, high quality services possible at a given point in time.
2. Current Operations:

Care Management is composed of Utilization Review, Care Coordination, Community Collaboration, Prevention Services, Screening, Triage, and Referral (STR), and Crisis Services.

Two Senior Clinical Five County staff is assigned to the function of Utilization Review. They review requests from providers for referral of consumers to services that are funded through State dollars to determine whether they should be authorized based on meeting medical necessity criteria. Decisions are also guided by Five County's Level of Care criteria, which are used to determine the units of service that are appropriate. They also review reauthorization requests for services for consumers to determine whether they still meet medical necessity criteria. As part of the authorization process, they review Person Centered Plans and Diagnostic Assessments for appropriateness. Referral and reauthorization requests and Person Centered Plans that are determined to be inadequate are forwarded back to the provider for correction or the submission of additional information. The Utilization Review staff processes referral and reauthorization requests and a written response sent back to the provider within three days. Prior to a denial of a service, the requests are also reviewed by the Care Management Director and, if the denial is upheld, the Clinical Director or Consulting Psychiatrist. The Clinical Director or Consulting Psychiatrist also reviews general Utilization Review policies and procedures as well as a random sampling of overall utilization review decisions. Staff also reviews a percentage of Medicaid PCP's to determine whether they meet quality standards. Utilization Review staff also authorize State Hospital and Alcohol and Drug Abuse Treatment Center admission and continuing stay requests. Utilization Review staff provide technical assistance to providers on a case by case basis as well as more general training such as writing crisis plans. Ongoing orientation training on current protocol and procedures is provided for providers by service management staff. Staff assists the Quality Management Department in targeted reviews of providers. Concurrent reviews are conducted to evaluate such issues as whether providers are following through with appropriate contact after referrals from STR, the quality of diagnostic assessments, and whether they are following the service definition for Community Support. They

also work closely with the QM department in terms of reporting to QM staff patterns of quality issues with particular providers and their failure to provide best practice clinical care.

Five County employs six Care Coordinators. Two clinical staff is assigned as liaisons to John Umstead and Cherry Hospital. They are responsible for ensuring that consumers admitted to the hospital or a crisis unit is connected to providers prior to discharge and that the consumer has sufficient support and services prior to discharge and their return to the community. The Care coordinators track all admission to the State Hospital and crisis facilities. If a consumer has an existing provider, they ensure that provider is notified regarding the admission and makes contact with the consumer while in the treatment facility. The Care Coordinators make sure that consumers new to the system are linked to a provider prior to discharge and that the provider initiates needed services in a timely fashion. They contact consumers who have not followed up with a provider to try and make that link. They participate in team meetings at the State Hospitals and assist providers in working with very difficult to serve consumers, especially those difficult to contact.

Two Care Coordinators, who have expertise in child and family development, are assigned to work with the Child and Family Support teams in Vance and Halifax County Schools. Staff is responsible for ensuring that children from the two school systems are linked with and are receiving all needed services. They serve as a liaison to the schools and provide training to school staff as appropriate. These staff also assists in the monitoring of school provided services and assist in the referral of youth for services.

One Care Coordinator, with experience in Developmental Disabilities, is assigned to consumers with Developmental Disabilities. They work with families, consumers, and providers in all five counties to ensure that consumers are receiving appropriate services as needed and assist providers with complex Developmental Disability cases. The staff maintains the CAP waiting list and is part of a committee that prioritizes individuals on the waiting list. They also liaison with the State Mental Retardation Centers.

One Care Coordinator is assigned to adult mental health cases. As with the other Care Coordinators, the main function is to assist consumers in receiving needed services, which frequently involves contacting a provider to determine why a consumer is not receiving certain services. They also assist providers with complex cases and consumers who are having difficulty accessing or receiving services. They review termination summaries from providers to assess for appropriateness to ensure that providers are not prematurely terminating consumers. This Care Coordinator is also assigned to monitor the initiation of new services by contacting providers seven days after referrals are made to ensure that services have been initiated. Care Coordination staff in

general have a priority of reviewing high cost, high use consumers to examine the appropriateness of services.

Five County has two Community Collaboration staff that serves as a liaison to community groups such as CFAC, the Community Collaborative, and National Alliance for the Mentally Ill, the Mental Health Association and related groups. They also represent the LME on community committees such as interagency groups, Juvenile Crime Prevention Council, Child Protection Teams, etc. They provide education programs to community partners, other community groups, at Health Fairs, and are involved in the Anti-Stigma project.

One staff person provides Universal Prevention services, including suicide prevention, smoking cessation, parenting classes, and coping with everyday stress, in the community. Specific programs employed include, "Coping With Work and Family Stress," "Nurturing Parent," "Parenting Matters," "Signs of Suicide Prevention," and "Freshstart," all of which are evidenced based universal prevention programs.

The Screening, Triage, and Referral unit consists of four clinical staff, a supervisor, and one support staff. They handle calls from 8:00 am to 5:00 pm Monday through Friday. Calls between 5:00 pm and 8:00 am, all day Saturdays and Sundays, and on Holidays are handled through a contract with Holly Hill Hospital. The STR staff assesses each call from a consumer for urgency of need following the guidelines for emergent (needing services within 2 hours), urgent (within 48 hours) and routine (within 7 days) calls. Those calls meeting emergent and urgent criteria are referred to Holly Hill's RESPOND Program crisis staff for Vance, Granville, Franklin, and Warren Counties and Halifax Regional Medical Center for Halifax County. STR staff coordinates this process to ensure that consumers receive the needed face-to-face crisis services during the day. Holly Hill Hospital provides Mobile Crisis and walk in face-to-face crisis services 24 hours a day under contract to Five County for Vance, Granville, Franklin, and Warren counties. Halifax Regional Medical Center provides face-to-face walk in crisis services 24 hours a day for Halifax County. For those meeting routine criteria, a telephone screening is completed and the information necessary to meet the Division standardized STR screening format is obtained. Consumers are evaluated for eligibility for services. The consumers are then referred to providers based on choice, service need, location, and provider capacity factors. The providers are contacted, whenever possible, while the consumer is on the phone to facilitate a timely and mutually acceptable appointment. All needed referral information is then sent to the provider. All referrals are tracked by Service Management staff to determine if the consumer was seen and, if not, if the provider is making a follow-up contact. In addition, STR tracks after hour's face-to-face contacts by the contracted crisis service providers. If the consumer is not hospitalized, STR staff contact the consumer regarding possible referrals for services as appropriate. Service Management

also oversees overall crisis services for Five County and ensures that appropriate crisis services are provided to Five County consumers.

3. Strategic Objectives

- a. Expand the use of Assertive Community Treatment Team services to individuals being discharged from inpatient psychiatric stays by ensuring that ACTT is considered for all discharges.
Target Date: June 30, 2007
Person Responsible: Care Management Director
- b. Care Coordinators shall participate in selected person centered team meetings for high cost/high utilization consumers.
Target Date: June 30, 2007
Person Responsible: Care Management Director
- c. Remove barriers in the STR phone screening process that makes it more difficult for consumers to access the system. This involves creating a system that responds to calls in an accurate manner. An individual who can respond appropriately and professionally to the need shall answer calls.
Target Date: June 30, 2008
Person Responsible: Care Management Director, STR Supervisor
- d. All calls to STR shall be answered within six rings/30 seconds. This will be measured through the phone system monitoring software.
Target Date: June 30, 2008
Person Responsible: Care Management Director, STR Supervisor
- e. There shall be no more than 5% dropped calls by consumers to STR. This will be measured through the phone system monitoring software.
Target Date: June 30, 2008
Person Responsible: Care Management Director, STR Supervisor
- f. Implement a more effective system for the tracking of consumers receiving services to ensure that consumers are receiving all needed and authorized services. This will entail contacting providers within five days of the referral appointment to ensure that the consumer has been seen and services initiated. If the appointment did not occur, information will be requested from the provider regarding their plan to make contact with the consumer.
Target Date: June 30, 2008
Person Responsible: Care Management Director
- g. Ensure that there is an internal system for the regular and systematic communication of information between Care Management, Provider

Services, and Quality Management regarding the quality of provider services.

Target Date: June 30, 2008

Person Responsible: Care Management Director, Provider Services Director, Quality Management Director

- h. Assist CFAC in complying with new legislative requirements.
Target Date: June 30, 2008
Person Responsible: Care Management Director
- i. Comply with all Division of MH/DD/SA Services STR readiness criteria.
Target Date: June 30, 2008
Person Responsible: Care Management Director, STR Supervisor
- j. Improve current system for monitoring high cost/high utilization consumers by establishing a review committee to review, on a monthly basis, high cost/high utilization consumers in order to determine appropriateness of service.
Target Date: June 30, 2008
Person Responsible: Care Management Director.
- k. Implement Universal Prevention programs in all five counties on smoking cessation, suicide prevention, parenting, and coping with everyday stress.
Target Date: June 30, 2008
Person Responsible: Care Management Director, Prevention Specialist
- l. Reduction of concerns in the community regarding a lack of adequate coordination of services by contracted providers through monitoring of providers and technical assistance to providers as needed. Facilitation of training to providers on crucial components of service coordination will also occur. Assessment of the effectiveness of this program will occur through survey of consumers and community partners.
Target Date: December 30, 2008
Person Responsible: Care Management Director and Quality Management Director.
- m. Implement at least one additional anti-Stigma project.
Target Date: December 30, 2008
Person Responsible: Care Management Director, Community Collaboration staff
- n. Meet all Division Utilization Review readiness criteria.
Target Date: June 30, 2009
Person Responsible: Care Management Director

- o. Revise STR system such that consumers are able to receive a specific provider appointment on a 24 hour a day 7 seven days a week basis for all needed services at the time of the call.
Target Date: June 30, 2008
Person Responsible: Care Management Director, STR Supervisor
- p. Reduce wait time for individuals being seen for mental health/substance abuse issues in hospital emergency rooms such that no consumers have to remain in the waiting room more than two hours by expanding Mobile Crisis services, use of telemedicine and by working with community hospital staff to station mental health staff in emergency departments.
Target Date: June 30, 2010
Person Responsible: Care Management Director and Clinical Director.
- q. Expansion of crisis services to include the establishment of crisis respite/crisis homes, facility based crisis, and comprehensive detox in order to divert admissions from hospitals, allow more individuals to remain in the community, and to intervene effectively in consumer crisis as early as possible.
Target Date: June 30, 2010
Person Responsible: Care Management and Provider Services Director.
- r. Reduce transportation barriers that limit consumer access to services by exploring alternative transportation systems, such as using volunteers, faith based community, advocacy groups, or incentives for private providers.
Target Date: June 30, 2010
Person Responsible: Care Management Director and Provider Services Director
- s. Ensure clear and timely communication and collaboration with appropriate community stakeholders/community partners through participation by Community Collaborative staff in relevant community interagency groups/committees. Measure through surveys of community partners.
Target Date: June 30, 2010
Person Responsible: Care Management Director
- t. Shall implement a system in which Five County staff provides after hours STR versus using a contracted provider.
Target Date: June 30, 2010
Person Responsible: Care Management Director, STR supervisor

- u. Reduce admissions to State Hospitals such that all bed day usage measures are below allocated numbers.

Target Date: June 30, 2010

Person Responsible: Care Management Director

FCMHA shall utilize a broad spectrum of stakeholders to assist in the planning process. These include other community agencies, consumers and family members, local government, internal staff advocacy groups, Providers of MH/DD/SA Services and law enforcement.

4. Resource Allocation

- a. A total of 20 positions are allocated to Service Management at Five County MHA. However, two of these are allocated to the child Care Coordinators. These two positions are funded separately and specifically to liaison with the Child and Family Support Teams for Vance and Halifax County schools.
- b. The budgeted amount for Service Management at Five County for Fiscal Year 06/07 is \$1,146,540.00. The cost model budget is \$1,614,274.00. The Cost Model budget is 29% higher than Five County's budget for Service Management. The variance between the Cost Model and Five County's budget is largely due to the current process that Five County is using for STR. Five County staff provides STR directly from 8:00 am to 5:00 pm during the week. The remainder of the time is contracted to Holly Hill Hospital. This significantly reduces the cost for Five County. However, Five County has as one of its Strategic Objectives to expand the amount of time that Five County staff directly provide STR such that Five County will be providing STR directly during weekday evenings. This will increase the cost of STR to Five County and reduce the cost variance.

5. Business Rules

- a. Enhance the efficiency and effectiveness

- 1. Rule: Providers must send the Standardized STR Interview and Registration Form within five days of initiating services.

The standardized STR format has been of benefit to STR functioning. The system has provided a Division sanctioned process for providers notifying the LME when they have begun services to new referrals. This has made tracking of referrals easier for the LME, increasing the likelihood that consumers will receive needed services or, if services have not been initiated, the ability of the LME to intervene at an earlier point. It would further benefit this process for the Division to issue a clear communication that providers must transmit this

information to the LME in a timely manner. Currently far too much time is spent by the LME staff contacting providers as to the status of referrals because they have failed to send in the form.

b. Inhibit the efficiency and effectiveness

1. Rule: Medicaid authorizations must be provided by a third party entity.
A lack of data on Medicaid consumers due to authorizations and billing no longer being the responsibility of the LME make it very difficult for the LME to provide effective care coordination for Medicaid consumers. This policy makes it difficult to track the types and frequency of services that are received and who is providing the service. This contributes to fragmented services, with gaps in services as well as a lack of consistent quality. Paid claims data and authorization data from Value Options would improve the LME's ability to ensure that consumers are receiving needed services with the correct intensity and frequency.
2. Rule: The LME must have an MOA with any willing and qualified provider.
This policy makes it difficult to monitor providers, track consumers and contributes to fragmented services. There is a need for the LME to be able to more closely control the number of providers in the catchment area by having more control over the endorsement process. In particular, this would include the LME being able to limit endorsement to providers who have a working office in the catchment area and who are providing comprehensive services or services for which there is a specific need. This would assist the LME in being able to provide adequate technical assistance and monitoring to local providers as well as more effective care coordination, thereby leading to a higher quality of care.
3. Rule: One member of the mobile crisis team must be a Certified Clinical Addictions Specialist, a Certified Clinical Supervisor or a Certified Substance Abuse Counselor.
This requirement is limiting the ability of the LME to recruit providers for this service. Individuals with these qualifications are extremely limited in our state particularly in rural areas. Changing the requirement such that QSAP's with supervision from appropriately credentialed individuals would increase the likelihood of LME's being able to contract for this service.
4. Rule: Funding for psychiatric inpatient goes to state institutions rather than the LME.
A lack of true control over State Hospital admissions and length of stay contributes to over usage of State Hospitals. Funding should be allocated directly to the LME in order to allow for the purchase of hospital bed days. Shifting funding from the State Hospitals to the LME would assist the LME in developing more adequate local crisis services, thereby diverting admissions from the hospitals and reducing length of stay. Also requiring

local community hospitals to provide inpatient or facility based crisis services would result in a significant reduction in admissions to state hospitals.

5. Rule: Providers may conduct STR screenings.

An increasing number of providers are bypassing the LME and conducting their own screenings, particularly Medicaid consumers. The Standardized STR form is not always being sent into the LME. As a result it is becoming increasingly difficult to track the services that are being provided and who is providing the service. Consumers are jumping from provider to provider, with the LME having limited ability to track these changes or to assess the appropriateness of the change in provider.

CHAPTER V

QUALITY MANAGEMENT & CUSTOMER SERVICES

1. Mission: The mission of the Quality Management function is to ensure high quality, and continually improving, services for all consumers based on standards of Best Practice by competent and skilled providers.

The mission of the Customer Services function is to ensure that all consumers and customers receive ready and respectful access, information, and assistance in the timely resolution of concerns, complaints, and grievances.

2. Current Operations:

Five County's current Quality Management and Customer Services functions are guided by a comprehensive Quality Management Plan, LME and Area Board Quality Management Committees, and Quality Management Department grounded in both philosophical and operational guidelines. The department is structured into three (3) functions focusing on Customer Services, Corporate Compliance, and Research and Development. Quality Management is understood to mean Quality Assurance in the form of compliance with regulatory statutes, rules, and standards of federal, state, local, and accrediting entities. It is also understood to mean Quality Improvement in the form of proactive self-assessment and activity that moves the agency and providers in a continuously improving direction from basic compliance to real excellence. Among the principles stated in the Quality Management Plan, quality is affirmed as a core value of the agency. It is driven and shaped not only by regulatory compliance, but also by the needs and expectations of customers (internal and external). The agency's focus is on processes, systems, and outcomes that reveal and influence quality. As an information management organization and department, all actions and decisions are based on the collection and analysis of facts and data.

In broad operational terms, the Quality Management Department has present responsibility and mechanisms to assess and address Five County's engagement with:

- The agency's mission, vision, and values.
- Compliance with the Performance Contract from the Division of MH/DD/SAS.
- Compliance with Accreditation & other regulatory requirements.
- The service performance of contract, non-contract, and endorsed providers.
- Systems advancement, problem resolution, and Customer Satisfaction.

Specific activities and responsibilities within the Quality Management function are currently implemented in the following manner:

a. Data Analysis / Reports

The Balanced Scorecard quarterly report is a nationally recognized, best-practice model used to analyze the agency's mission within four (4) major domains of Finance, Business Operations, Customer/Stakeholder Satisfaction, and Organizational Growth/Learning/Innovation. Data is collected to assess 18 specific core functions within those domains. This report is prepared by the Quality Management Department and reviewed by the LME Executive Team for identification of quality improvement needs.

The Organizational Performance Report is a monthly report on 66 key performance indicators that cross all departments of the agency. Quality Management coordinates data collected and submitted by each departmental director. The LME Executive Team, reviews this report by departmental staff, and by the Area Board for identification of performance trends and quality improvement needs.

The Provider Profile is a preliminary provider report card collated and reported quarterly assessing provider compliance with a set of 15 contractual and clinical performance measures. While still in a process of refinement, to date the instrument and results have been shared with providers for 3 quarters in FY 05-06 and 06-07. It is anticipated to be used increasingly for feedback on provider performance, information in the aid of consumer choice, and evaluation for consideration of contract renewal.

Consumer Outcomes (NC TOPPS / DD COI / NC SNAP) are submitted as required by the Division of MH/DD/SAS Performance Contract. The agency facilitates this compliance through a designated Quality Management staff person. Tracking is done daily. There is regular, direct contact with providers to facilitate compliance and to resolve reporting problems. A monthly report goes to the QM Director. The LME Executive Team and the Quality Management Committee receives updates on this data, including the semi-annual reports created by The National Research and Development Institute.

The Core Indicators Annual Project (DD Consumers) is facilitated as required by the Division of MH/DD/SAS Performance Contract. The agency ensures this compliance through the Consumer Affairs Coordinator of the Quality Management Department. Five County has been consistently successful in coordinating processes with contract providers to achieve the required number of consumer consents. Related reports from Division of MH/DD/SAS to the LME are routinely reported to the Executive Team and the QM Committee.

Consumer Surveys are an integral part of the Quality Management system. The agency meets the Division requirement for participation in the annual Consumer

Satisfaction Survey. The QM Support Staff and the Consumer Affairs Coordinator coordinate this project. As well, the agency conducts its own quarterly Consumer Satisfaction Survey. Contract providers may elect to participate in this survey, or may elect to conduct their own internal survey. However, providers who choose not to participate in the LME survey must submit outcomes to the Area Authority. Provider demonstration of consumer satisfaction surveys is noted as a performance indicator on the Provider Profile. Outcomes on quarterly and annual surveys are communicated to the Executive Team, Quality Management Committee, Area Board, and CFAC.

Service Utilization Patterns are reported and analyzed in the Executive Team's monthly update and review of the Organizational Performance Report. These include IPRS, Screening, Triage, and Referral (STR), and Hospital Utilization data.

Division of MH/DD/SAS Compliance Reports are developed and submitted by the designated departmental staff or contract providers. Adherence to required content and schedules is overseen by Quality Management's Data and Research Analyst and reported to the Quality Management Director and Executive Team. Reports include:

Monthly

- Provider Monitoring Report
- DD COIs
- NC SNAP
- CDW

Ongoing

- NC TOPPS
- Paybacks within 90 days of notice
- Level III Incidents

Quarterly

- Work First
- Critical Incidents
- Complaints
- Fiscal Monitoring
- SA/Juvenile Justice
- Reports requiring response to DMH

Semi-Annually

- SAPTBG Compliance

Annually

- Division Consumer Satisfaction Survey
- Core Indicators
- QM studies
- Cost Finding

The LME utilizes one full-time data analyst position within the QM Department to assist with the coordination, analysis, and application of information pertinent to reports and quality assurance/improvement endeavors.

b. Quality Assurance

Quality Assurance is a primary focus of Five County's Quality Management function. Personnel and systems are currently in place to monitor services, risk management, and health and safety issues in the LME and community of providers. To date, the Provider Monitoring function has been incorporated into the Quality Management Department of the LME. Five (5) Corporate Compliance Officers ensure that all contract and endorsed providers in the catchment area receive appropriate Quantitative and Qualitative monitoring at a minimum of one review annually. Providers have been subject to more frequent review and/or specific targeted reviews as complaints or performance issues have warranted. A checklist of performance measures based on North Carolina statutes guides monitoring reviews and administrative rules originating from Division of MH/DD/SAS. The checklist has been further enhanced by the inclusion of particular Best Practice and CARF accreditation indicators. Compliance Officers submit outcome reports to providers and direct plans of correction as needed. Monitoring review scores are factored into providers' composite outcomes on the Provider Profile. Monthly reports on reviews are submitted to both the Division of MH/DD/SAS and the Quality Management Committee. Aggregate data on the frequency and type of monitoring, and trends on provider performance are provided to the Executive Team and the Area Board through the monthly Organizational Performance Report.

In the first quarter of FY 06-07, the Quality Management Department increased coordination with the Business Management Department so that the existing quantitative review process further assessed consistency between claims data and service record documentation.

c. Customer Services

Current quality management functions include systematic attention to safety/welfare issues and the Incident Review and Reporting requirements. The Consumer Affairs Coordinator position within the department manages the receipt and transfer of information, the analysis of data, and applications for problem resolution or quality improvement for all Level I, II, and III Incident reports. Provider compliance with reporting requirements to the LME and the Division are tracked and reported via the monthly Organizational Performance Report. The QM Department submits the quarterly Incident reports to the Division. The Quality Management Committee receives a monthly report detailing the frequency and type of consumer incidents per contract provider. Aggregate data on the frequency and type of incidents is provided for the Executive Team and the Area Board through the Organizational Performance Report. Providers are subject to technical

assistance, targeted reviews, and/or plans of correction based on the acuity or trends of issues identified.

Current quality management functions additionally include a systematic process for addressing Consumer and Provider Concerns, Complaints, and Grievances. The Consumer Affairs position manages the receipt, resolution, and trend analysis of contacts from consumers and family members. The Provider Accounts Representative within the department manages the receipt, resolution, and trend analysis of contacts from providers and community stakeholders. A monthly report by each representative is provided to the Quality Management Committee. Aggregate data on the frequency and type of complaints is provided for the Executive Team and the Area Board through the Organizational Performance Report. Providers are subject to technical assistance, targeted reviews, and/or plans of correction based on the acuity or trends of complaints identified.

d. Quality Improvement

All of the agency's quality management functions are driven by a working definition: Quality Management is a structured system capable of quantifying how identified needs are met or exceeded, how internal and external customers are satisfied, and how processes and outcomes continually improve. The emphasis of the Research and Evaluation Unit is to assist the agency in the advancement of this improvement culture, and more specifically in the design or adoption of measurement tools, the collection and analysis of data, and the application of data for improvement.

The monthly review of the Organizational Performance Report routinely identifies self-corrective action plans or CQI projects. The quarterly review of the Balanced Scorecard routinely identifies self-corrective action plans or CQI projects. The quarterly review of the Strategic Plan identifies completion or advancement toward established goals, or the necessary revision of goals based on accumulated data and improvement needs. The Policy and Operations Committee (POC), currently chaired by the QM Director, serves as an operational extension of the Executive Team. It is the problem-resolution and improvement-project coordinator that advances the agency's efficiency and effectiveness. Specific CQI teams, generally determined by the Executive Team, take the form of ad hoc interdepartmental committees that are time-limited and project-focused. The monthly meeting of the Quality Management Committee also devotes attention to trend analysis and systems review. This committee is purposefully structured for broad representation. It consists of ten (10) members. In addition to four (4) LME representatives, it is composed to include two (2) consumers or family members, two (2) private providers, and two (2) community partners. Recommendations for improvements are routinely generated from the committee.

In compliance with the contract between the State Department of Health and Human Services and the LME and Best Practices target, the QM Department

coordinates interdepartmental identification and engagement with five (5) quality improvement projects, and submits an annual report to Division of MH/DD/SAS. In similar manner, providers are contractually required to identify and report on a minimum of three (3) improvement projects during the fiscal year. Providers are invited to provide quarterly updates with their submission of the Provider Quarterly Performance Report. Compliance with improvement efforts is indicated on the agency's Provider Profile. Additionally, Corporate Compliance Officers are charged to provide technical assistance so that deficiencies or plans of correction coming from the monitoring process can become opportunities for improvement projects.

The department currently utilizes a variety of surveys to elicit performance or satisfaction feedback to use in improvement efforts. Quarterly consumer satisfaction surveys are conducted, with provider-specific outcomes reviewed by the Quality Management Committee for improvement issues. A semi-annual Provider Satisfaction survey is conducted eliciting provider feedback on the perception of partnership with the LME. Corporate Compliance Officers utilize a Compliance Review Satisfaction Survey at the close of monitoring reviews to receive provider feedback for improving the review experience. The Consumer Affairs Coordinator completes all complaint-resolutions with a letter of findings to the complainant that includes a satisfaction questionnaire about the process. All QM Orientations to new employees and providers includes an evaluation questionnaire to guide refinement of information and presentation.

The Consumer and Family Advisory Committee (CFAC) are regularly utilized, as an advisory partner in the determination of improvement needs. The QM Department regularly submits to CFAC the quarterly Local Business Plan Update for its review. CFAC representation, including the CFAC Chair, participates with the Area Board's Quality Management Committee where analysis of the monthly Organizational Performance report leads to specific recommendations for improvement.

In summary, the agency has policies, processes and system indicators presently in place to:

- Monitor and report on all risk management and health/safety issues and incidents.
- Monitor and report on the corporate compliance of all providers, including provision for corrective action, suspension, and termination.
- Collect and report on consumer and provider satisfaction.
- Monitor and report on consumer rights.
- Address and resolve consumer and provider concerns, complaints, and grievances.
- Monitor and report on LME compliance with Division contract and regulatory compliance.
- Coordinate interdepartmental monitoring and reporting of service access and service utilization.

3. Strategic Objectives:

- a. Fully operationalize the Provider Profile report card system for use in provider compliance, consumer choice, and contract evaluation.
Target Date: July 1, 2007
Person responsible: QM Data Analyst
- b. Implement the mystery shopper calling system to evaluate access response.
Target Date: October 1, 2007
Person responsible: Consumer Affairs Coordinator & CFAC Liaison
- c. Enhance provider monitoring through a process of unannounced site visits, direct observation of services, increased monitoring of newer or non compliant providers, and decreased monitoring of providers who substantially comply with expectations.
Target Date: December 31, 2007
Person responsible: QM Director
- d. Ease the regulatory burden on providers by consolidating surveys/audits with other LME's.
Target Date: December 31, 2007
Person responsible: QM Director
- e. Develop a system for community partners to effectively communicate information, experience, and satisfaction with private providers.
Target Date: December 31, 2007
Person responsible: Provider Accounts Representative
- f. Advance comprehensive data collection/analysis through integration of Profiler or other IT systems.
Target Date: December 31, 2007
Person responsible: QM Director & Business Mgt. Director
- g. Develop a system for enhancing and ensuring support coordination and person-centered planning in providers' service delivery.
Target Date: December 31, 2007
Person responsible: QM Director & Care Management Director
- h. Enhance mechanisms to systematically assign, track, and evaluate continuous quality improvement endeavors for the LME and providers.
Target Date: December 31, 2007
Person responsible: QM Director
- i. Develop mechanism(s) for increasing customer/stakeholder awareness and use of the Network of Care.
Target Date: December 31, 2007

Person responsible: Consumer Affairs Coordinator, Provider Accounts Representative & Public Affairs Officer

- j. Develop mechanism(s) for increasing consumer awareness on how to access and navigate the mh/dd/sa system.
Target Date: December 31, 2007
Person responsible: Consumer Affairs Coordinator & Public Affairs Officer
- k. Achieve Best Practice compliance with all Division requirements on consumer outcomes reporting.
Target Date: December 31, 2007
Person responsible: QM Director
- l. Create a way to rate providers on the efficacy of services offered.
Target Date: July 1, 2008
Person responsible: QM Director
- m. Develop a provider-oversight system based on risk management that balances technical assistance with regulatory compliance.
Target Date: July 1, 2008
Person responsible: QM Director
- n. Develop additional mechanisms for consumers and family members to be involved in the quality management process.
Target Date: July 1, 2008
Person responsible: QM Director
- o. Develop a system for ensuring, promoting, and supporting the use of evidence-based service models and best practices through general and specific technical assistance.
Target Date: July 1, 2008.
Person responsible: QM Director
- p. Utilize consumer outcomes instruments (e.g. NC TOPPS) for specific age/disability cohort studies.
Target Date: July 1, 2008
Person responsible: QM Director and Data Analyst
- q. Utilize consumer outcomes instruments for analyzing provider performance in treatment efficacies.
Target Date: July 1, 2008
Person responsible: QM Director and Data Analyst
- r. Develop a system for ensuring and tracking consumer choice of service providers.
Target Date: December 31, 2008

Person responsible: QM Director and Data Analyst

FCMHA shall utilize a broad spectrum of stakeholders to assist in the planning process. These include other community agencies, consumers and family members, local government, internal staff advocacy groups, Providers of MH/DD/SA Services and law enforcement.

4. Resource Allocation

The Quality Management and Customer Services units at FCMHA consists of the following positions:

Quality Management Director	1.0
Corporate Compliance Officers	5.0
Customer Services Representatives	2.0
Data Analyst	1.0
QM & CS Support	1.0

The Division Cost Model projects 2.5 positions for the Quality Management function, with direct expenses and general/administrative expenses totaling \$174,934. Five County has allotted 7.5 positions for the Quality Management function, with a FY '07 budget allocation of salaries and expenses totaling \$451,639. The difference of \$276,705 is explained and justified on the basis that the agency has currently structured the provider monitoring and support role within the Quality Management Department rather than within the cost model configuration of the Provider Relations Department. Six (6) positions are currently allocated to QI and Outcomes Evaluation in the form of 5 Corporate Compliance Officers (4 Qualitative; 1 Quantitative) and 1 Data Analyst. Five County's cost is a 158% deviation from the cost model and attributed to this difference in departmental structuring between Quality Management and Provider Relations.

The Division Cost Model projects 3.3 positions for the Customer Services function, with direct expenses and general/administrative expenses totaling \$260,046. Five County has allotted 2.5 positions for the Customer Services function, with a FY '07 budget allocation of salaries and expenses totaling \$163,095. The difference of \$96,951 is explained and justified on the basis that currently the CFAC coordination and interagency collaboration roles are configured within the Outreach function of the Service Management Department. Five County's cost is a 37% deviation from the cost model and attributed to this difference in departmental structuring.

5. Business Rules

a. The business rules that enhance the efficiency and effectiveness of the Quality Management functions are:

1. Rule: Local provider monitoring, correction, and enforcement shall

demonstrate consistency through a standardized process.
The actions that would further enhance this rule involve advancing greater standardization on monitoring processes across area programs.

2. Rule: LME and provider performance shall be measured and improved by the collection of data. The actions that would further enhance this rule involve advancing the identification of key performance measures and the development of data processing systems.

3. Rule: The LME shall promote and support Best Practices and consumer focused outcomes.
The actions that would further enhance this rule involve the development of mechanisms to both monitor and incentivize evidence-based Practices, and develop mechanisms to measure/track treatment outcomes.

b. The business rules that inhibit the efficiency and effectiveness of the Quality Management functions are:

1. Rule: All contract/endorsed providers shall receive at minimum an annual quantitative and qualitative monitoring review.
Efficiency and effectiveness could be aided by shifting to monitoring and review schedules based upon a risk management model.

2. Rule: Providers shall be expected to attain clinical and administrative mastery.
Greater clarity needs to be obtained in defining a balance between regulatory oversight and technical assistance.

3. Rule: Consumers shall be provided guidance and choice among an adequate array of high-quality services and providers.
Greater effectiveness is dependent upon the refinement of the LME's Provider Profile report card, or the development of a statewide report Card with standardized performance measures. Effectiveness is also linked to the further development of an adequate and right-size network of providers in this rural area.

c. The business rules that enhance the efficiency and effectiveness of the Customer Services functions are:

1. Rule: The reporting of Consumer incidents shall follow a standardized process.
The actions that would further enhance this rule involve facilitating increased provider compliance to the reporting format and timeline.

2. Rule: Shall collect consumer complaints in a standardized process to determine improvements needed.

The actions that would further enhance this rule involve advancing Five County's introductory studies regarding complaint and provider trends.

3. Rule: The LME and Providers shall participate in the electronic submission of Consumer Incidents.

The actions that would further enhance this coming rule involve promoting the technological readiness of providers for compliance.

- d. The business rules that inhibit the efficiency and effectiveness of the Customer Services functions are:

1. Rule: The LME shall resolve consumer complaints within ten calendar days.

Ten calendar days can be problematic in resolving more complex cases that involve multiple providers. Adjusting the timeline to 10 business days could reduce barriers to effectiveness.

2. Rule: Shall utilize and comply with the Division's Annual Consumer Satisfaction Survey in its regular analysis of consumer satisfaction. Consumer outcomes are not available to the LME. For satisfaction outcomes in that particular quarter, the LME must either make duplicate efforts in surveying consumers, or compute outcomes from the Division's survey before submitting. The Division making outcomes available to the LME could enhance the process.

3. Rule: Shall utilize and comply with the Division's Annual Core Indicators Project.

As above, satisfaction outcomes on DD consumers are not forwarded to the LME. The process could be enhanced by the Division making outcomes available to the LME.

CHAPTER VI

LOCAL BUSINESS PLAN PROCESS

The Five County Mental Health Authority 2007-2010 Local Business Plan was developed using the process identified in the Pre-Plan. There were adjustments made to the process in terms of enhanced features however strategies identified in the Pre-Plan were all utilized. The Process began with scheduling targeted community forums in each of the five counties. A broad spectrum of individuals were invited including consumers, family members, advocacy groups, city, county, and state political leaders, local business people, law enforcement, school personnel, DSS, local Health Department, Juvenile Justice, Community Corrections, Chamber of Commerce, local hospital personnel and contract providers of MH/DD/SA Services.

The forums were held on November 17, November 27, November 28, November 30, and December 1. Each forum was held in the same manner using the same agenda. After a brief welcome and stated purpose for the meeting, the Area Director gave a PowerPoint presentation describing the functions of the agency and the activities associated with each function. Following the presentation the group was divided into six subgroups, one for each of the LME functions. The subgroups were charged with very specific tasks, to write a mission statement for the function, to brainstorm ways that the FCMHA operation of that function could be improved and to list barriers and enhancements to efficiency and effectiveness. Each group had a FCMHA staff person that acted as a resource person. The groups used brain storming techniques and rules that guided their work. At the completion of the task each group made a short presentation of their ideas and suggestions. One enhancement made from the Pre-plan was asking for volunteers who would make up a workgroup that would review a draft of the LBP document and provide feedback. We received at least one volunteer from each county for this task. The information from each forum was placed into one document for easy review and retrieval. In addition the LBP was provided to and reviewed by the Consumer and Family Advisory Committee.

A second enhancement to the plan was holding a sixth forum that was targeted solely at FCMHA staff. This forum was held on December 15 and utilized the same format and structure as the other five forums.

The manager of each FCMHA function was responsible for writing the Chapter of the LBP that corresponds to their function. Per the pre-plan the information used to develop the draft included: 1) information from six forums held in November and December 2006, 2) information from community forums held in the spring of 2006, 3) feedback from advocacy groups and 4) feedback from the five county governments. A draft plan was developed and reviewed by the volunteer committee. Suggestions for improvement were made and these were incorporated into the final version. A third enhancement from the Pre-plan involved having a copy of the draft plan in hard copy for citizen review as well as being available on our web page. All forums had been informed of the availability of the plan via these means.

A third enhancement involved a review of the draft LBP by a group of individuals who had participated in the forums and had volunteered to review a draft of the plan once ready for distribution. This was accomplished by a face-to-face meeting of the group. A fourth enhancement was the distribution of a press release to all local newspapers informing the public of the existence of the plan, where to go to find a copy and how to make comments or suggestions. A fifth enhancement was to provide the same information to the local Provider Council. In addition all individuals who attended a community forum were sent an electronic copy of the LBP or if no e-mail was available to them they were directed to the Five County web page.

The original time lines have been met and/or were accomplished sooner than expected. Both the Area Board and all County Commissioners received the plan in advance for review and consideration. We believe that the format of these forums resulted in good participation by all who attended and provided Five County with very specific information in order to write the local business plan. We would like to thank all of our community stakeholders for participating in the process and in the creation of a plan to improve the mh, dd, and sa system in our five counties.