



**Quarterly Provider Webinar
June 13, 2018
Hosted by Partners BHM Provider
Network Department**



**Quarterly Provider Forum
6/13/2018
Provider Network Updates
Beth Lackey, MSW, LCSW**

State Funded Contracts 18-19

We are sending out State Funded provider contracts for the 2018-2019 Fiscal Year using the following parameters:

- If the provider has overutilized their contracted amount, they will start July 1, 2018 at the amount they started July 1, 2017.
- If the provider has underutilized their contract amount, they will start July 1, 2018, with the amount they have utilized.

As always, this is a starting point for providers. We hope to receive the same level of funding as we did on July 1, 2017; however, we do not know that yet.



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MH/SU Block Grant Important Dates

Attention Providers of Block Grant-Funded Programs: Fiscal Year 2018 Review

- ▶ The State Fiscal Year (SFY) 2018 annual monitoring of State and Federally-Funded Services is currently underway.
- ▶ Any provider that has gotten paid under any of the following programs:
 - SAPTBG Work First/CPS
 - SAPTBG IV
 - SAPTBG Set Aside Program for Women Who are Pregnant, Who have Dependent Children, and are Seeking Custody of Children (WASF)
 - JJSAMHP
 - CMHBG
- ▶ may be subject to the audit and may be required to be present at the Systems Review with consumer records.



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MH/SU Block Grant Important Dates

The Systems Review is scheduled for:

- ▶ **Date:** Wednesday, July 18, 2018
- ▶ **Location:** Partners Behavioral Health Management
1985 Tate Blvd. SE (Basement Multipurpose Room)
Hickory NC, 28602
- ▶ The review will include programs funded by the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), the Community Mental Health Services Block Grant (CMHSBG) and the Social Services Block Grant (SSBG). The review will consist of program and clinical monitoring.
- ▶ Partners will receive consumer record numbers ten days prior to the audit date. At that time, providers will be alerted to whether they will need to be present at the audit and which records will be reviewed.
- ▶ Please visit <https://www.ncdhhs.gov/divisions/mhddsas/lme-mco/audit> to review the block grant audit notification memorandum, a webinar overview, and the block grant audit tools.
- ▶ Should you have any questions, you can contact Jamie Sales at **828-323-8053** or by email jsales@partnersbhm.org



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Please Help Us with Feedback for the Community Needs Assessment/Gap Analysis

We want your feedback, please help us to strengthen our communities by completing this brief survey about service accessibility. This will help us plan for new services and continue to improve existing services. https://www.surveymonkey.com/r/Partners_NeedsAssessment2018



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Clinical Coverage Policy Public Comment Opportunities

- ✓ The North Carolina Division of Medical Assistance has posted the following new or amended Medicaid clinical coverage policies for review.
- ✓ Please visit <https://dma.ncdhhs.gov/get-involved/proposed-medicaid-and-nc-health-choice-policies> to review all policies available for public comment, or click on the links below.
- ✓ Comment should be submitted to dma.webmedpolicy@dhhs.nc.gov by June 17, 2018.



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Clinical Coverage Policy Comment Period

Proposed Policy	Date Posted	Submit Comments	Comment Period ends
8A-3, Mobile Crisis Management	Posted May 3, 2018	dma.webmedpolicy@dhhs.nc.gov	June 17, 2018
8A-4, Psychiatric Rehabilitation (Psychosocial Rehabilitation)	Posted May 3, 2018	dma.webmedpolicy@dhhs.nc.gov	June 17, 2018



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Cultural Competency Expectations

- ▶ As explained in Communication Bulletin #62, Partners expects all providers to ensure that Cultural Competency is an integral component of quality services for our mutual beneficiaries. Cultural Competency expectations were rolled into the Provider Monitoring process as of January 1, 2017. Monitors are reviewing providers for evidence of the following, at minimum:
 - Ensure that your cultural competency plan includes the mission and/or vision statement and indicates the promotion of cultural diversity, cultural competency, and linguistics as an integral part of the system. *Examples may include annual reports, brochures, communications to staff, website information, etc.*
 - Ensure that there is a written plan for cultural competency that promotes awareness, respect, and attention to the populations and persons served. *Evidence would include board or governance approval, frequency of review and revisions, and a written approval process.*
 - Ensure that staff orientation includes instruction on the vision, mission, policies and procedures and practices of the organization. *Examples of evidence may include a provider orientation manual, staff information regarding cultural competency, handouts and/or printed material, staff training, etc.*
 - Ensure that there is a process to communicate with individuals needing interpretation/translation services. *Examples of evidence may include relationships in the community for interpretation and translation services for staff and individuals.*



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Cultural Competency Expectations

- ▶ During the Routine Monitoring process, providers have consistently requested a sample template to guide in the development of the required Cultural Competency Plan. Partners is pleased to announce we have heard your request and have developed an optional [Cultural Competency Sample Template Plan](#).
- ▶ This template is posted on the Provider Knowledge Base at <https://providers.partnersbhm.org/cultural-competency/>.



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CABHA Who?

- ▶ CABHA has not been removed from Clinical Coverage Policy or the law the General Assembly passed several years ago.
- ▶ Even though it is not being monitored at this time DMA is not ready to make that change but is being discussed.
- ▶ The MCO will hold you accountable to the clinical coverage policies and rule.
- ▶ In a clinical committee made up of DMA and LME/MCOs the following has been communicated as to the status:
 - There is no change in the status of CABHA currently;
 - CABHA continues with the guidelines in policy and statute but without the CABHA rules that expired;
 - Once the legislature acts on the special provision, DMA and DMH will remove CABHA language from policy and statute and revise the CABHA services to strengthen their medical and clinical oversight;
 - State staff have conducted stakeholder meetings for some of the services to gather input about how this increased medical and clinical oversight might occur;
 - There is no timeline to determine if the legislature will address this in the near future;
 - This has not been addressed in the current legislative session of the General Assembly has not addressed this again in the current session;
- ▶ Once this is resolved the State will send a Communication Bulletin



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NC HealthConnex Who is Required to connect?

- ▶ All health care providers who receive state funds (e.g., Medicaid, NC Health Choice, State Health Plan, etc.) for the provision of health care services must connect to NC HealthConnex by specific dates in 2018 and 2019 to continue to receive payments for services provided (NCSL 2015-241 as amended by NCSL 2017-57).
- ▶ Specifically:
 - Hospitals, physicians, physician assistants and nurse practitioners who provide Medicaid services and who have an electronic health record system must connect by **June 1, 2018**.
 - All other providers of Medicaid and state-funded services must connect by **June 1, 2019**.
 - Local Management Entities/Managed Care Organizations (LMEs/MCOs) are required to submit encounter and claims data by **June 1, 2020**.
 - Providers who do not receive state funding for the provision of health care services may also connect to the NC HIEA on a voluntary basis to support whole-person care.



NC HealthConnex Extension Process

- ▶ *Per NCGS § 90-414.4 (a2) the NC HIEA, in consultation with the Department of Health and Human Services (DHHS), has established a process to grant limited extensions of the time for providers and entities to connect to NC HealthConnex and begin submitting data as required by law.*
- ▶ The NC HIEA and DHHS understand that many health care providers will not be able to connect to NC HealthConnex by the [mandated deadlines](#). The General Assembly has permitted the NC HIEA and DHHS to receive and grant extensions to health care providers if they can meet certain criteria. If your organization would like to request a connection extension, you must meet all of the following criteria:
- ▶ Have signed an NC HIEA [Participation Agreement](#)
- ▶ Can demonstrate how your organization plans to connect to NC HealthConnex within one (1) calendar year
- ▶ If your organization can comply with these criteria and you need to request an extension, please complete the [form](#).



NC HealthConnex Extension Process (continued)

- ▶ Your organization can only request an extension if your connection deadline is within the next six (6) months.
- ▶ That is, if your deadline is June 1, 2019, the first day that you can submit an extension request form is December 1, 2018. Extensions received prior to the permitted period will be rejected and the provider must resubmit the extension request within 6 months of their deadline.
- ▶ Extensions will last until the next connection deadline provided by law.
- ▶ Your organization can request additional extensions if you are unable to connect to NC HealthConnex by your extended deadline.
- ▶ All health care providers must connect to NC HealthConnex by June 1, 2020, as required by law, so no extension deadlines will be set beyond June 1, 2020.
- ▶ This process is not a request for a waiver/exemption from the state's requirements, but an extension of time to meet the state's requirements.



NC HealthConnex Extension process (continued)

- ▶ [Link to the website to see the information regarding the extension process](#)
- ▶ <https://hiea.nc.gov/documents/extension-process-faqs>



NC HealthConnex: How to Connect

- ▶ The first step is reviewing and signing the Participation Agreement, which is the contract that governs the data sharing between the health care provider and the NC HIEA. This agreement can be found on our website with instructions for completion. For more information, visit our [How to Connect page](#).
- ▶ The second step is to have required technology in place. The NC HIEA Participation Agreement requires EHRs that are minimally capable of sending HL7 messages, version 2 and higher. EHR products that are ONC-certified for Meaningful Use for Centers for Medicare & Medicaid Services (CMS) Incentive Programs are preferred. The NC HIEA has also created a technology specification and minimum data target that can be found here. This document can also be used to ensure that your EHR vendor can meet our technology standards.
- ▶ *Providers who are planning to install and use an electronic health record system (EHR/EMR) in their practice should expect the process to last on average 12 to 18 months, as follows:*
 - six to nine months for procurement
 - three to six months for implementation and training
 - and three to four months for onboarding to NC HealthConnex.



NC HealthConnex: What does Connected Mean?

- ▶ A health care provider is considered “connected” when its clinical and demographic information pertaining to services paid for by Medicaid and/or other state health care funds are sent to NC HealthConnex daily. This transmission of information may be through a direct connection to NC HealthConnex or through an indirect connection, such as through another HIE, EHR vendor or a similar affiliate. Participation agreements must provide details of indirect connections through other affiliates.



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Provider Annual Performance Reviews Update

- ▶ We have been systematically working to ensure that the provider performance reviews are completed and results provided to the provider
- ▶ This has been a good process to validate data throughout this year
- ▶ We have received great feedback from the providers
- ▶ We will be updating the information moving forward to further define and refine this process
- ▶ Stay Tuned



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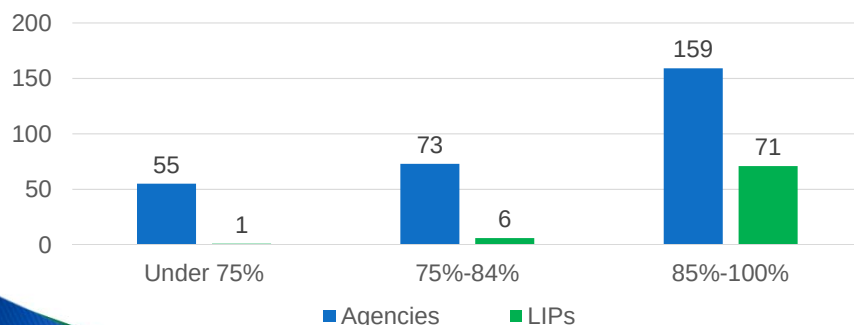
Annual Provider Performance Reviews Data

Timeframe = July 2017 – April 30, 2018

Total = 315

Agencies Reviewed = 237

Licensed Independent Practitioners Reviewed = 78



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Provider Network Changes

- ▶ Provider Network has been in transition as a department
- ▶ Provider Network Account Specialists have moved under the management of Sherry Reese-Cota, Regional Provider Network Manager and remain in the Provider Network Department
- ▶ Provider Monitoring has moved to the Quality Management department with Larry Holcombe as the Monitoring Manager



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Next Up: A Credentialing Update Fielding Yelverton Credentialing Supervisor

Credentialing Potpourri

- ▶ CAQH
- ▶ Application submission deadlines
- ▶ National Plan and Provider Enumeration System (NPPES)/NC Tracks/Alpha
- ▶ Fair Credit Reporting Act (FCRA) release for background checks
- ▶ Electronic Health Record (EHR)/NC HealthConnex
- ▶ Hospital Admitting Privileges Requirement Change



CAQH

- ▶ All clinicians must ensure that their CAQH information is up-to-date
 - You **must** complete *and upload* a state release/authorization specific to Partners in CAQH
 - This form can be found in CAQH
- ▶ Partners uses the contact information contained in your CAQH application as primary contact for clinician credentialing.



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Re-Credentialing/Contract Notices

- Six Months prior to the expiration of credentialing each provider (clinicians, LIPs as well as agencies) receives a re-credentialing notification.
 - The notice to associated clinicians and LIPs goes to the e-mail address on the clinicians' CAQH application.
 - The notice for agency re-credentialing goes to the agency credentialing contact via e-mail as well as to the CEO via certified mail.
- If Partners has not received a **complete** application 90 days prior to credentialing expiration then providers receive another e-mail notification.
 - Agencies and LIP's also receive a **contract warning** notice via certified mail at this point.
- No further notification is sent to associated clinicians. If an application is not received prior to the expiration date of credentials then the clinician is removed from the network.
- If Partners has not received a **complete** re-credentialing application from LIPs and agencies **60 days prior to credentialing expiration** then Partners issues a **contract non-renewal letter** via certified mail ending your participation in Partners' network effective the date of the credentialing expiration. Partners is required to begin notifying consumers that the provider is no longer eligible to offer services in the network at this point.



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Application Deadlines (cont)

- ▶ Please note that **receiving** the application will **not** stop the clock
- ▶ The application must be **complete** in order to avoid or stop the contract non-renewal process
- ▶ Also note that submitting the application on the deadline date does not allow time for review and could potentially result in contract non-renewal notification being issued in error. We ask that you allow ten (20) business days for your application to be reviewed.
- ▶ **Please remember: the contract non-renewal process can be avoided entirely by submitting your complete re-credentialing application in advance of the deadline specified in the notification(s) you receive from us.**



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NPPES

- ▶ Addresses, taxonomies, NPI numbers must all match in:
 - NC Tracks
 - NPPES
 - Alpha
- ▶ Inconsistencies among these databases will not stop your credentialing application from being processed but **will** prevent you from billing
- ▶ For practices with multiple site addresses:
 - Partners staff can only see the first site address in NPPES.
 - You will need to print screen shots for all other site addresses and submit them along with your application materials



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NPPES – Making Changes to Information

- ▶ How to make changes to information in NPPES:
 - For **individual** NPI numbers:
 - Call: **800-465-3203**
 - Ask for “**role request**” to gain access to NPI information
 - For **organization** NPI numbers:
 - Call **866-484-8049**
 - Select the option called “**Identity & Access**” (**I&A**)
 - Ask for guidance in processing a “**role request**” to gain access to organization NPI information
 - For all changes related to the organization NPI, you will likely need to have your W-9 handy when you call.
 - Partners cannot process your credentialing application until your current practice site address (associated with your organizational NPI) is entered in NPPES



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FCRA form – from whom required

- ▶ In addition to the verifications and monitoring we are required to perform on clinician applicants, Partners is required to perform background checks and exclusions monitoring on:
 - Owners
 - Directors, and
 - Managing employees
- ▶ The FCRA form included in the re-/credentialing application materials is the release allowing us to perform the required background check



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EHR/NC HealthConnex

- ▶ Effective June 1, 2018 – All hospitals, physicians, physician assistants, and nurse practitioners with an EHR system must have initiated a connection to NC HealthConnex
 - NC HealthConnex is NC's designated statewide health information exchange network.
- ▶ Providers who cannot meet the deadline may receive an extension for their connection
- ▶ For full details, please visit
<https://www.nctracks.nc.gov/content/public/providers/provider-communications/2018-announcements.html>



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EHR/NC HealthConnex (cont)

- ▶ Providers are responsible for remaining abreast of and in compliance with all NC Tracks requirements.
- ▶ Failing to do so may at some point impact your Medicaid enrollment and/or payment of claims for behavioral health services.



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Hospital Admitting Privileges Requirement Change

- ▶ For the past two years, CCME, DMA's external quality review (EQR) vendor has placed Partners on a Plan of Correction that specifically instructed us to require that all physician applicants for credentialing either have admitting privileges or an admitting plan through another physician who has admitting privileges
- ▶ New guidance received from DMA on June 7, 2018, indicates that this requirement has changed:
 - We must still ask if the physician has admitting privileges, and
 - If the physician does have admitting privileges, they must be in good standing, **but**
 - A response of 'n/a' is now acceptable, if the physician does not have admitting privileges



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Questions?

- ▶ Fielding Yelverton, Credentialing Supervisor
 - (704) 884-2505
 - fyelverton@partnersbhm.org
- ▶ Credentialing Department
 - (704) 842-6483
 - CredentialingTeam@partnersbhm.org



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Let's hear from Program Integrity...

6/14/20183



**Department of Program Integrity
Self-Audits
Tamar Conyers, PI Auditor**

Program Integrity Mission

The mission of the Program Integrity department is to work with providers to advance the integrity of the Medicaid program. We are committed to detecting potential fraud, waste and abuse within the Partners BHM catchment area and recovering improper payments.



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What is a Self-Audit

NCDHHS Provider Self-Audit Protocol (May 9, 2014) states that *The self-audit protocol facilitates the resolution of matters that, in the provider's reasonable assessment, potentially violate state or federal administrative law, regulation or policy governing the Medicaid and Health Choice Programs, or matters exclusively involving overpayments or errors that do not suggest violations of law.*



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Self-Audits Advantages

- Encourages provider internal review process
- Forms a partnership with the providers in our closed provider network
- Can offer a better review outcome
- Can give the provider a better understanding of Program Integrity audit and investigatory process



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When to disclose the Self-Audit

- When an improper payment is discovered
 - Potential violations of state and federal laws
 - Alpha and or NCTracks errors
- When an outside agency is auditing/investigating and a discovery is made
- Report it AS SOON AS POSSIBLE!!



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The Self-Audit Process

1. Prepare a memorandum of the self-audit discovery(ies) to include, but not limited to the following
 - How it was discovered
 - The time period covered
 - The issue(s) that were discovered
 - The potential financial impact
 - The program rule potentially implicated
 - The contact information and title of the individual making the report on behalf of the provider



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Self-Audit Process

2. Complete an adverse findings chart. The chart must include the following items:
 - The Individuals name: (Last, First, Middle initial)
 - Medicaid ID Number
 - Date of Service
 - Procedure Code
 - Individual Claim Number (ICN)
 - Provider Number
 - Amount Billed
 - Amount Paid
 - Paid Date
 - Refund Amount
 - Reason for Error
3. Develop a provider plan of correction with SMART goals.
4. Complete the Provider Self-Audit Refund Attachment with a refund check



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Who gets the Information

Partners Behavioral Health Management
Finance Department-Self-Audit
901 S. New Hope Rd
Gastonia, NC 28054

Partners' Finance Department will provide Program Integrity with a **copy** of the following:

- ▶ Your Self-Audit Memorandum
- ▶ Your adverse findings
- ▶ Your refund attachment & check



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Conclusion

Questions relating to the Provider Self-Audit process may be directed to programintegrity@partnersbhm.org



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Contacts

Teresa Shirley, AHFI
Lead Program Integrity Auditor
(704) 842-6325

Tamar Conyers, QP, CFE
Program Integrity Auditor
(704) 884-2522



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**UM has a few updates to
share...**



Presented by
Charity Bridges, MA, LPA, HSP-PA
UM Director

Facility Based Crisis Requirements for Authorization

REQUIREMENTS FOR AUTHORIZATION

SAR must be submitted on the day of admission if not before

Provider is given two days to submit required documentation which includes:

- **Service Order**
- **Pre-admission nursing screening**
- **Onsite psychiatric assessment completed within 24 hours of admission**
- **Clinical Assessment completed at time of admission**
- **Treatment Plan and Crisis Plan developed during admission**
- **CALOCUS score of 3 – 5**
- **ASAM score of 3.7 is there is a SU diagnosis**
- **Service is billed hourly**
- **Service not to exceed 30 days per 365 calendar days (rolling calendar)**



Rapid Response Requirements for Authorization

RAPID RESPONSE SERVICE FOR CHILDREN AND ADOLESCENTS:

- Youth, ages 5 up until their 21st birthday, are presenting in crisis, however do not meet the imminent danger to self or others threshold and can be diverted short term while a sound long term plan is formulated and executed.
- Crisis is characterized as serious conflict in current environment, adding to emotional dysregulation, requiring removal to allow de-escalation/assessment and further development of the crisis plan as needed.
- If Rapid Response placement is needed, a referral from Care Coordination, Community Providers, stakeholders (DJJ/DSS) or the consumer themselves are to contact ACCESS who will conduct an intake to obtain all required information.
- If client meets entrance criteria and if placement can be secured, this information will be submitted to UM who will create a SAR for Rapid Response. If they do not meet criteria or if there are no available beds, alternative services will be offered such as possibly mobile crisis.



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Adult Services

- Notification SARs are no longer required for :
 - State-funded Hospital Diversion Planning and Treatment (HDPT)
 - Assertive Engagement (AE)
 - Peer Support Services (Medicaid & State Funded)
- Assertive Community Treatment Team Services (ACTT)
 - Upon the first Concurrent Authorization request, submit documentation to show Application for Medicaid has been completed



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Inpatient Services

- Medicaid beneficiaries age 21-64 who meet medical necessity criteria for inpatient level of care may be treated for up to 15 days per calendar month in an Institute for Mental Disease (IMD).
- Code 0160
- This population was not previously reimbursed through Partners at these facilities
- If you have questions, call the Inpatient Work Group at x6434



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What's new with the Opioid Initiatives?



Cures Act Funding

21st Century Cures Act

Signed December 13, 2016 by President Obama

Much broader than behavioral health, designed to help accelerate medical product development and bring new innovations and advances to patients who need them faster and more efficiently.

More than \$6.3 billion, much of it going to the National Institute of Health for research and to the FDA to streamline processes.



Two Year SAMHSA Grant:

State Targeted Response to the Opioid Crisis

NORTH CAROLINA	
Year 1	Year 2
\$ 15,586,724	\$ 15,586,724
PROJECT SUMMARY	
The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDAS) of the North Carolina Department of Health and Human Services (NC DHHS), the State Mental Health Authority (SMHA) and the Single State Authority (SSA) for substance use will serve North Carolinians at highest risk for Opioid Use Disorder (OUD) through the proposed project, the NC State Targeted Response to the Opioid Crisis (NC Opioid STR). Opioid use disorders are pervasive throughout North Carolina, due to the use of illegal opiates such as heroin, as well as misuse of prescription opioids; as such, this proposal will identify the areas of highest need with the intent of serving as many individuals and areas as funds will allow. Over the past several years, North Carolina has experienced an increase in opioid and heroin use, misuse and overdose. In response, the state has developed strategies and implemented several initiatives to address the problem. The Cures Act provides the opportunity to consolidate those efforts, as well as enhance and expand services and supports to meet the needs of the citizens of North Carolina. Given the impact on our state, the governor has made this a top priority of his administration. Under the leadership and direction of the Office of the Governor, the Office of the Attorney General and the Secretary of DHHS, this project will strengthen the foundation for prevention, treatment and recovery services, an essential component of North Carolina's broader efforts to address this challenge and ensure the health and safety of individuals, families and communities in our state.	



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NC Award runs 5/1/17 – 4/30/19

- ▶ Prevention (20% of funding)
 - Expansion of Partnership For Success (PFS) grants
 - **Surry** and **Yadkin** now have Prevention Coordinators through Insight Human Services
 - 3 of our existing PFS grants received funding to provide technical assistance to the new recipients
- ▶ Treatment and Recovery Services (80%)
 - Increasing the number served with Medication Assisted Treatment (MAT)
 - Must serve 1,460 new individuals (1,520 for 2nd year)



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Distributing the Money

Allocations

Allocations have been made to Local Management Entities/Managed Care Organizations (LME/MCOs), which manage the care of individuals receiving mental health, intellectual/developmental disabilities and substance use disorder services in North Carolina.

The allocation requires LME/MCOs to carefully track their spending to claim the funding, and they must ensure that they continue to spend other existing resources to treat individuals at the same rate as prior years. LME/MCOs may not use any of the funding provided by this grant for administration.

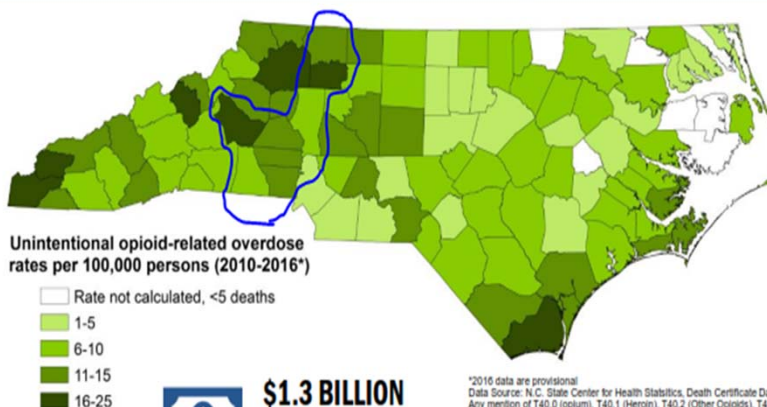
Allocation amounts for each LME/MCO were determined based on:

1. The percentage of the population of each LME/MCO service area;
2. The number of naloxone administrations by EMS during 2015;
3. The number of emergency department visits for opioid overdoses during 2012 through 2014; and
4. The number of opioid overdose deaths.



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Unintentional Opioid-related Drug Overdose Death Rates by County, N.C. Residents, 2010-2016*



\$1.3 BILLION
total combined costs
for 2015 alone

*2016 data are provisional
Data Source: N.C. State Center for Health Statistics, Death Certificate Data
Any mention of T40.0 (opioid), T40.1 (heroin), T40.2 (Other Opioids), T40.3 (Methadone) and/or T40.4 (Other synthetic opioid) and unintentional intent (X40-X44). Does not include non-resident or out of state resident deaths.
Economic Impact: CDC WISQARS for opioid-related drug deaths (unintentional), Cost of Injury Reports, National Center for Injury Prevention and Control, CDC. Base year (2010) costs indexed to state 2015 prices for poisoning deaths.



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Partners Cures Funding FY18

Funding Type	Funding Amount	Purpose
UCR for persons in ASOUD	\$229,675	Any ASOUD provider
NonUCR	\$225,000	OD response teams, meds & drug testing OBOTS
UCR for persons in ASOUD	\$453,750	ASOUD service array, no less than 50% on H0020
NonUCR	\$146,100	Naloxone kits
UCR for persons in ASOUD	\$400,000	ASOUD service array, specified OTP Providers
NonUCR	\$87,447	Medication
NonUCR	\$50,000	Certified Peer Support Specialists in OTP
	\$1,591,972	

New IPRS Target Population was restricted to a small number of providers

Allocations became increasingly prescriptive (more for MAT)

Concerns were raised with high spend on FBC/Detox, eliminated 12/31/17



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Lessons Learned

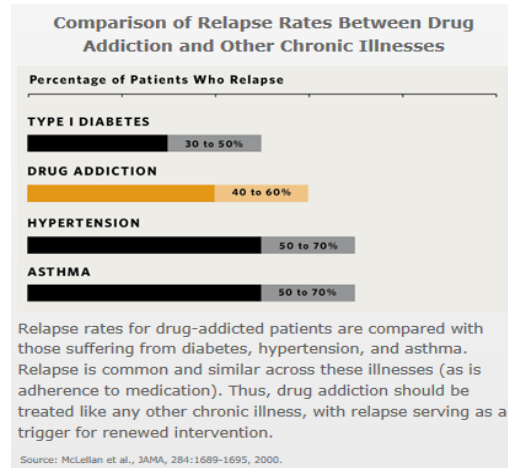
- Great deal of prejudice & stigma still exists against what the clinical evidence shows as the most effective treatment for OUD – Medication Assisted Recovery (MAT)
- Detox increases the risk of overdose death and turns people off from treatment (withdrawal symptoms last for months & brain functioning remains impaired for a year or more)
- Treatments must be recovery-focused and respectful of the chronic disease model



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Relapse is not unique to addiction

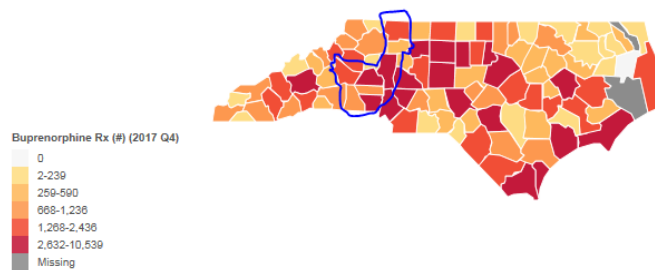
Typical in any chronic disease. Maintaining changes takes work and focus; people are human.



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Increasing Use of Medications as Key Component of OUD Treatment

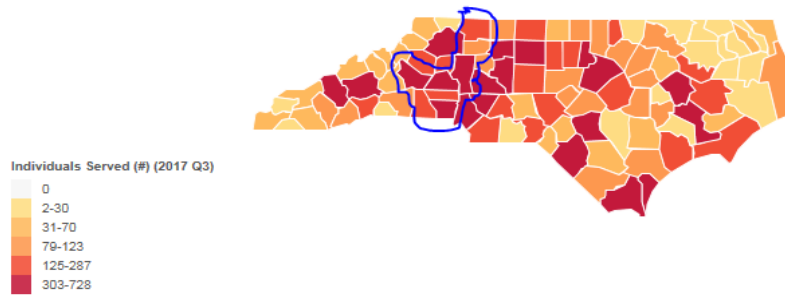
Most Recent Quarter's Buprenorphine Prescriptions by County



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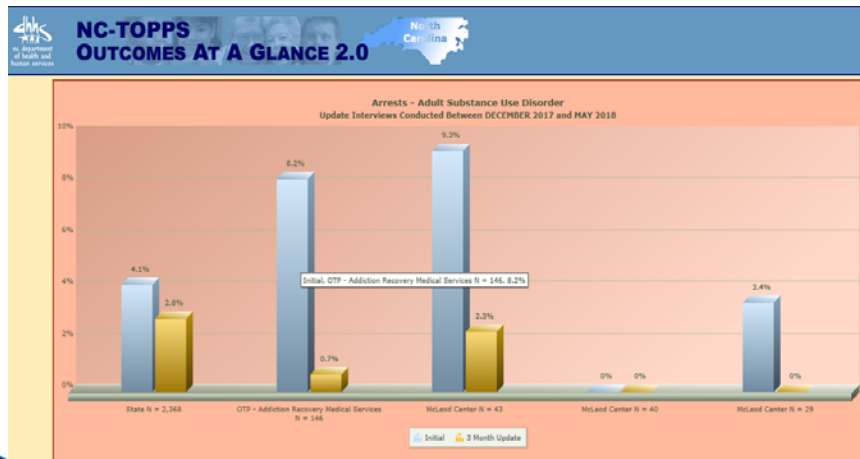
Increasing Engagement in Services

Most Recent Quarter's Individuals Served by Treatment Programs by County



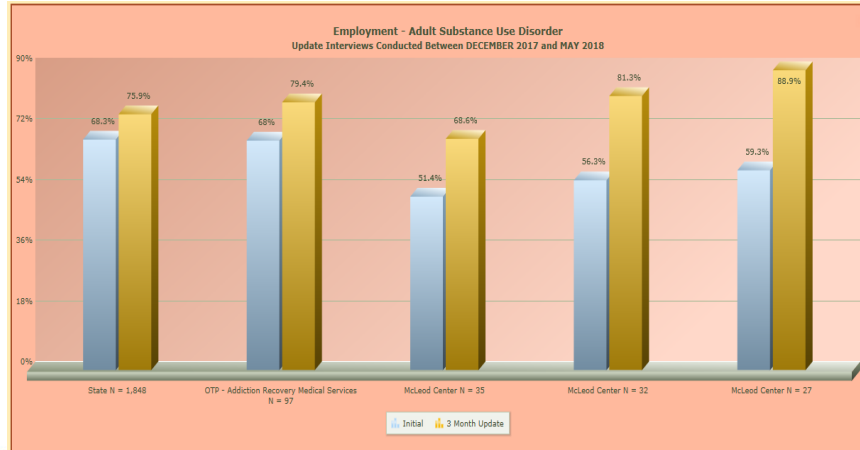
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Outcomes



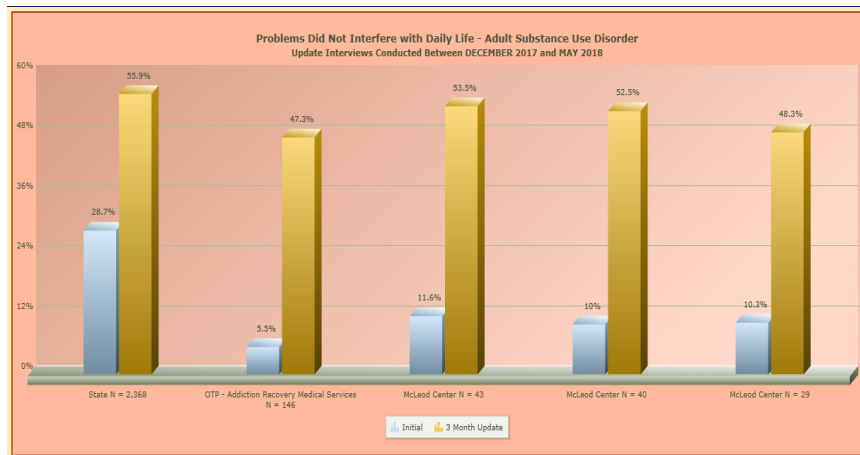
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Employment



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More Control Over Life



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Recovery

Home, Health, Purpose & Community

A process of change
through which individuals
improve their health and wellness,
live a self-directed life,
and strive to reach their full potential.



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The Right Fix

Medication Assisted Treatment (MAT) is gold standard

- Includes medication and psychosocial treatments
- Bulk of Cures funding goes to this modality

Overdose Response Teams

- Rapid engagement of survivors for harm reduction & treatment
- Using Certified Peer Support Specialists
- Staying connected to individuals for up to 3 months

Naloxone distribution

- 1,948 additional doses through Cures funding
- Distribute to high risk consumers through providers
- Trained and equipped community first responders



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More Solutions

Expanding Peer Support Services

- Embedded CPSS staff into all four of the OTPs
- First in the state to pull off this collaboration

Community Coalitions

- Change through changing attitudes & Collective Impact

Strengthening sober living options

- Oxford House (funded through Medicaid Savings Reinvestment)
- Therapeutic Communities (Exodus Homes, First at Blue Ridge, Hope Haven, and Safe Harbor) all received support

Harm Reduction

- Needle exchange, dirty needle collection, fentanyl test strips, HIV & Hep C testing, Good Samaritan Law education, naloxone distribution, safe use sites



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Contact Information

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**And to wrap things up, QM
will share an update about
NC TOPPS...**



NC-TOPPS

North Carolina Treatment Outcomes and Program Performance System
For Substance Use Disorder & Mental Health Services

Tamikka Woods, QM Supervisor



NC-TOPPS is a web-based system for gathering outcome and performance data on behalf of consumers receiving qualified services.

Any Changes...?

- ▶ Every fiscal year NC-TOPPS assess & evaluates interview questions and functions within the system
- ▶ Make sure to use the most current interview questions along with guidelines after July 1, 2018
 - Print out new interview questions/guidelines to assist staff



Remember...when is NC-TOPPS required?

If you provide the following services...

- ▶ Periodic Services
- ▶ Community Based Services
- ▶ Facility Based Day Services
- ▶ Opioid Services
- ▶ Residential Services
- ▶ Therapeutic Foster Care Services



Note:

- ▶ All substance use disorder consumers receiving the above services through State funds must participate in NC-TOPPS in order to comply with federal block grant requirements
- ▶ All children and adolescent consumers under the supervision of the juvenile justice system who are receiving any mental health and/ or substance use disorder treatment services are required to be in NC-TOPPS, if an LME/MCO enrolls them into Consumer Data Warehouse (CDW)



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Training Information

IMPORTANT

- ▶ Old way: held via webinar every quarter
- ▶ **New way**: training webinar will be posted on Partners website for access at any time by August 1, 2018
 - Links to documents as well as Frequently Asked Questions
 - Training will be updated at least annually and whenever there is a change



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Using Grant Funds or Medicaid?

- Both should be submitted under the LME/MCO in NC-TOPPS
- If the consumer is really “self pay” and switches to Medicaid, the provider needs to ensure that the consumer is transferred to being under the LME/MCO in a timely manner
 - QM is monitoring this through a submitted claims report:

(919) 515-1310 [Help Desk]: nctopps@ncsu.edu



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Transfers

- Communicate both before and after services take place
 - Make it protocol that NC-TOPPS information is being requested during the referral process, i.e. the initial date
 - Contact LME/ MCO to assist



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Resources

- ▶ **NC-TOPPS Help Desk:** Center for Urban Affairs & Community Services, NC State University:
 - Website:
 - <https://www.ncdhhs.gov/providers/provider-info/mental-health/nc-treatment-outcomes-and-program-performance-system>
- ▶ **Partners Email: NCTOPPS Questions**
 - nctoppsquestions@partnersbhm.org



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Wrapping up...

- ▶ We will have the recording posted on our website in the next couple of days. You can see the recordings at this link:
- ▶ <https://providers.partnersbhm.org/provider-webinars/>
- ▶ Please submit questions to: questions@partnersbhm.org

Thank-you for your participation! Please notify us if there are topics you would like to hear about at the next webinar. Contact rnewton@partnersbhm.org with your suggestions.



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This concludes our webinar..

