





Welcome & Announcements

Odds & Ends about the webinar:

- ▶ Beth Lackey, Provider Network Director, is your moderator for today's webinar.
- ▶ The audience is in "listen only mode." You can only hear us talking, but you can't talk with us through the phone in an interactive way.
- ▶ You may submit questions from today's webinar to:
questions@partnersbhm.org



Odds & Ends continued...

- Today's webinar is recorded and will be posted to the Partners BHM web page under the Provider Knowledge tab. Handouts will be uploaded to this page as well. Previous webinars are also on this page for your viewing pleasure!



Acorn Tool Providers: Reminder

- Please do **NOT** fax your Acorn surveys to Clinical Informatics!! This incurs an additional cost to Partners BHM above and beyond our contracted agreement with Clinical Informatics. Partners BHM has paid this surplus fee, but **WILL NOT** continue to do so.
- Any providers that continue to fax surveys will be financially responsible for the cost associated with Clinical Informatics processing fees.



12/12/2018 6

A message from Whole Person Integrated Care

- ▶ “Thank you to those who completed our initial survey. We received responses from about 20% of our network on efforts to collaborate care with Physical Health. We request that everyone complete the included follow up survey whether you completed the initial survey or not.
<https://www.surveymonkey.com/r/CQCV6VZ>
- ▶ This will help one of the Network Cross Function Team Subcommittees to address the gap in knowledge of integrated health efforts. Integrated Health is one strategy Partners is employing to increase access to behavioral health services. Thank you in advance for your attention in this matter.”





PARTNERS
Improving Lives. Strengthening Communities.

Integrated Care of Greater Hickory

Doug Blakeman
Chief of Operations



*Recovery....
Not Treatment*

Integrated Care
of Greater Hickory

Mission Statement & Goal

To promote self-sufficiency and pro-social life choices through effective person-centered education, training, and treatment programs.

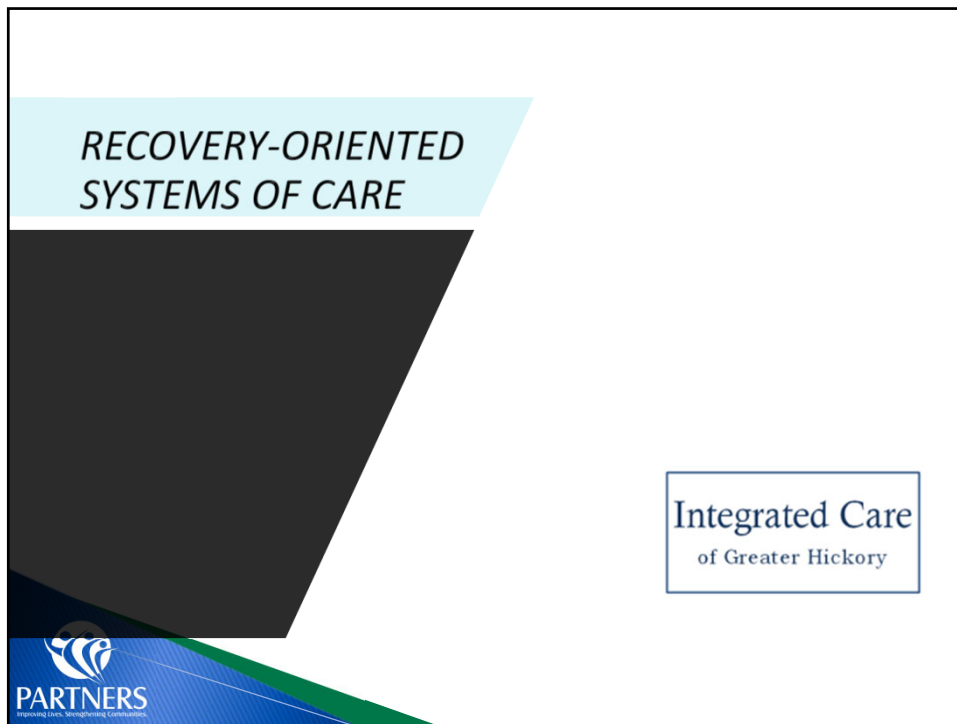
To empower persons suffering from behavioral health disorders to become as independent and self-reliant as possible by teaching them the skills they need to succeed in life.



What is *Addiction*?

- It is our goal for clients and their families to understand that substance use disorders, formerly known as addiction, is a disease, to show them the paths to recovery, and to enable them to live *Clean and Sober*, happy, and meaningful lives with the tools we **provide** in our prevention and treatment programs. We provide Evidence-based medical, pharmacy, toxicology, and behavioral health services to both insured and uninsured individuals of communities served.





What sets Integrated Care apart?

- Limited group size for group counseling allows for a more meaningful experience for the patient/client. Individual counseling at all levels of care.
- Flexible counseling scheduling, including evening and weekend appointment options.
- Close interaction between counselors, medical staff, certified lab tech, toxicologist, pharmacist, and the mutual-help communities to ensure a holistic approach to the patient's recovery.

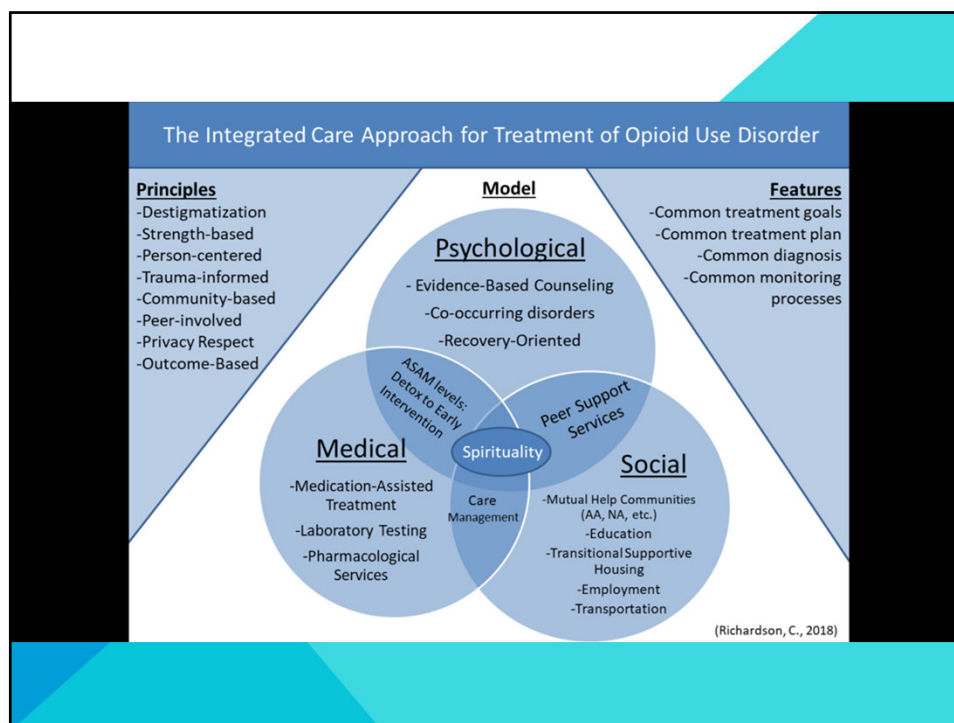
PARTNERS
Improving Lives, Strengthening Communities

What sets Integrated Care apart?

- Our counselors have personal experience or close familial experience with the disease of addiction, and the 12-step process. Mandatory participation in Mutual-Help Recovery Communities.
- Acceptance of Medicare, Medicaid, private insurances, and availability of state funding for those without coverage.
- IOP services available for those with private insurance.
- Care for all behavioral disorders with appropriate medication management, including MAT, as well as non-addictive treatment for depression, anxiety, PTSD, ADHD, etc. Not just treatment for addictive processes.



Recovery Oriented Model of with
a core focus on modified 12-step
facilitation for **all** substance use
disorders.



Medical

- Physicians
- Physician Assistants

Providing care *Every Day*



Services Provided for Adults

- Comprehensive Clinical Assessment
- Individual and Family Counseling
- Outpatient Therapy
- Dual Diagnosis Groups
- Intensive Outpatient Therapy (SAIOP)
- Substance Abuse Comprehensive Outpatient Therapy (SACOT)
- Transportation
- “Suboxone” Clinic (Medication Assisted Treatment and Medication Management) Same Day Service
- Peer Support Services
- Referrals to Inpatient Treatment Facilities
- Linking to Employment/Training Resources, Educational, & Housing Resources
- Civil Commitment First Evaluation On-Site



Medication-Assisted Treatments and Medical Supervision for all Behavioral Health Services

- Provided by NCMB licensed providers, including physicians, nurse practitioners, and PAs.
- Walk-in and scheduled Services Monday thru Friday
- On-Call Coverage 24 hours a day, 365 days a year
- Addressing Substance Use Disorders as well as other behavioral health issues, including Anxiety and Depression
- Detecting medical disorders and referring as needed for treatment



Pharmacy Services

- Licensed Pharmacist
- Dispensing Medical Providers
- On-Site Low-Cost Pharmacy
- Free generic Suboxone for uninsured
- Easy, Confidential Pick-up of Medications at time of Office Visit



Pregnancy Support Services

- We expedite induction of pregnant patients when they seek care.
- Psycho-education is offered in a compassionate and supportive manner to prepare the mother for the process of giving birth, and the possible challenge of weaning in hospital due to medication-assisted-treatment during pregnancy.
- Due to the group-based nature of counseling at our clinic, pregnant women are able to easily forge healthy relationships with other women in the program.
- A nurse in recovery who delivered her child during the course of her care with ICGH helps other pregnant women in the program.



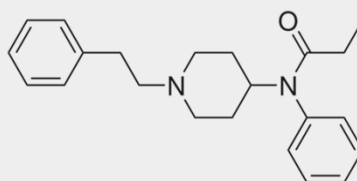
Full Laboratory Services In-house

- Biolis 24i Chemistry Analyzer
- 6420 Triple Quadruple Liquid Chromatography – Mass Spectrometry
- **PhD Toxicologist and certified lab technician**
- CLIA and COLA certified**



Benefits of In-house Laboratory Testing

- IMMEDIATE High quality point of care testing
- 24 hour turn-around for confirmation LC/MS testing
- Higher quality of testing due to low volume
- More precise, targeted testing ordered by providers



In Conclusion

- *Integrated Care of Greater Hickory* focuses on the person-centered concepts related to RECOVERY instead of rigid, service-focused programs that neglect participation in recovery communities.
- ↗ Our counseling, medical, nursing, and administrative staff have personal experiences or close contact with the disease of addiction and long-term recovery. Applying this experiential knowledge ties to successful *recovery-oriented* treatment.
- ↗ We are equipped to serve uninsured, Medicare/Medicaid, and privately-insured individuals seeking treatment at several levels, including IOP.
- ↗ Our diversely-trained staff, on-site laboratory, and on-site pharmacy enable us to provide higher quality, lower cost care at all levels of treatment.

Contact Information

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and Corporate Office**
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Lincolnton, NC 28092

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Integrated Care
of Greater Hickory





PARTNERS
Improving Lives. Strengthening Communities.

Old Vineyard Behavioral Health

Alyssa Haynes
Director of Business Development



The graphic features a gold circular seal from The Joint Commission National Quality Approval in the top left. The main title "OLD VINEYARD BEHAVIORAL HEALTH" is written diagonally across the center, with "OVERVIEW OF SERVICES" below it. To the right is the Old Vineyard Behavioral Health Services logo. Contact information for Winston Salem, NC, including phone and fax numbers and the website, is listed at the bottom right.

OLD VINEYARD BEHAVIORAL HEALTH
OVERVIEW OF SERVICES

Old VINEYARD
BEHAVIORAL HEALTH SERVICES

Winston Salem, NC

336-794-3550 Phone
336-252-2404 Fax

www.oldvineyardbhs.com

Overview of old vineyard services

- *"Compassionately caring for patients and their families in crisis"*
- Recent expansion to 164-bed facility dedicated to the behavioral health patient population with inpatient and outpatient treatment
- Programs to serve general psych for adolescents (12-17), adults, seniors and specialty programs for Dual Diagnosis, Trauma Recovery and Mood Disorders
- Adult Outpatient Partial Hospitalization and Intensive Outpatient Programs
- Various therapeutic techniques including CBT, DBT, TF-CBT, 12-step, recreation and pet therapy, and expressive arts (yoga) in trauma and mood disorders
- Longer length of stay than inpatient medical-surgical hospital units
 - (LOS average is approximately 7-10 days, 10 for teens and seniors)
- Accredited by The Joint Commission
- High patient satisfaction
- Strongly encourage family involvement





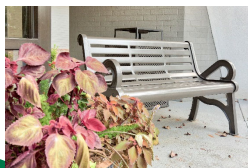
- 24/7 free assessments
- 24/7 staff are all clinical
- Will waitlist patients if no beds available
- Will send out alerts on request when significant open beds available
- Measured and assessed regularly for quality process by 3rd party (Marketpower)
- Accept patients from across North Carolina, all 100 counties
- Accept most insurance including Medicare and Tricare



ASSESSMENTS AND ADMISSIONS

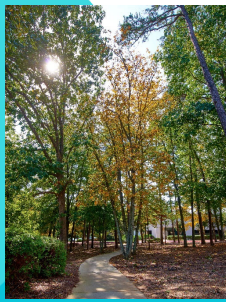
CLINICAL

- Manage a variety of patients at various acuity levels with minimum 15 minute rounds
- Psycho-educational training to teach individual about their personal triggers, warning signs, and coping skills (choice of 116)
- 5-6 structured group therapy sessions daily including CBT, DBT, relaxation, recreation and pet therapy, yoga, current events, healthy living, 12 step and mental health relapse prevention
- Multi-disciplinary approach with strong emphasis on communication and medical team assigned to each unit (doctor, therapist, nurse)
- On site psychiatrists meet with patients daily, internists meet on-site with patients on individual basis
- All licensed staff therapists with masters degrees
- All direct care staff providers are trained in Verbal De-Escalation and Crisis Prevention & Intervention
- Certified and licensed recreational therapists
- All nurses hired for critical care expertise
- Discharge plans for every patient require documented behavioral health professional appointment within 7 days and medication management appointment within 30 days





ADOLESCENTS (AGES 12-17) -- ADAMS & TRUMAN BUILDINGS



- Highly structured day with several group therapy (CBT and DBT) sessions including recreation and pet therapy
- Licensed Winston-Salem Forsyth County school teachers meets 1 ½-2 hours each day with teens
- Daily session of evidence-based cognitive behavioral program designed to build critical thinking skills (gender-specific)
- Individual workbooks to address specific diagnoses



SENIORS UNIT—UNIT B



- Designed and built with larger rooms, handicap access, special flooring
- Hospital beds to assist with mobility issues
- Call buttons are at each bed for heightened access to care
- Age specific group programs include relaxation and healthy living emphasis to manage anxiety, learn how to reduce stress and improve nutrition
- Program design focuses on creating hope and building a new life



DUAL DIAGNOSIS PROGRAM-- 2ND FLOOR FRANKLIN BUILDING



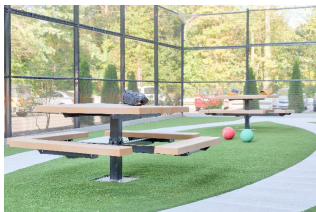
- DBT based techniques with 12-step approach
- Psycho-educational skill building groups throughout the day
- Integrated programming on Mental Health and Substance Use Disorder
- Mental health relapse prevention groups
- Modern medication to facilitate treatment



TRAUMA RECOVERY PROGRAM-- 3RD FLOOR FRANKLIN BUILDING



- Holistic program designed to address physical, sexual or emotional trauma
- Adult adaptation of Evidence-Based Trauma Focused Cognitive Behavioral Therapy (TF-CBT) combined with yoga, deep breathing, and relaxation
- Involves psycho-education stress and symptom management, emotion regulation, thought distortion, and self-esteem
- Education for patients and their families to better understand how trauma affects the body
- Led by staff who are all trained with a trauma informed care focus




MOOD DISORDERS 3RD FLOOR IN FRANKLIN

Our latest adult program addition opened in October 2018.

- Focus on mood disorders such as major depression, persistent depression, and bipolar disorder without psychoses.
- Treatment involves cognitive and dialectical therapies
- Recreation, yoga, and pet therapy for positive patient outcomes.



MARSHALL CENTER

PARTIAL HOSPITALIZATION PROGRAMS (PHP) & INTENSIVE OUTPATIENT PROGRAM (IOP)

Distress tolerance

Med Management

Interpersonal skills

Emotion regulation

Mindfulness

- PHP—Day programs M-F
Mental Health or Dual Diagnosis tracks
- IOP—Morning program 3x a week
- Focus on Life Management
- DBT focused therapy daily with emphasis on Coping Skills
- Structured sessions focused on education
- Psychiatrist on site
- Dedicated psychiatric nurse
- Very high patient satisfaction scores
- Covered by most insurance

QUESTIONS?

336-794-3550 Phone
336-252-2404 Fax

www.oldvineyardbhs.com



**Let's get an update on the
1115 Waiver....**



1115 Waiver

1115 Waiver Status

- On Oct. 24, 2018, the federal Centers for Medicare and Medicaid Services (CMS) approved North Carolina's 1115 Demonstration Waiver application submitted November 2017.
- The approval is effective Jan. 1, 2019 through Oct. 31, 2024.
- The amended waiver is the result of collaboration among DHHS, beneficiaries and their families, advocates, health care providers, health plans and associations, lawmakers and other stakeholders throughout North Carolina.



Vision for North Carolina's Medicaid Managed Care Program

- August 9, 2018 the RFP for the Medicaid Managed Care Prepaid Health plans was released
- In 2015, the General Assembly directed the transition of Medicaid to a managed care structure.
- In managed care, DHHS will oversee all aspects of the Medicaid and NC Health Choice programs. However, PHPs will directly manage certain health services, assume financial risk and contract with providers to provide services for beneficiaries.
- This RFP reflects three years of collaboration with and extensive feedback from beneficiaries, clinicians, hospitals, counties, health plans, elected officials, advocates and other stakeholders to design the managed care program.
- DHHS hosted listening sessions across the state, reviewed more than one thousand written public comments and released 15 policy papers on different aspects of the program.
- This RFP is the largest procurement in DHHS history. It clearly communicates DHHS' requirements and defines the standards that PHPs must adhere to in contracting with DHHS. All plans will be subject to rigorous oversight by DHHS to ensure strong provider networks, a full range of benefits, accountability for quality and outcomes, a positive beneficiary experience and timely payments to providers among aspects of a successful managed care program.



12/12/2018 43

Why an 1115 Waiver?

- Fundamentally, the waiver provides North Carolina with federal authority to implement Medicaid managed care and phase certain populations into managed care over time.
- Under the waiver, North Carolina has further federal authority to incorporate the following innovative features into its new managed care delivery system, further enhancing the program's ability to deliver on the state's transformational goals



12/12/2018 44

Transformational Goals of the 1115 Waiver

- Behavioral Health Integration, Tailored Plans and Specialized Health Homes
- Opioid Strategy
- Healthy Opportunities Pilots

<https://files.nc.gov/ncdhhs/CMS-1115-Approval-FactSheet-FINAL-20181024.pdf>



12/12/2018 45

Behavioral Health Integration and Tailored Plans

Description

North Carolina will **integrate physical, behavioral and pharmacy benefits** into both Standard Plans and Tailored Plans. **Tailored plans** will provide:

- Integrated physical, behavioral and pharmacy benefits to people with a serious mental illness, serious emotional disturbance, severe substance use disorder, intellectual/ developmental disability or a traumatic brain injury
- A specific, more intensive set of behavioral health benefits that are not available in Standard Plans (as approved in the 1115 demonstration waiver)*
- Care management through a specialized behavioral health home model designed to meet beneficiaries' complex needs

Impact

Supports the State's goal to provide managed care beneficiaries seamless access to coordinated care and benefits through one managed care plan and to ensure those with serious behavioral health conditions get the care they need.

*Individuals eligible for Tailored Plans may elect to enroll in either Standard Plans or Tailored Plans, but will only have access to the more intensive behavioral health benefits in the Tailored Plans



12/12/2018 46

Opioid Strategy

Description

As part of the State's comprehensive strategy to address the opioid crisis, North Carolina will (1) increase access to inpatient and residential substance use disorder treatment by beginning to reimburse for substance use disorder services provided in institutions of mental disease (IMD), and (2) expand the substance use disorder service array to ensure the State provides the full continuum of services.

Impact

Strengthens the State's approach to improving care quality and outcomes for patients with substance use disorders, including by decreasing the long-term use of opioids and increasing the use of medication-assisted treatment (MAT) and other opioid treatment services.



12/12/2018 47

Healthy Opportunity Pilots

Description

- North Carolina will implement within its Medicaid managed care program a groundbreaking **pilot program** in two to four regions of North Carolina to improve health and reduce health care costs.
- Working with managed care plans, these pilots will **identify cost-effective, evidence-based strategies** focused on addressing Medicaid enrollees' needs in five priority areas that drive health outcomes and costs: **housing, food, transportation, employment and interpersonal safety**.
- The State will increasingly **link pilot payments to improvements** in health outcomes and efficiency.
- North Carolina will use a **rigorous rapid-cycle assessment strategy** to evaluate pilot performance and tailor service offerings to those with demonstrated efficacy.

Impact

Overall health is driven by many factors beyond the four walls of a hospital or clinic. The Healthy Opportunities pilots leverage federal funding to ensure the most efficient and effective managed care program and to strengthen work already underway in communities to improve population health.



12/12/2018 48

Goal of Medicaid Managed Care: Create an Innovative, Integrated and Well-Coordinated System of Care

- ▶ This RFP procures Standard Benefit Plans, which will provide integrated physical health, behavioral health and pharmacy services to the majority of Medicaid and NC Health Choice beneficiaries with lower intensity behavioral health needs.
- ▶ Beginning in 2021, most individuals with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability or a traumatic brain injury will receive integrated physical health, behavioral health, pharmacy services and I/DD services through Behavioral Health Intellectual/Developmental Disability Tailored Plans (BH I/DD Tailored Plans), an integrated specialized managed care product.
- ▶ BH I/DD Tailored Plans will be procured later through a separate process, and this population will continue receiving benefits through a combination of Medicaid Fee-for-Service and LME-MCOs as they do today until BH I/DD Tailored Plans begin.



12/12/2018 49

Ensure PHPs maintain strong networks...

- The RFP contains specific standards around network adequacy, including time and distance and appointment wait time standards. In addition, Medicaid beneficiaries will receive adequate and timely coverage of out-
- of-network services (that have been pre-approved) if the PHP is unable to provide coverage within network on a timely basis.
- DHHS will closely monitor PHP Network Access Plans, which must demonstrate that the PHP has a network with the capacity to serve the expected enrollment.
- The Access Plan will be submitted annually and whenever there are substantial changes.
- To assist members in obtaining covered services from network care providers, PHPs will produce, monitor, and maintain consumer facing network care provider directories that are compliant with content requirements outlined in the RFP.

<https://files.nc.gov/ncdhhs/RevisedWebcastQuestionSummary-FINAL-POSTING-FOR20180712.pdf>



12/12/2018 50

Next Steps

RFP evaluation and award:

- DHHS has received bids from potential PHPs and this has closed as of October 19, 2018.
- DHHS will first review offers to determine that they are in the proper form and include all required documents. The Evaluation Committee will then screen the offers to determine if the minimum qualifications have been met.
- The Evaluation Committee will evaluate proposals meeting the minimum qualifications and develop consensus ratings, ultimately developing an award selection that is aligned with state law, and will provide supporting documentation for their selection.
- DHHS will submit the contracts to the Federal Centers for Medicare & Medicaid Services for its approval.
- PHP contract awards are anticipated to be announced in February 2019.



12/12/2018 51

RFP #30-190029-DHB Bid Opening
Prepaid Health Plans
October 19, 2018 at 2:00 PM

Bids were received from eight offerors.

OFFEROR NAME
Aetna
AmeriHealth Caritas North Carolina
BCBSNC – Healthy Blue
Carolina Complete Health
My Health by Health Providers
Optima Health
United Health Care
WellCare Health Plans



12/12/2018 52

Anticipated Timelines

Now and ongoing. Care providers may be contacted by potential PHPs who wish to initiate contract discussions.

- **February 2019.** NC will award contracts to the selected health plans to be PHPs in managed care.
- **Summer 2019.** PHPs must have contracted with enough care providers for their network to meet DHHS standards.
- **July 2019.** PHPs must have all call centers operational and all relevant staff located in North Carolina.
- **July-September 2019.** Managed care will start in two phases. For regions of the state in Phase 1, this will be the window in which beneficiaries select a PHP.
- **November 2019.** The Medicaid managed care program will launch in regions in Phase 1.
- **October-December 2019.** For regions of the state in Phase 2, this will be the window in which beneficiaries select a PHP.
- **February 2020.** The Medicaid managed care program will launch in regions in Phase 2.



For more information as this transition occurs, please see this website:
<https://www.ncdhhs.gov/medicaid-transformation>

12/12/2018 53

Provider Payments

- **Rate floors/ceilings**
 - PHPs will comply with Department-established rate floors for certain in-network providers
 - PHPs and providers can mutually agree to different rates through PHP/provider contract
 - Department will monitor PHP/provider contracts to determine if rate ceilings need to be established
- **Department will hold PHPs to prompt pay requirements**
- **Out-of-network services will be covered if PHP provider network is unable to provide necessary services covered under the contract, subject to prior authorization**
- **Out-of-network provider of emergency or post-stabilization services will be paid no more than Medicaid fee-for-service rates**



12/12/2018 54

Rumors about Medicaid Managed Care

Providers must sign a contract with a plan NOW to continue serving Medicaid patients in the future

You may have heard...



12/12/2018 55

Rumors about Medicaid Managed Care

FALSE

Providers must sign a contract with a plan NOW to continue serving Medicaid patients in the future

TRUE

- PHPs must contract with DHHS
- PHPs must be licensed by the state
- PHPs must have their provider manuals, contracts and contracting policies and procedures approved by DHHS
- Medicaid Fee-for-Service program will remain operational to serve excluded populations – although a smaller program.



12/12/2018 56

Before PHP contracts are awarded

Pre-Award Period

Build relationships with health plans

Understand contract terms, conditions, payment and reimbursement methodologies

Contracting Guidance

- **Letters of intent**
Non-binding indication of health plan and provider's intent to enter into contract negotiations
- **"Any willing provider"**
PHPs must contract with providers willing to accept reimbursement unless "objective quality" concerns
- **Department-approved contracts**
Mandated clauses and specific provisions



12/12/2018 57



Partners Vision and the 1115 Waiver Transition

Partners Vision: Culture of Collaboration

The Partners approach fosters strong collaboration and delivers quality care.

We believe in and are committed to:

- ✓ Maintaining collaboration
- ✓ Enhancing our collaboration as we seek participation of the best thinkers at all levels of the system to achieve effective care and raise the level of healthcare for all populations served
- ✓ Focus on specific outcomes, network accountability and re-investment in our providers and communities

1115 Transformation is a new lever that allows enhancement of our culture to improve performance of provider organizations and ultimately, population health.

Partners Vision & 1115 Waiver: Key Components

Partners is well positioned for the State's system transition and is actively evaluating and designing our role in preparation for the transformation.

Value Based Payment

Improved outcomes
Improved cost
Leveraging our provider's expertise and innovation
Improving the total network -raise all boats

Innovation

Whole Person Care
Evidence Based
Collaborative Care with Peers and Social Determinants of Health (SDOH)

Population Health

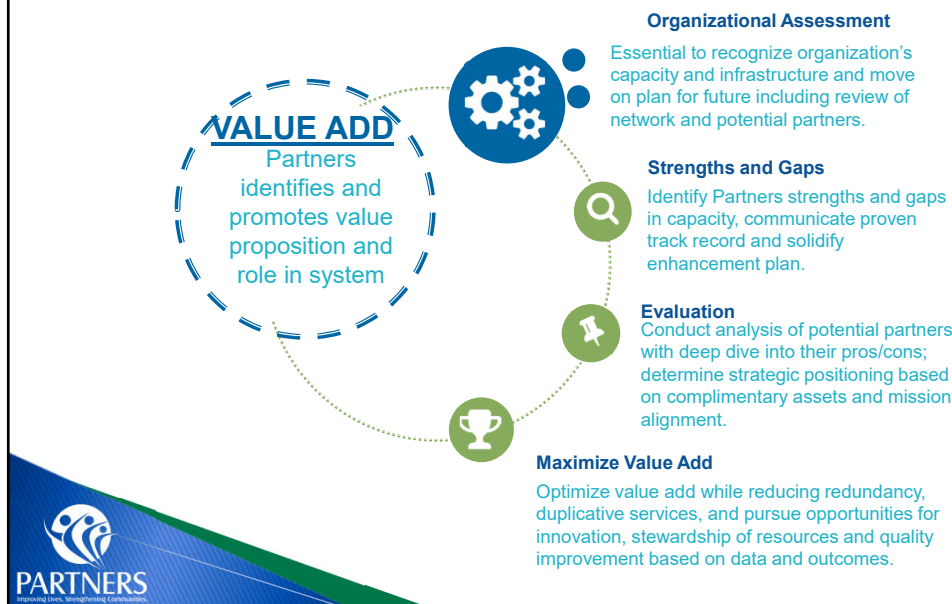
Provide network solutions that support population health across the full continuum of care

Health Plan Partner

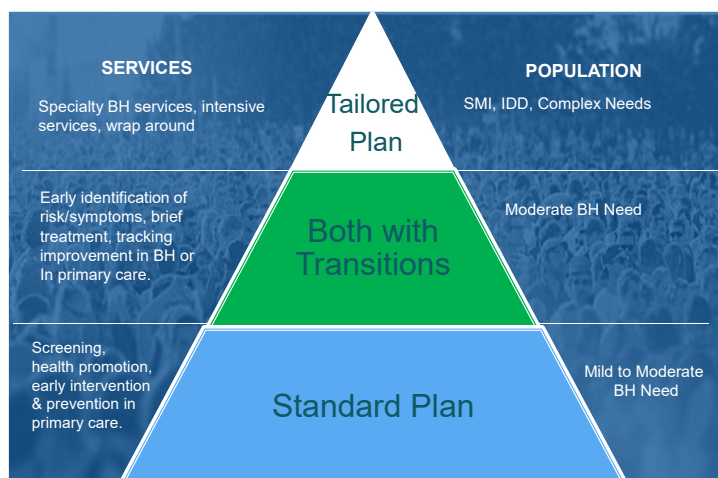
Shares mission and values
Believes in collaborative approach
Offers infrastructure to enhance current models and system of care



VISION: Achieving Vision Means Strong Network Through Collaboration and Accountability



POPULATION HEALTH FOR BEHAVIORAL HEALTH



Are you ready?

- ▶ The National Council of Behavioral Health has a great readiness assessment tool that is relevant in 1115 waiver planning.
- ▶ As an organization, assessing your strengths and weaknesses can assist in your focus and planning efforts.

https://www.thenationalcouncil.org/dl.php?file=/var/www/vhosts/thenationalcouncil.org/public_html/wp-content/uploads/2013/01/Provider-Readiness-Assessment.pdf



12/12/2018 63

1115 Waiver Planning

- ▶ Partners has constituted a CEO Roundtable Discussion regarding 1115 waiver planning
- ▶ This Roundtable connects directly to the Provider Council as the chair of the Provider Council sits on this group
- ▶ The roundtable consists of large and small providers, across all disabilities, local, regional and statewide provider representation
- ▶ The purpose is to gain stakeholder input and planning to prepare for an 1115 waiver transition



12/12/2018 64



Network Develop Plan

Four Work Groups:

- **Prevention and Education**
- **Quality Monitoring and Management**
- **Social Determinants**
- **Treatment**
 - **Accessing Care**
 - **Adult Services**
 - **Children and Families**
 - **Dual Diagnosis**
 - **Evidenced Based Practices and In Lieu of Service Definitions**



12/12/2018 67

Prevention and Education

Goal	Progress
Goal 1: To promote community awareness of behavioral health services and criteria for service eligibility, four articles will be written and published in the Behavioral Health Focus (BHF) by 6/30/19.	Qtr 1: Developed plan to and publish first article in November issue for Hunger and Homeless Awareness week.
Goal 2: To promote awareness of behavioral health stigma, in our catchment area, Public Relations' campaigns will include 4 community speaking engagements/presentations by 6/30/19.	Qtr 1: Partners' helped sponsor 5 events in September for National Recovery Month. Sept 28-Gaston County Recovery Month Celebration and Candlelight Vigil; Sept 28-Iredell County Walk for Recovery; Sept 29-Catawba County Recovery Rally; Sept 29-Burke Rally for Recovery; Sept 29-Surry and Yadkin County Hope Fest for Recovery.
Goal 3: Increase consumer support group presence within Partners catchment area by three new groups by 6/30/19.	Qtr 1: Group working on a current listing of support groups in the catchment area and potential for partnering on efforts.



12/12/2018 68

Quality Monitoring and Management

Goal	Progress
Goal 1: All Partners' providers will enroll in Health Connex or have an approved extension by 5/31/19.	Qtr 1: List of Health Connex resource links from the state website was made available to providers.
Goal 2: Consumers "episode of completion" reason is "completed treatment" based on NC Topps data for 25% of consumers by June 30, 2019.	Qtr 1: Plans developed for a link for the Health Connex website to be placed on Partners website.
Goal 3: Treatment effectiveness/consumer satisfaction will increase by 55% by June 30, 2019.	Qtr 1: Not started
Goal 4: Develop or obtain software with capability to provide the data analytics and predictive modeling to meet Partners identified needs by June 30, 2019.	Qtr 1: Reviews of software are being conducted.
Goal 5: Identify barriers and develop plan to reduce barriers to consumers missing follow up appointments by June 30, 2019.	Qtr 1: Not started



12/12/2018 69

Social Determinants

Goal	Progress
Goal 1: In partnership with the North Carolina Housing and Finance Agency (NCHFA) and Reinvestment In Communities (RIC), develop 2 small homes in Gaston County.	Qtr 1: Application delayed, to be submitted in January.
Goal 2: Expand inventory of affordable apartments in catchment area by 6/30/19.	Qtr 1: Not started
Goal 3: Coordinate at least one workforce summit in Gaston County by 6/30/19 to educate local businesses about hiring people with MH/SUD and criminal backgrounds.	Qtr 1: Met with Gaston Chambers Workforce Development 9/25/18. Processed services, discussed educating business on benefits of hiring those w/disabilities, and identify possible businesses for employment submit.
Goal 4: Engage at least 3 providers through the provider council on the benefits of participation in regional homeless Continuum of Care Committees by 2/1/19	Qtr 1: Attended Provider council meeting 9/28/18. Identified 2 new providers to invite to lunch and learn.
Goal 5: Research at least 2 new transportation options.	Qtr 1: New flex route began October 1, 2018 in Burke County



12/12/2018 70

Treatment

Accessing Care

Goal	Progress
Goal 1: Access-Collaborate with 60 In Network Providers to adopt protocols to obtain preventive physical care and annual physical data for behavioral health consumers by 6/30/19.	Qtr 1: Determined need for survey instead of RFI. Delays in drafting survey.
Goal 2: Access-Implement three strategies to increase access to psychological evaluations by 6/30/19.	Qtr 1: Obtained list of in-network providers from Provider Network, updating for providers who had not previously responded. Out of Network still needed. Obtained feedback internally from Care Coordination departments.
Goal 3: Access-Partners will increase Behavioral Health Urgent Care capacity by 50% through development of one additional center by 6/30/19.	Qtr 1: Request for feedback made, other facilities toured for comparison. Initial conversations with Mike Welch. Obtained and shared new laws for group review.



12/12/2018 71

Treatment

Adult Services

Goal	Progress
Goal 4: Adult-Partners will develop and release at least one RFP designed to increase capacity for and access to comprehensive substance use disorder services throughout the Partners catchment area by 6/30/19.	Qtr 1: 9/11/18 reviewed the results of the 2018 needs assessment. Reports manager could not give data needed. Revised activity to reflect IT request to build a report to obtain data that will be used to assess capacity.
Goal 5: Adult-Develop transitional housing program for adults diagnosed with substance use disorders in Partners northern region by 6/30/19.	Qtr 1: Identified a need to continue a contract with Oxford House for development in Northern Region. Contracted and Oxford house looking for property in Mt. Airy.



12/12/2018 72

Treatment

Children and Families

Goal	Progress
Goal 6: Child-Increase capacity for residential treatment facilities to treat children/adolescents diagnosed with problem sexual behaviors by one facility by 6/30/19.	Qtr 1: Decision made to go with RFP. Consulted with EBP workgroup. Recommendation was to let providers submit EBPs relevant to service. RFP posted 9/5/18. Met with potential providers on 9/17/18.
Goal 7: Child-Develop and implement one Level II Residential Treatment home in Burke County for boys ages 10-15 with MH/SU diagnosis by 6/30/19.	Qtr 1: RFI posted 8/22/18. On 9/5/18, withdrew RFI to review rates based on provider feedback.
Goal 8: Child-Develop one residential treatment facility for adolescents with substance use disorders by 6/30/19.	Qtr 1: Not Started



12/12/2018 73

Treatment

Dual Diagnosis

Goal	Progress
Goal 9: Dual Diagnosis-Develop and implement one dual diagnosis (IDD/MH/SU [ASD]) 3-4 bed residential group home that serve adults ages 18-35 by 6/30/19.	Qtr 1: ROI posted 7/3/18. RFP posted 8/29/18. 9/20/18 RFP Responses received and sent for review.
Goal 10: Dual Diagnosis-Develop and implement one dual diagnosis (IDD/MH/SU [ASD]) 1 person placement (IAFT) serving ages 12-17 by 6/30/19.	Qtr 1: ROI posted 7/3/18; RFP posted 8/29/18. 9/20/18 RFP Responses received and sent for review.
Goal 11: Develop one Dual Diagnosis (IDD/MH/SU-ASD) Level III Residential Treatment Facility that serves female children ages 12-17 by 6/30/19.	Qtr 1: Not Started



12/12/2018 74

Treatment

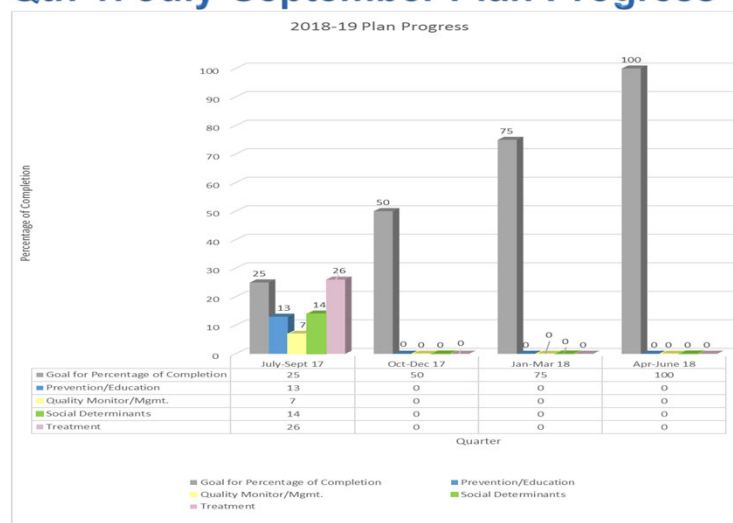
Evidenced Based Practices/In Lieu of Service Definitions

Goal	Progress
Goal 12: Evidenced Based Practices/Service Definitions-Fully implement two previously approved In Lieu of Service Definitions by 6/30/19.	Qtr 1: 7/3/18-Identified Long Term Community Supports (LTCS) and Young Adults in Transition(YAT) to implement. Met with potential providers of LTCS on 8/13/18. Providers participating are all current providers of residential levels of service-Family Living and Supervised Living. YAT to be implemented as a pilot project with Sipes Orchard Homes and Youth Villages. 8/27/18-Sipes Orchard Homes submitted complete credentialing application for YAT.
Goal 13: Develop an alternative definition/payment for at least two new services by 6/30/19.	Qtr 1: Identified Intercept and Family Partners as services to obtain approval for alternative payments.
Goal 14: Evidenced Based Practices/Service Definitions-Implement an enhanced rate for two Evidenced Based Practices by 6/30/19.	Qtr 1: 7/3/18-prioritized Trauma Informed Comprehensive Clinical Assessments (TICCA). 8/22/18-met with Family Net regarding their use of TICCA's.



12/12/2018 75

Qtr. 1: July-September Plan Progress



Note: First quarter percentages may be significantly lower than 25% due to goals being added during the 2018 Needs Assessment final report and planning session in September. Implementation of new goals did not begin in the first quarter.



12/12/2018 76

Contact Information

Roanna Newton
Provider Network Development
rnewton@partnersbhm.org



12/12/2018 77

NC Health Connex:

REMINDER!

- ▶ NC HealthConnex
- ▶ **All** providers must be enrolled or have a State approved extension by June 1, 2019
- ▶ If you don't, you won't get paid.



78

- ▶ Handouts with information pertaining to NC Health Connex will be uploaded to the Partners BHM webpage under the webinar tab.
- ▶ Link for Provider webinar:
- ▶ <https://providers.partnersbhm.org/provider-webinars-forums/>



12/12/2018

79



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**Plan of Correction
Training**
Larry Holcombe
**Quality Management Monitoring
Manager**

12/12/2018



Provider Responsibilities when responding to a Plan of Correction (POC) request

Purpose of the Plan of Correction

- Having to submit a POC means that we found something is out of compliance or not up to standards.
- The purpose of the POC is to correct the problem and prevent the problem from reoccurring.
- The POC is your tool to improve your agency's performance and to assure the LME-MCO that performance will improve.
- It is a Quality Improvement Issue and is a great way to implement a Quality Improvement Project/Activity within your organization.



Step 1

Review the Request

- Do you understand the issues cited?
- What are the rules, service definitions or regulations that the issues relate to?
- Do you understand what the desired outcome of the correction should be?
- Are you able to correct the issues?



Step 2

Developing the Plan of Correction

Once you understand the request, develop a plan to include the following:

- Clear restatement of the issues and what needs to be corrected.
- Clear interventions/steps that will resolve the problem at a systemic level and prevent the problem from reoccurring.
- Clear, reasonable and achievable timeframes for each intervention.



Things to consider

- What policies and procedures do you need to revise, change completely or develop?
- Should you implement immediately, or must you divide the issue into smaller steps?
- What staff should be involved in developing the POC?
- Do you need assistance from a consultant or outside trainer, etc?
- Do you have a way to train staff on changes?
- Can you self-monitor/audit your performance?



Step 3 Submit Plan of Correction within timeframes

- Plan should be submitted on or before the due date
 - The Provider has 15 calendar days from the receipt of the POC request or first attempted delivery to submit a POC for approval.
 - All POC letters sent out by Partners BHM are sent certified return/receipt mail or electronically for tracking purposes.
- Keep a copy of the POC.
- Provide any and all supporting documentation that you have made changes or that support your intention to make changes



Step 4

Participating in the review of the Plan of Correction

- Partners BHM will let you know if we need your staff available when we review the POC.
- Make sure you have staff who are knowledgeable about the service/issues and who can speak on behalf of your agency.
- Note: If the initial POC submission is found to be unacceptable/not meet criteria to be approved, a request will be sent out to resubmit the POC. The provider will have 10 calendars from the date of receipt or first attempted delivery to submit the second plan for review and approval.



Step 5

Implement the Plan of Correction

- Implement the POC within specified timeframes
- Assigned QM Monitoring Specialists will conduct a follow up review within 60 calendar days from the date the plan was approved to verify implementation of the POC.
- If a the follow up review reveals that the POC was not implemented, then an additional review will be conducted within 20 calendar days from the first review date.



Step 6 Follow-up on your Plan of Correction

- You should continuously monitor your performance on your POC.
- It is your POC and its purpose is for you to be sure that you are doing things right.
- Make it part of your Quality Improvement process.



Plan of Action (POA)

- * There may be an occasion when an out of compliance issue needs to be corrected and implemented immediately.
- * If this is the case the LME-MCO will issue a POA directing the provider as to what steps are expected to be taken to correct the deficiency and when it is expected to be completed.



Disputing a Plan of Correction

The finding of a monitoring review that result in a POC may be disputed informally or formally, however, even if there is a dispute in regards to a finding the timeframes for submission of the POC do not cease and the POC must be submitted within the required timeframe.

An informal dispute may be made to the QM Monitoring Manager and an informal meeting to discuss the issues in question will be scheduled.

Formal disputes must follow the Provider Dispute process:

<https://providers.partnersbhm.org/provider-disputes/>



12/12/2018 91

Maintain Quality

Quality Service Delivery Requires:

Year-round,
Agency-wide,
Self-Monitoring
Against well understood
Rules
Regulations
Clinical Coverage Policies
and
Other Guidelines



Questions?

Feel free to contact me if you have any questions or need clarification in regards to the Plan of Correction or Plan of Action process.

Larry F Holcombe
QM Monitoring Manager
704-884-2528

lholcombe@partnersbhm.org



12/12/2018 93



Referral Screening Verification Process (RSVP)

Tammy Godfrey
TCL Supervisor



12/12/2018



Transition to Community Living **RSVP**

TCLI-RSVP

What does RSVP stand for?

- ▶ **R**eferral
- ▶ **S**creening
- ▶ **V**erification
- ▶ **P**rocess



What is the purpose of RSVP?

- ▶ The Department of Health and Human Services (DHHS) is implementing RSVP for individuals being considered for admission to adult care homes effective November 1st, 2018.
- ▶ RSVP will replace the PASRR for adult care homes and provide a more streamlined and effective process to screen Transitions to Community Living Initiative (TCLI) target populations.



12/12/2018 97

Referral Submissions

Who should and should not be referred?

- ▶ **Who should be referred:**
 - Regardless of diagnosis, ALL Medicaid eligible individuals who are being considered for admission to an adult care home under G.S. 131 D-2,4, with the exception of group homes will require the RSVP.
 - All Medicaid eligible individuals requesting Personal Care Services (PCS). Beneficiaries will NOT be assessed for the PCS without a **Referral Screening ID #**



12/12/2018 98

Referral Submissions

Who should not be referred:

- Individuals who have had a previous PASRR prior to 11/1/2018 for an ACH and enter a medical or psychiatric hospital, and acute rehabilitation facility, or a long term acute care hospital for medical or psychiatric treatment and who return to an ACH. These individuals do not need an additional Referral Screening through RSVP unless there has been a significant change in psychiatric or medical status (for those with SMI/SPMI).
- Individuals who request a transfer from one ACH to another, that have a PASRR prior to 11/1/2018, can transfer if they are medically and psychiatrically stable.



12/12/2018 99

Who can make a referral?

ANYONE can submit a referral using RSVP

(i.e. individual consumers, guardians, family, advocates, providers, hospital, LME/MCO staff)

If an individual has a guardian that is considered “guardian of the person or general guardian” but not “guardian of the estate,” that guardian **MUST** give consent **BEFORE** making the referral.



12/12/2018 100

How to Submit a Referral

Option #1: URL (<https://www.socialserve.com/nc/rsvp>)

***Not accessible until 11/1/18**

Option #2: Paper version (Input form)

<https://files.nc.gov/ncdhhs/documents/tcli/RSVP-input-form.pdf>

You will not need to purchase or install software to access RSVP. It is web based and only requires access to the internet to complete the online referral. The link to submit referrals is public.

The DHHS website is a resource for additional information.

<https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living-initiative>



12/12/2018

10
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Paper referrals and additional information about RSVP submittals

Paper Referrals should be submitted to:

DMH/DD/SAS

Attention: Mental Health Section – RSVP

FAX: 919-508-0953

OR

Mailing Address:

3001 Mail Service Center

Raleigh, NC 27699-3001

For RSVP questions and technical assistance, please contact:

RSVP.referral@dhhs.nc.gov



12/12/2018

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What information is needed for the referral form?

- Referrer role and contact information
- Guardian information
- Consumer information to include: DOB, Contact numbers, location type and address, Medicaid number.
- Reason for referral (MH, SA, IDD, TBI, Medical, PCS)
- Mental Health Diagnosis
- Medicaid eligibility information
- Medicaid county or county of residence
- Space for a narrative, or additional information about assessment dates, medications, etc.



12/12/2018

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What happens after the form is submitted?

- Once submitted the referrer will see a referral submission page that contains a Referral ID#.
- The referrer will be able to save or print the referral submission.
- Once the MCO receives the referral, the RSVP team will gather additional information that includes medical, behavioral health, and financial assessments. RSVP will link consumers for CCA's or other assessments as needed to make a determination of eligibility for TCLI. The RSVP team will communicate with the referrer, the individual and/or guardian, and providers. This process occurs within a given timeframe of 30-60 days.



12/12/2018

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What happens after determination of eligibility?

- ▶ If the consumer meets eligibility for TCLI and makes an informed decision to live in the community, the RSVP team will refer the consumer for the normal TCLI process.
- ▶ If the consumer meets criteria for TCLI, but does not want to live in the community, they will be assigned to In-Reach.
- ▶ If the consumer does not meet criteria, the RSVP team will educate on additional resources or refer to care coordination if appropriate.



12/12/2018

10
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About the RSVP team

- ▶ The RSVP team consists of a Referral Nurse Coordinator, a Referral Coordinator, and Referral specialists. The team will cover all 8 counties within the Partners catchment area. Consumers will not be assigned to RSVP team members through Alpha, as this is only a screening process.
- ▶ If you have any questions please contact:
Jeffrey Sanders MHSU TCLI Program Manager
jsanders@partnersbhm.org Office 704-772-4281

Tammy Godfrey TCLI Supervisor
tgodfrey@partnersbhm.org Cell 980-925-1466



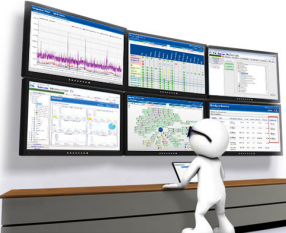
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Performance Monitoring



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10
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Provider Performance Reporting



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Strategic Planning Goal: Improve Provider Performance

PERFORMANCE SCORING METHODOLOGY



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What will determine the composite score?

- The composite performance score will factor in performance in the 4 weighted performance categories on a 0-100 point scale
(Quality+Resource Use+Clinical Practice+Promoting Interoperability=)



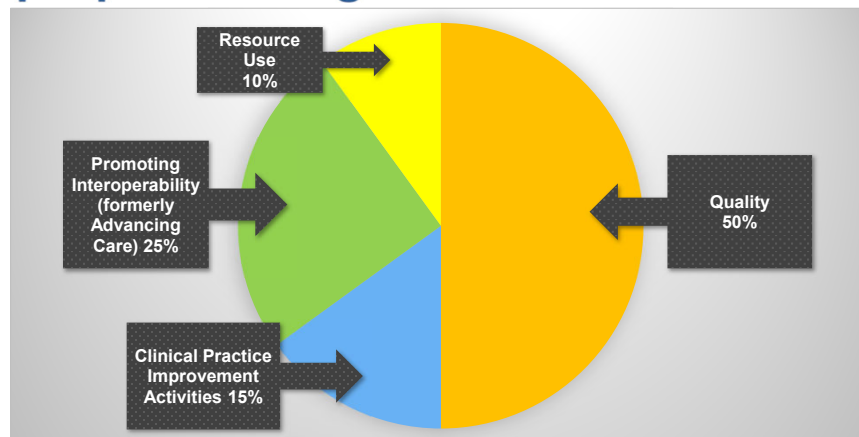
Performance Score



12/12/2018

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Year 1: Performance categories and proposed weights



12/12/2018

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Performance Category Scoring

Performance Category	Maximum Points Possible	Percentage of Overall Score
Quality: category consists of 9 performance measures (5.55 points each)	50 points	50%
Promoting Interoperability (Advancing Care): category consists of 3 performance measures (8.33 points each)	25 points	25%
Clinical Practice Improvement: category consists of 5 performance measures (3.00 points each)	15 points	15%
Resource Use: category consists of 3 performance measure (3.33 points each)	10 points	10%



12/12/2018

11
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Performance Score Reporting

- Providers to receive their performance score with an opportunity for input
- Upon a 30 day review of the performance score, Partners will publish provider performance
- If corrective measures are taken after the APR has been completed, scores will be updated (monthly updates only)



12/12/2018

11
4

Performance Measure Scoring

Measure Met = 1 Point

Measure Not Met= 0 Points

Measure N/A = 1 Point



12/12/2018

11
5

Quality Performance Measures (50%)

Quality # 1

- ▶ Sanctions/POC: Partners has issued 2 or more consecutive Plans of Correction against the Network Provider for the same or substantially similar findings within the 3 year credentialing cycle and/or re-credentialing cycle

Quality # 2

- ▶ Sanctions/POC: The Network Provider has failed to implement a Plan of Correction Issued by Partners and the time for so has expired



12/12/2018

11
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Quality Performance Measures (50%)

Quality # 3

- Sanctions: Partners has issued 2 or more sanctions or administrative actions against the network provider in a consecutive period of time

Quality # 4

- Sanctions: The Network Provider has failed to remit an identified overpayment to or enter into an approved payment plan with Partners within the designated time frame



12/12/2018

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Quality Performance Measures (50%)

Quality # 5

- Quality of Care: Partners BHM has logged quality of care concerns or other serious grievances about the network provider that have NOT been satisfied in requirement timelines.

Quality # 6

- Monitoring: If Provider Overall Score 85% and above, then measure is met



12/12/2018

11
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Quality Performance Measures (50%)

Quality # 7

- ▶ Provider provides a service that requires a fidelity review and is in compliance with fidelity score

Quality # 8

- ▶ If the provider has a performance measure regarding ambulatory follow up in their contract and they are meeting the standard as indicated in their contract, then measure is met

Quality # 9

- ▶ Provider maintains PBHM accreditation standard, if required



12/12/2018

11
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Promoting Interoperability Performance Measures (25%)

Promoting Interoperability # 1

- ▶ If Provider has established connectivity to NC HealthConnex, then measure is met

Promoting Interoperability # 2

- ▶ If Provider is submitting information to the NC-SNAP database, then measure is met

Promoting Interoperability # 3

- ▶ If Provider is submitting information to the Rapid Resource for Families database, then measure is met



12/12/2018

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Clinical Practice Improvement (15%)

Clinical Practice Improvement # 1

- ▶ If NCTOPPS initial interview submissions are in compliance with timely submission requirements (70% or higher), measure is met

Clinical Practice Improvement # 2

- ▶ If NCTOPPS episode completion reason (completed treatment) score is in compliance (25% or higher), measure is met



12/12/2018

12
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Clinical Practice Improvement (15%)

Clinical Practice Improvement # 3

- ▶ If NCTOPPS in-person & telephonic episode completion interview submissions are in compliance with timely submission requirements (65% or higher), then measure is met

Clinical Practice Improvement # 4

- ▶ If Provider is participating in the ACORN tool, then measure is met



12/12/2018

12
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Clinical Practice Improvement (15%)

Clinical Practice Improvement # 5

- ▶ If Provider has implemented a patient-centered behavioral health model, then measure is met



12/12/2018

12
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Resource Use (10%)

Resource Use # 1

- ▶ If Provider has met the PBHM standard (80%) for overall claims approval rate (State funds), then measure is met

Resource Use # 2

- ▶ If Provider has met the PBHM standard (80%) for overall claims approval rate (Medicaid B funds), then measure is met

Resource Use # 3

- ▶ If Provider has met the PBHM standard (80%) for overall claims approval rate (Medicaid B funds), then measure is met



12/12/2018

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Provider Performance Reporting

- ▶ Questions?
- ▶ Comments?
- ▶ Suggestions?

questions@partnersbhm.org



12/12/2018 12
5



Credentialing Update

Credentialing Potpourri

- ▶ Personnel Change
- ▶ CAQH
- ▶ Re-credentialing/Contract Notices/Application Deadlines
- ▶ Credentialing vs. Enrollment
- ▶ National Plan and Provider Enumeration System (NPPES)/NC Tracks/Alpha
- ▶ Fair Credit Reporting Act (FCRA) release for background checks



12/12/2018

12
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Personnel Change

- ▶ Fielding Yelverton's last day at Partners will be 1/4/19
- ▶ The position is posted, and a replacement will be named in due course.
- ▶ It was an honor to work with all Partners' providers over the past few years. I wish you all the best!



12/12/2018

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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.



12/12/2018

12
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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.



12/12/2018

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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 (10) 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.**



12/12/2018

13
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Credentialing vs. Enrollment

- ▶ Credentialing and enrollment are two different processes within Partners
- ▶ Partners enrollment is separate from NC Tracks enrollment
- ▶ Application for enrollment with NC Tracks should be completed first (for providers who are new to Partners)
- ▶ While this application is being processed, the provider should apply for credentialing with Partners.
- ▶ The **credentialing** application process with **Partners CAN** be completed while enrollment with **NC Tracks** is still **pending**.
- ▶ **Enrollment** (in Alpha) with **Partners CANNOT** be completed until enrollment with **NC Tracks** is **completed**



12/12/2018

13
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Credentialing vs. Enrollment (cont)

- ▶ In sum:
 - A provider CAN be **credentialed** with Partners BEFORE being **enrolled** with NC Tracks OR Partners
 - A provider CANNOT be **enrolled** with Partners before being BOTH **enrolled** in NC Tracks AND **credentialed** with Partners
- ▶ Recommendation: There is a PowerPoint presentation on Partners' Provider website that addresses the differences between credentialing and enrollment in depth.



12/12/2018

13
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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



12/12/2018

13
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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



12/12/2018

13
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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



12/12/2018

13
6

Questions?

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



12/12/2018 13
7



Provider Council has an update...



Provider Council

Julie Walker, Chair

Provider Council Updates

The Provider Council meets the 4th Friday of every month at PBHM Hickory, NC location from 9:30am to 12pm. (Telephone Conference call to participate with this Council meeting too is available) PBHM staff join this meeting at 10:30am to provide updates to the Provider Council Network as well as are available to answer questions that the Provider Council may have.

Next meeting date will be January 25th, 2019 (No December meeting scheduled)

Current topics/updates of review:

Continued Committee updates:

- EHR & HIE Connection
- Quality Improvement Plan
- Clinical Advisory
- Credentialing Committee
- Global CQI



Provider Council Updates

The Council has voted to develop a committee of interested Providers to review the new Peer Support Service Definition Proposal and prepare a collective response to the State about the concerns of this proposal if implemented. (If you are interested in serving on this committee—please contact Beth Brown at beth.brown@phoenixcc.us)



12/12/2018

14
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Provider Council Updates

Update of CEO Roundtable as PBHM continues to help the Provider Network prepare for the 1115 Waiver changes and moving toward Valued Based Contracts

New Provider Council Leadership Elects for 2019:

Chair: Tim Lentz –CVBH

Co-Chair : Beth Brown-Phoenix

Secretary: Alicia Emmons—Developmental Disabilities Resources, Inc.

THANK YOU for your commitment to service within PBHM's Provider Council leadership and Congratulations!

Wishing All a Wonderful Holiday Season!!!



12/12/2018

14
2



**And now Access to Care
has some info to share....**

12/12/2018¹⁴₃



**Partners Access to Care
And how
we can be of service
To you**

- ▶ The Access to Care department is available to callers on a 24/7/365 basis
 - We can link your clients to you when they are experiencing an emergency
 - We can refer clients to you with or without slots in the scheduler
 - We can refer insurance enrollees to you
 - If you have a special service (ie sex offenders, IDD services, Trauma based services, CBI etc) we can refer callers for those as well. MC3
 - You MC1 are welcome to present at our staff meeting to highlight your services.



- ▶ We offer support to the hospitals on a 24/7/365 basis as well.
 - MR/IDD diversions
 - Waiting list status
 - Available bed status across our region
 - Discharges appointments 24/7



Slide 145

MC1 **service**
Melissa Cline, 11/28/2018

MC3 **callers**
Melissa Cline, 11/28/2018

▶ Timely follow-up for hospital discharge appointments

- Access to care staff are committed to give callers appointments within 7 days of hospital discharge for both mental health and substance use appointments.
- For assistance call 1 888 235-4673



▶ Providers have the ability to enter slots into the scheduler.

- You can enter evening and weekend slots if you offer those.
- Slots can be entered for Medicaid and IPRS funding
- Slots can be entered for specialty services
- Talk to your provider specialist about training to use the slot scheduler
- Being accurate with the information assists in tracking services needs across the Partners region.
- Keeping appointments up to date, helps clients and A2C with timely referrals



► For Urgent appts.....

- A2C will do your reminder calls the day before service
- A2C will attempt to contact those whom we have scheduled for follow up if they do not come to their scheduled appointment.
- You can see view follow-up notes in the Alpha system.....



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**And last but not least, it's
Quality Management....**



Tamikka Woods Quality Management Updates

National Core Indicator (NCI)

What is this...?

- ▶ The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. [Employment, Rights, Service Planning, Community Inclusion, Choice, and Health and Safety]
- ▶ A collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI).
- ▶ **Purpose:** support member agencies to gather a standard set of performance and outcomes measures that can be used to track performance over time, to compare results across states, and to establish national benchmarks.



12/12/2018

15

2



National Core Indicators

- ▶ Uniquely valuable source of information about individuals with developmental disabilities receiving services across a large sample of states.
- ▶ Database includes randomly-selected representative samples by state
 - 39 states are expected to participate this year
- ▶ Efforts to analyze the multi-state datasets have been supported by (CMS) Center for Medicare and Medicaid Services, (AIDD) Administration on Intellectual and Developmental Disabilities, and (NIDRR) National Institute on Disability and Rehabilitation Services.
 - Results of these analyses have been published in both national and international peer-reviewed journals and presented at research conferences around the world.



12/12/2018

15
3

Adult Survey Outcomes

Key Strengths	Opportunities
Individuals able to go out and do activities he/she wants to do (Community Inclusion)	Individuals have choice or input on where he/she goes during the day (Choice-Decision Making)
Individual likes where he/she lives (Satisfaction)	Individual has a paid community-based job (Work/Daytime Activities)
Individual likes community-base job (Satisfaction)	Individual volunteers in the community (Work/Daytime Activities)
Services/supports help individual live a good life (Satisfaction)	Individual uses self-directed supports (Self-Determination)
Service planning meeting included people individual wanted involved (Service Coordination)	Individuals had an eye exam in the past year (Health)
Staff come and go when they are supposed to (Service Coordination)	Individuals had a hearing test within the past five (5) years (Health)
Individual has a primary Care Physician (Health)	Individuals has a Pap test screening within the past (3) years (Health)
Individual has privacy at home (Respect and Rights)	Individual had a mammogram within the past two (2) year (Health)



12/12/2018

15
4

Family Survey Outcomes

Key Strengths	Opportunities
Individual able to go out and do activities he/she want to do (Community Inclusion)	Individuals has choice or input on where he/she goes during the day (Choice and Decision-Making)
Individual likes where he/she lives (Satisfaction)	Individual had a paid community-based job (Work/Daytime Activities)
Individual likes community-based job (Satisfaction)	Individual volunteers in the community (Work/Daytime Activities)
Services/supports help individual life a good life (Satisfaction)	Individual uses self-directed supports (Self-Determination)
Service planning meeting included people individual wanted involved (Service Coordination)	Individual had an eye exam in the past year (Health)
Staff come and go when they are supposed to (Service Coordination)	Individual had a hearing test within the past five (5) years (Health)
Individual has a Primary Care Physician (Health)	Individual has a Pap test screening within the past three (3) years (Health)
Individuals has privacy at home (Respect and Rights)	Individual had a mammogram within the past two (2) years (Health)
Individual has someone to talk to if he/she is afraid (Safety)	



12/12/2018

15
5

NC-TOPPS Updates

- ▶ **NC-TOPPS Treatment Engagement:** A decrease of members receiving Adult Substance Use services who reported engagement as a barrier to treatment
 - (Oct) 15.5%
 - Target Goal: 10.5%
- ▶ **NC-TOPPS Initial Interviews Completed On Time**
 - (Jun) 71.7%
 - Target Goal: 80%
 - *Was just increased after meeting target goal of 70% since Jan. 2018*
- ▶ **NC-TOPPS Symptom Improvement MH/SU:** Consumer treatment was “very helpful” with improving their symptoms
 - (Oct) 53%
 - Target goal: 55%
- ▶ **NC-TOPPS Episode Completion Reason-Completed Treatment**
 - (Aug) 21.7%
 - Target Goal: 25%



12/12/2018

15
6

Contact Information

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12/12/2018

15
7

Wrapping things up...



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12/12/2018

15
8