



PARTNERS

Improving Lives.
Strengthening Communities.

QUALITY MANAGEMENT PROGRAM ANNUAL EVALUATION

Partners Behavioral Health Management

901 S. New Hope Road, Gastonia, North Carolina 28054

State Fiscal Year (SFY) 2019
(July 2018-June 2019)

QM Director Review Date:	8/20/19
Chief Medical Officer/QIC Approval Date:	9/3/19
Board Review Date:	10/17/19
Regulatory References:	URAC Core v. 3.0 Standard 20(i); DHB Contract Section 7.1.2; DMH Contract Section 15; NCQA QI 1.B

I. INTRODUCTION

Partners Behavioral Health Management (Partners) oversees and manages member-centered local services for behavioral issues or illness, intellectual and developmental disabilities, and substance use.

The objective of the QM Program is to systematically use performance information and data to drive improved member outcomes, training and support. The functional structure of the program not only guides and supports business decisions but creates a system of continual integrity and readiness for external review agents such as the Department of Health and Human Services (DHHS), Intra-departmental Monitoring Team (IMT), External Quality Review (EQR), national accrediting bodies and other agents.

This annual report presents an evaluative summary of the QM Program activities accomplished, discovered, mediated, or improved during the State fiscal year (SFY) of 2019 (July 1, 2018-June 30, 2019).

II. Overview

The Quality Management Program of Partners BHM is designed to ensure that Partners' core functions delivered in a manner consistent with the State Plan, the Division of Mental Health/Intellectual Developmental Disabilities/Substance Use Services (DMH) and Division of Health Benefits (DHB), formerly the Division of Medical Assistance (DMA), contracts, national accreditation standards, and Partners' mission, philosophy, values and working principles. As the LME/MCO, Partners BHM oversees and manages member-centered local services for behavioral issues or illness, intellectual and developmental disabilities, and substance use. These services include, but may not be limited to, Member Services with a 24/7/365 Access to Care call center, Provider Network, Care Coordination, and Utilization Management Services.

Table 1a. Medicaid Population for Partners' Catchment Area

	SFY 2019
Unduplicated Count of Medicaid Members in Catchment Area	146,677
% Members Receiving MH Services	7.3%
% Receiving SU Services	1.1%
% Members Receiving IDD Services	1.7%

**Data from LME/MCO Monthly Monitoring Report*

Table 1b. Uninsured Population for Partners' Catchment Area

	SFY 2019
Estimated Number of Uninsured in Catchment Area	93,680
% Uninsured Receiving MH Services	2.1%
% Uninsured Receiving SU Services	1.4%
% Uninsured Receiving IDD Services	0.5%

**Data from LME/MCO Monthly Monitoring Report*

A. PROGRAM STRUCTURE

The overarching function of the Quality Management Program is to ensure the following objectives:

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

The ultimate authority for the QM Program is Partners' Board of Directors. The Board of Directors delegates this authority to the Quality Improvement Committee (QIC) through the Chief Executive Officer (CEO), and the CEO assigns clinical oversight to the Chief Medical Officer (CMO), who is a board-certified M.D.

QIC Structure

The QIC is responsible for guiding the QM Program, including the annual review and approval of *the QM Program Plan and Program Description* and the *Annual QM Program Evaluation*. The Board is kept up-to-date on quality improvement initiatives, at least annually, through reported updates and Board review of the *Annual Quality Management (QM) Program Evaluation*.

The QIC Membership is composed of a cross-functional team of representatives from various units within Partners, the Provider community, and the Consumer and Family Advisory Committee (CFAC). All members are voting members unless identified as non-voting or designee.

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

The QIC sub-committees include:

- Quality of Care Committee (QOCC)- *Also Reports to NMC Committee*
- Network Management Committee (NMC)- *Also Reports to Credentialing Committee*
- Credentialing Committee (CC)- *Includes Provider Representation*
- Regulatory Compliance Committee (RCC)
- Clinical Advisory Committee (CAC)- *Includes CFAC and Provider Representation*
- Utilization Management/Utilization Review Committee (UMUR)- *Includes Provider Representation*
- Quality Improvement Projects (QIP) Committee
- Network Development Cross Function Team (Reports to NMC)- *Includes CFAC Representation*

Each of these committees report their activities to QIC at least quarterly so that feedback and input is possible.

Quality Management Staff

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

Key QM Personnel Include:

- **Quality Assurance and Quality Improvement Teams:** The Quality Improvement and Quality Assurance Teams are responsible for quality improvement projects, facilitation and analysis of applicable satisfaction surveys, internal monitoring of accreditation standards, and various other tasks.
- **QM Monitoring Team:** The QM Monitoring Team includes Consumer Rights Officers and QM Monitoring Specialists. The Consumer Rights Officers monitor incident reports, sentinel events, and safety issues which may arise in the provision of care. QM Monitoring Specialists conduct routine provider monitoring that may include customer service issues such as quality of practitioner office space and other identified areas including, but not limited to, “for cause” audits and other audits as requested or required for services delivered in the Provider Network.
- **QM Data Team:** The QM Data Team is responsible for data analysis and data management, which includes measuring outlined performance indicators in the core functional areas to assure compliance with DMH and DHB contract requirements, as well as accreditation standards. The data unit generates reports, analyzes data, and identifies significant trends and patterns for various internal quality measures. When applicable, data reports are submitted to the Executive Leadership Team (ELT), Cross Functional Teams, and/or the QIC. Organizational decisions and recommendations are made by these groups based on the data provided.
- **Chief Medical Officer:** The Chief Medical Officer (CMO) is the senior clinical staff person responsible for providing guidance to the clinical operational aspects of Partners BHM and to provide oversight to all QIC activities. This individual is responsible for the oversight of the clinical decision-making aspects of the program and has periodic consultation with practitioners in the field. The CMO is also responsible for ensuring the organization utilizes qualified clinicians who are accountable to the organization for decisions affecting members. He/she provides regular supervision and clinical support to clinical departments of Partners BHM. The CMO oversees peer review activities as well as provides quality review and quality assurance oversight for Partners BHM clinical actions.

Table 2. QM Department Staff

Position	Credentials/#
Chief Medical Officer	1 (MD)
Chief Performance & Compliance Officer	1 (MHA)
QM Director	1(LPC)
Assistant QM Director	1 (BS)
QM Manager	1 (MBA)
External Review Coordinator (PRN)	1 (MS)
QM Analyst	2(BS) 2 (AAS)
Grants Monitoring Specialist	1 (LPC)
QM Data Manager	1 (BA)
QM Data Analysts	2 (BA)
QM Processing Assistant	1 (AAS)
QM Monitoring Manager	1 (CCS, CSAC)
QM Monitoring Specialists	1 (BA) 3 (BS) 1 (LCSWA) 1 (LMFT)
Consumer Rights Officers	1 (LCSW) 1 (LCSW, LCAS)

**Data from Partners Organizational Chart*

QM Program Activities

Quality Improvement Projects (QIP):

Partners is contractually required to develop and maintain Quality Improvement Projects (QIPs). These are developed and prioritized to meet the clinical and non-clinical project requirements in the DHB contract, along with current accreditation standards. Each QIP is carried out under the guidance and oversight of the MCO Chief Medical Officer (CMO).

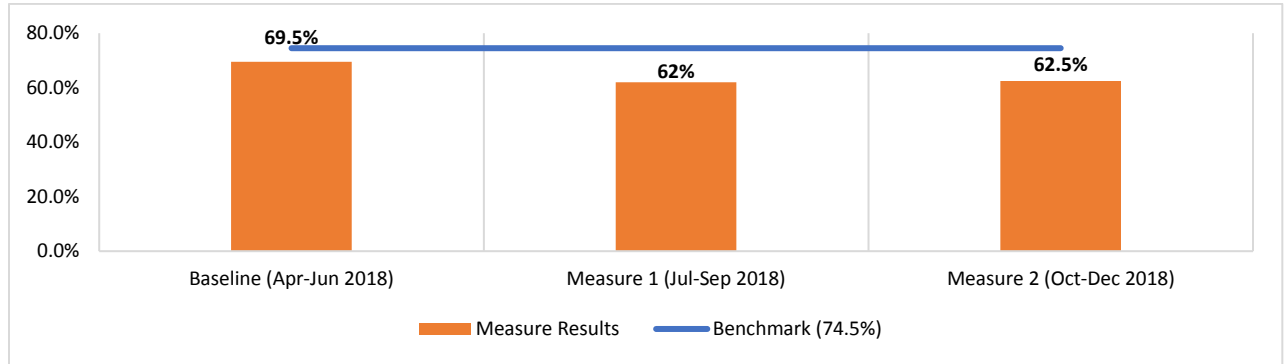
Table 3a. Engagement in Opioid Treatment Services QIP

QIP#: QIP005		QIP Name: Increase Opioid-Initiated Engagement of Members with Opioid Use Disorders in Services within 1-34 Days after an Assessment/Evaluation is Completed	
Category: Clinical		URAC Applicability: HCC, HNM, HUM	Safety QIP: Yes
DMH/DHB Approval: N/A		QIP Committee Approval: 1/15/19	QIC Approval Date: 2/5/19
Data Source(s): Claims Data/ Data Cubes			
Goal(s)/Target End Date:			
1) 74.5% of Non-Medicaid Individuals with opioid abuse/dependence diagnosis who initiated treatment by evaluation/assessment who had 2 or more additional services (excluding crisis services) within 1-34 days after the initial assessment or evaluation. (Target End Date: June 2020)			
2) 71.2% of Medicaid Individuals with opioid abuse/dependence diagnosis who initiated treatment by evaluation/assessment who had 2 or more additional services (excluding crisis services) within 1-34 days after the initial assessment or evaluation. (Target End Date: June 2020)			

**Data from Quality Improvement Project (QIP) Tracking Sheet*

**Data from Partners BHM Quality Improvement Project (QIP) Form*

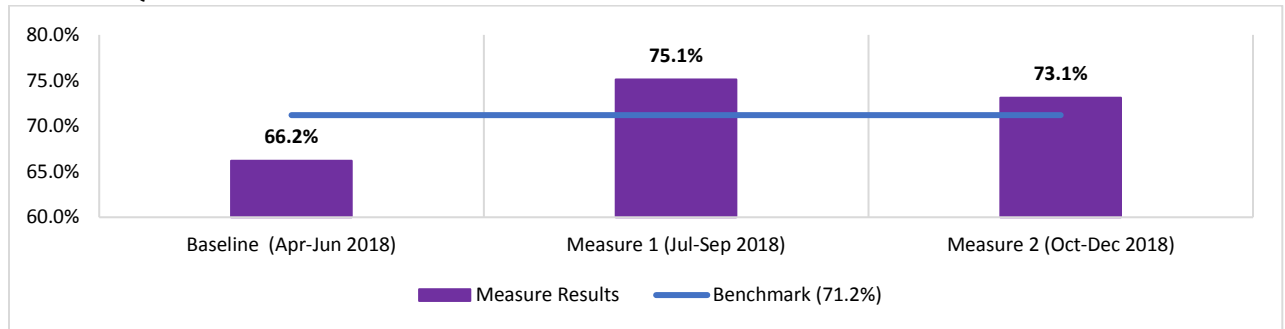
Table 3b. QIP005 Measurement Results for SFY 2019- Goal 1



**Data from Partners BHM Quality Improvement Project (QIP) Form*

**Data from Partners BHM Quality Improvement Projects at a Glance*

Table 3c. QIP005 Measurement Results for SFY 2019- Goal 2



**Data from Partners BHM Quality Improvement Project (QIP) Form*

**Data from Partners BHM Quality Improvement Projects at a Glance*

Status/Evaluation:

- This is a revised QIP regarding engagement in opioid treatment. It was approved by the QIP committee January 2019 and by QIC February 2019.
- Goal 1: Measure 1 was below the target goal of 74.5% by 12.5 points and Measure 2 was below the target goal by 12 points.
- Goal 2: The first two measures exceeded the target goal of 71.2% by 3.9 (Measure 1) and 1.9 (Measure 2) points.

Identified Issue(s)/Barrier(s):

- Substance Use Disorder (SUD) providers are not utilizing evidenced based practice (EBP) for treating opioid use disorder.
- Lack of awareness in the community of available resources.
- Lack of transportation to and from appointments.
- Lack of childcare.
- Lack of collaboration among MCO, OTP providers and enhanced SUD service providers.
- Lack of access to safe transitional housing in the communities.
- Lack of opportunities for employment.

Intervention(s):

- Partners has embedded Peer Support Specialists with the opioid treatment providers to help with engagement.
- Educate providers on Partners' housing initiatives with Exodus Homes and Oxford Houses.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

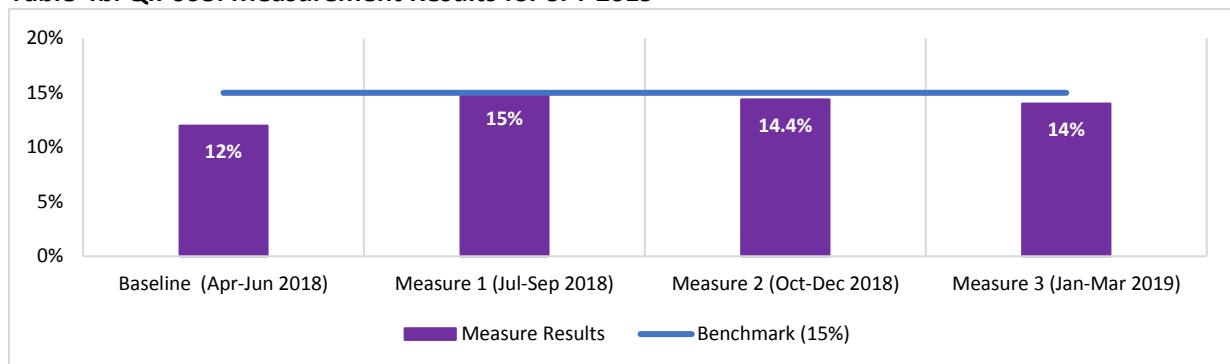
Table 4a. Primary Care Physician Referrals to Behavioral Health QIP

QIP#: QIP008		QIP Name: Physical Health /Primary Care Physician (PCP) Referral to Behavioral Health	
Category: Non-Clinical		URAC Applicability: HCC, HNM	Safety QIP: No
DHB/DMH Approval: August 2016		QIP Committee Approval: July 2016	QIC Approval Date: August 2016
Data Source(s): Access to Care Report in Partners’ Reports Manager			
Goal(s)/Target End Date:			
1) Maintain 15% referral rate from PCP and CCNC for Medicaid only. (Target End Date: June 2019)			

**Data from Quality Improvement Project (QIP) Tracking Sheet*

**Data from Partners BHM Quality Improvement Project (QIP) Form*

Table 4b. QIP008: Measurement Results for SFY 2019



**Data from Partners BHM Quality Improvement Project (QIP) Form*

**Data from Partners BHM Quality Improvement Projects at a Glance*

Status/Evaluation:

- Partners met the goal during Measure 1, but percentage dropped by 0.6 points for Measure 2 and by 0.4 points for Measure 3.
- Prior to the beginning of SFY 2019, it was decided to revise the goal to focus only on Medicaid members. The results above reflect the measurement period after goal revision.

Identified Issue(s)/Barrier(s):

- Primary Care Physician/Office Managers lack awareness of available behavioral health resources to refer individuals when behavioral symptoms are identified.

Intervention(s):

- PCP education during Partners' events.
- One-on-one meetings with office managers.

- Provider informational material to medical offices regarding crisis services and how to contact Partners for appointments.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

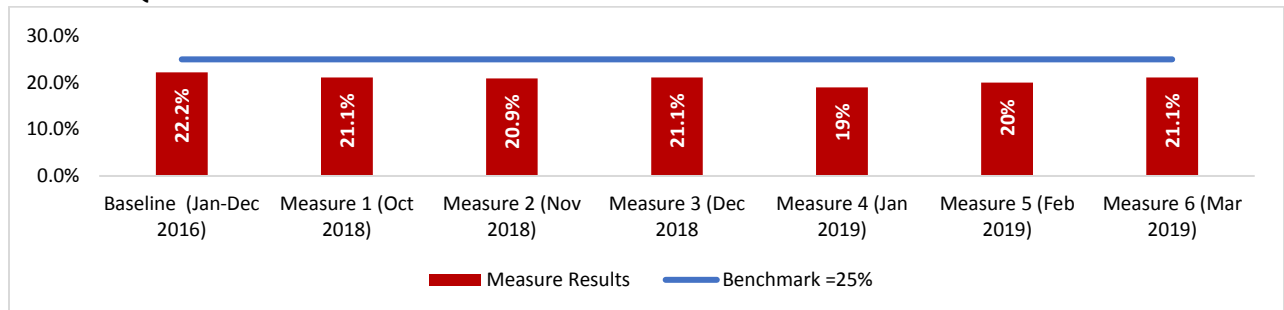
Table 5a. NC-TOPPS Episode Completion QIP

QIP#: QIP0010	QIP Name: Increase the Percentage of Members Completing an Episode of Treatment.	
Category: Non-Clinical	URAC Applicability: HNM	Safety QIP: No
DHB/DMH Approval: N/A	QIP Committee Approval: March 2017	QIC Approval Date: April 2017
Data Source(s): NC-TOPPS raw data		
Goal(s)/Target End Date:		
1) Increase in the Episode Completion reason, in the NC-TOPPS database, as “Completed Treatment” to 25%. (End Date” June 2019)		

**Data from Quality Improvement Project (QIP) Tracking Sheet*

**Data from Partners BHM Quality Improvement Project (QIP) Form*

Table 5b. QIP0010: Measurement Results for SFY 2019



**Data from Partners BHM Quality Improvement Project (QIP) Form*

**Data from Partners BHM Quality Improvement Projects at a Glance*

Status/Evaluation:

- Partners did not meet the target goal of 25% during SFY 2019.
- The measurement percentages averaged 20.5% for the six measures completed during SFY 2019.
- The January 2019 measure of 19% was the lowest measure of SFY 2019.

Identified Issue(s)/Barrier(s):

- Lack of communication about NC-TOPPS status between a member’s previous provider and new provider. There are a few providers that are not completing transfer requests when they receive a new member. This is causing the previous provider to complete an Episode of Completion via chart review.
- Member engagement in services may be impacted by social determinants not identified and addressed at the start of services.

Intervention(s):

- Recorded and posted the NC-TOPPS 101 and Superuser Training on the Partners NC-TOPPS Webpage.
- A tracking sheet was created to track providers that contact the Quality Improvement Team to notify the Team that a member is still showing up on a provider “Updates Needed” list.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

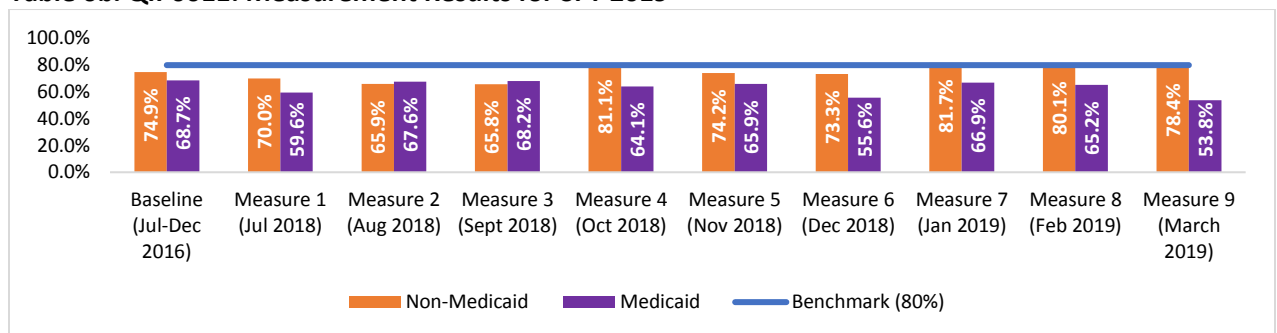
Table 6a. Initial NC-TOPPS Interviews QIP

QIP#: QIP0011	QIP Name: Increase Initial NC-TOPPS interviews	
Category: Non-Clinical	URAC Applicability: HNM	Safety QIP: No
DHB Approval: N/A	QIP Committee Approval: March 2017	QIC Approval Date: April 2017
Data Source(s): Claims/encounter data and NC-TOPPS Initial Interview search		
Goal(s)/Target End Date:		
1) 80% of the members with a claim requiring an initial NC-TOPPS interview show data in the NC-TOPPS system. (End Date: July 2019)		

**Data from Quality Improvement Project (QIP) Tracking Sheet*

**Data from Partners BHM Quality Improvement Project (QIP) Form*

Table 6b. QIP0011: Measurement Results for SFY 2019



**Data from Partners BHM Quality Improvement Project (QIP) Form*

**Data from Partners BHM Quality Improvement Projects at a Glance*

Status/Evaluation:

- Partners met or exceeded the 80% benchmark for the following measure months and funding source for SFY 2019:
 - October 2018 (Non-Medicaid)
 - January 2019 (Non-Medicaid)
 - February 2019 (Non-Medicaid)
- Partners did not meet the 80% benchmark for Medicaid funded services during SFY 2019.

Identified Issue(s)/Barrier(s):

- Providers are not able to attend the quarterly scheduled trainings.
- Some treatment services are started prior to authorization to prevent a gap in services. This causes a gap between the date the NC-TOPPS initial interview was submitted and the submitted claims date.

Intervention(s):

- Recorded and posted the *NC-TOPPS 101 and Superuser Training* on the Partners NC-TOPPS Webpage.
- Reconcile submitted claim with paid claims.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

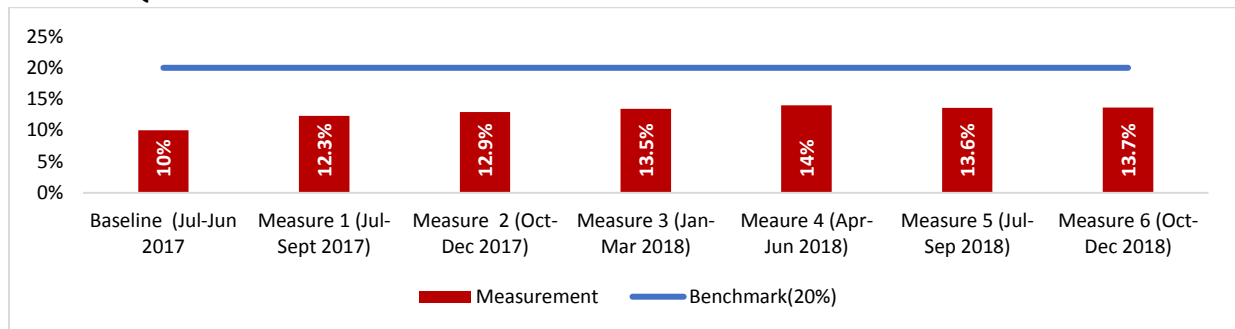
Table 7a. I/DDD Members Engaged in B3 Supported Employment QIP

QIP#: QIP0012	QIP Name: Increase Utilization Rate of B3 Supported Employment Services by IDD Population	
Category: Clinical	URAC Applicability: HUM	Safety QIP: No
DHB/DMF Approval: 6/30/17	QIP Committee Approval: April 2017	QIC Approval Date: May 2017
Data Source(s): Claims/encounter data		
Goal(s)/Target End Date:		
1) Maintain 20% of I/DD members engaged in B3 Supported Employment. (End Date: June 2019)		

**Data from Quality Improvement Project (QIP) Tracking Sheet*

**Data from Partners BHM Quality Improvement Project (QIP) Form*

Table 7b. QIP0012: Measurement Results for SFY 2019



**Data from Partners BHM Quality Improvement Project (QIP) Form*

**Data from Partners BHM Quality Improvement Projects at a Glance*

Status/Evaluation:

- Partners did not meet the benchmark for this goal during SFY 2019.
- The SFY 2019 average measurement percentage for this goal was 13.3%.

Identified Issue(s)/Barrier(s):

- Limited B3 funding
- Concerns about possible exploitation of IDD individuals with general employment in the community.
- Members and families express concerns about the possible negative impact of benefits if employed.

Intervention(s):

- Utilization Management (UM) has increased recommendations for eligible B3 supported employment individuals.
- Provided education to members, families, providers and stakeholders regarding service.
- UM will identify individuals in state funded supported employment that are Medicaid B eligible and provide care management to transfer B3 Supported Employment.
- A cross functional B3 Supported Employment workgroup has been established to address barriers in QIP.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

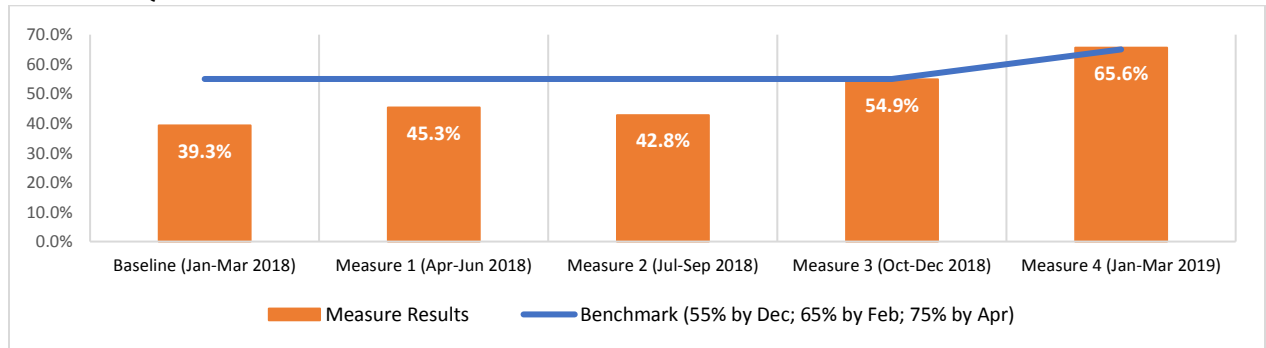
Table 8a. 7-Day Follow-up for Mental Health QIP

QIP#: QIP0014	QIP Name: Promoting Follow-up within One (1) to Seven (7) Days of Discharge from a Community Hospital, State Hospital and Facility-Based Crisis Service for Mental Health		
Category: Clinical	URAC Applicability: HCC, HNM, HUM	Safety QIP: Yes	
DHB/DMA Approval: July 2018	QIP Committee Approval: May 2018	QIC Approval Date: June 2018	
Data Source(s): Claims			
Goal(s)/Target End Date:			
1) Increase the percentage of <u>Non-Medicaid</u> Mental Health members with treatment follow-up within seven (7) days of Community Hospital, State Psychiatric Hospital, or Facility Based Crisis Service discharge incrementally from the 40% State benchmark to 55% by December 2018, 65% by February 2019 and 75% by April 2019. (End Date: June 2020)			
2) Increase the percentage of <u>Medicaid</u> Mental Health members with treatment follow-up within seven (7) days of Community Hospital, State Psychiatric Hospital, or Facility Based Crisis Service discharge incrementally from the 40% State benchmark to 55% by December 2018, 65% by February 2019 and 75% by April 2019. (End Date: June 2020)			

*Data from QIP Tracking Sheet

*Data from Partners BHM Quality Improvement Project (QIP) Form

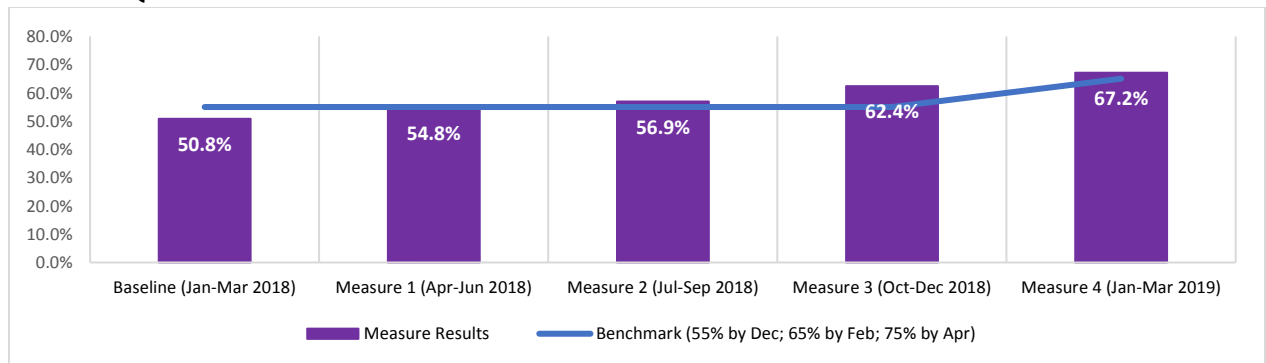
Table 8b. QIP0014: Goal 1 Measurement Results for SFY 2019



*Data from Partners BHM Quality Improvement Project (QIP) Form

*Data from Partners BHM Quality Improvement Projects at a Glance

Table 8c. QIP0014: Goal 2 Measurement Results for SFY 2019



*Data from Partners BHM Quality Improvement Project (QIP) Form

*Data from Partners BHM Quality Improvement Projects at a Glance

Status/Evaluation:

- An incremental goal increase was implemented by Partners 10/1/18 to reach 75% by April 2019.
- Partners met the 55% by December 2018 incremental measure benchmark for both goals for this QIP.
- As of the most recent measurement period (Jan 2019-March 2019), Partners had not reached 75% but appears to be on track to meet goal. Due to 90-day lag in paid claims, data for next measurement period (Apr 2019-June 2019) has not been reported at the time this report was being completed. *Measurement 5* data will be reported in the SFY 2020 evaluation.

Identified Issue(s)/Barrier(s):

- Limited availability of follow-up slots for timely (within 7 days) scheduling for hospital discharge appointments.
- Limited means of identifying and engaging discharged members so that potential for first appointment follow-up is increased.
- Gaps in coordinated care between hospital and community treatment
- Duplication of discharge planning (i.e. MCO Hospital Liaison vs. Hospital MSW).
- Delayed notification to the MCO regarding discharges prior to the date of discharge.
- Access to the correct member contact information to communicate with the member.

Intervention(s):

- Partners has implemented a process to partner providers with hospitals to facilitate follow-up within 7 days.
- Developed procedure where Care Coordination Staff and/or Peer Supports connect with member while inpatient they are inpatient to ensure ongoing communication.
- On-going meeting with providers to discuss barriers and processes for timely follow-up.
- A twice a month snapshot report was developed and shared with providers to show status of follow-up within 7 days.

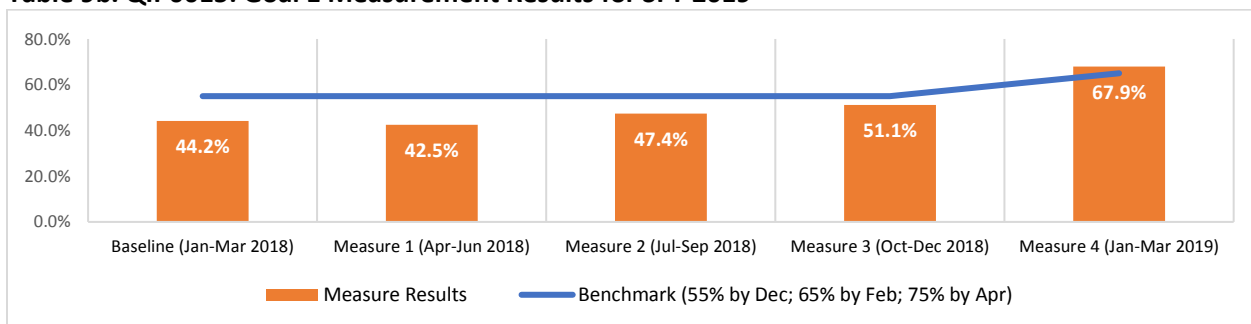
Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes**Table 9a. 7-Day Follow-up for Substance Use QIP**

QIP#: QIP0015	QIP Name: Promoting Follow-up within One (1) to Seven (7) Days of Discharge from a Community Hospital, State Hospital and Facility-Based Crisis Services for Substance Use Treatment.		
Category: Clinical	URAC Applicability: HCC, HNM, HUM	Safety QIP: Yes	
DHB/DMH Approval: July 2018	QIP Committee Approval: May 2018	QIC Approval Date: June 2018	
Data Source(s): Claims			
Goal(s)/Target End Date:			
1) Increase the percentage of <u>Non-Medicaid</u> Substance Use Disorder members with treatment follow-up within seven (7) days of Community Hospital, State Psychiatric Hospital, or Facility Based Crisis Service discharge incrementally from the 40% State benchmark to 55% by December 2018, 65% by February 2019 and 75% by April 2019. (End Date: June 2020)			
2) Increase the percentage of <u>Medicaid</u> Substance Use Disorder members with treatment follow-up within seven (7) days of Community Hospital, State Psychiatric Hospital, or Facility Based Crisis Service discharge incrementally from the 40% State benchmark to 55% by December 2018, 65% by February 2019 and 75% by April 2019. (End Date: June 2020)			

**Data from Quality Improvement Project (QIP) Tracking Sheet*

*Data from Partners BHM Quality Improvement Project (QIP) Form

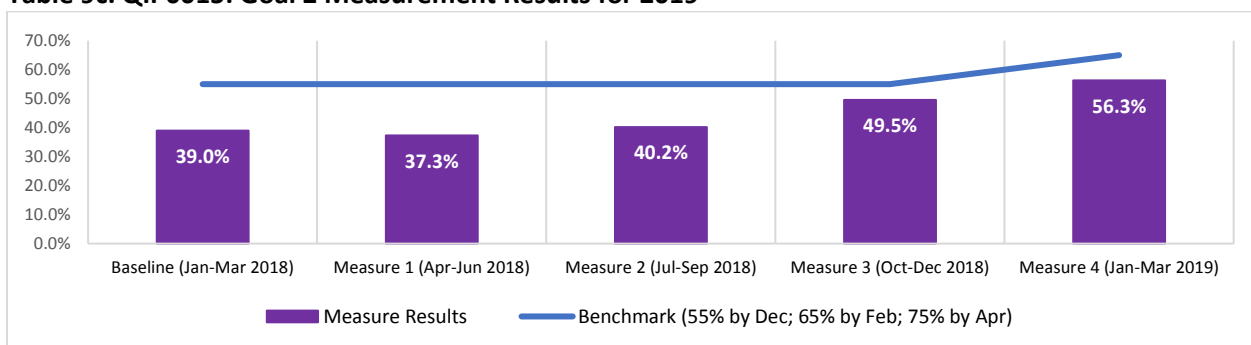
Table 9b. QIP0015: Goal 1 Measurement Results for SFY 2019



*Data from Partners BHM Quality Improvement Project (QIP) Form

*Data from Partners BHM Quality Improvement Projects at a Glance

Table 9c. QIP0015: Goal 2 Measurement Results for 2019



*Data from Partners BHM Quality Improvement Project (QIP) Form

*Data from Partners BHM Quality Improvement Projects at a Glance

Status/Evaluation:

- Partners did not meet the 55% by December 2018 incremental measure benchmark but did meet the 55% by February 2019 benchmark for Goal 1.
- Partners did not meet the 55% by December 2018 incremental measure benchmark or the 65% by February 2019 benchmark for Goal 2.
- Due to 90-day lag in paid claims, data for next measurement period (Apr 2019-June 2019) has not been reported at the time this report was being completed. *Measurement 5* data will be reported in the SFY 2020 evaluation.

Identified Issue(s)/Barrier(s):

- Limited availability of follow-up slots for timely (within 7 days) scheduling for hospital discharge appointments.
- Limited means of identifying and engaging discharged member so that potential for first appointment follow-up is increased.
- Gaps in coordinated care between hospital and community treatment
- Duplication of discharge planning (i.e. MCO Hospital Liaison vs. Hospital MSW).
- Delayed notification to the MCO regarding discharges prior to the date of discharge.
- Access to the correct member contact information to communicate with the member.

Intervention(s):

- Partners has implemented a process to partner providers with hospitals to facilitate follow-up within 7 days.
- Developed procedure where Care Coordination Staff and/or Peer Supports connect with member while inpatient they are inpatient to ensure ongoing communication.
- On-going meeting with providers to discuss barriers and processes for timely follow-up.
- A twice a month snapshot report was developed and shared with providers to show status of follow-up within 7 days.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

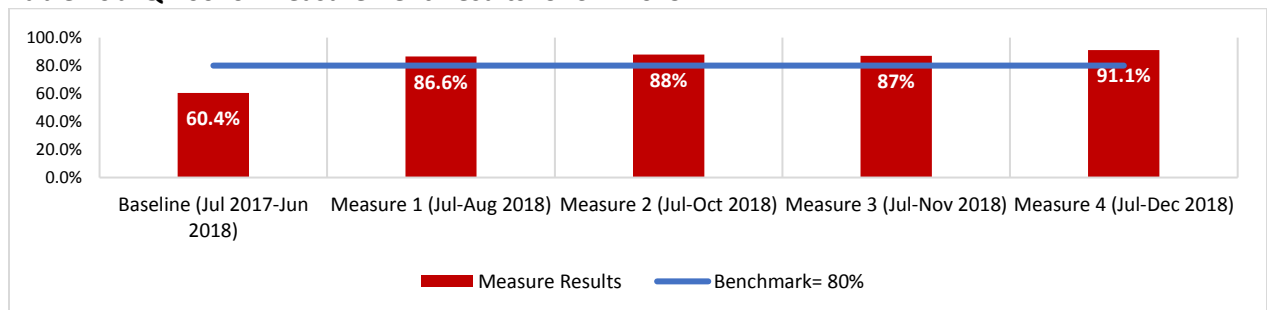
Table 10a. Quality Improvement Project: TCLI- 90 Day Transition

QIP#: QIP0016	QIP Name: TCLI- Individuals Transitioned within 90 Days of House Slot Issue Date	
Category: Non-Clinical	URAC Applicability: HUM	Safety QIP: No
DHB Approval: October 2018	QIP Committee Approval: June 2018	QIC Approval Date: August 2018
Data Source(s): TCLI Dashboard		
Goal(s)/Target End Date:		
1) 80% of Individuals transition within 90 days of housing slot issue. (End Date: June 2019)		

**Data from Quality Improvement Project (QIP) Tracking Sheet*

**Data from Partners BHM Quality Improvement Project (QIP) Form*

Table 10b. QIP0016: Measurement Results for SFY 2019



**Data from Partners BHM Quality Improvement Project (QIP) Form*

**Data from Partners BHM Quality Improvement Projects at a Glance*

Status/Evaluation:

- Partners has met the 80% measure benchmark for this QIP for SFY 2019.

Identified Issue(s)/Barrier(s):

- Lack of transportation in the community.
- Members fear loss of benefits if they move out of a facility and into the community.
- Members fear they will not be able to pay for their medications if they move out of a facility.

Intervention(s):

- Educate Adult Care Homes and Individuals regarding housing opportunities and the use of benefit counselors.

- Explore transportation options to assist members with means to get to appointments and work once they have a housing slot.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes. Although the QIP Committee voted to sunset this project, DHB always requires an active TCLI-related QIP. Therefore, this QIP will remain until new QIP can be developed.

QM Audits:

The purpose of the audit program is to ensure compliance with national accreditation standards, Partners BHM policies, procedures, program plans/descriptions, Department of Health and Human Services (DHHS) and/or Division of Health Benefits (DHB) contract requirements for specific LME/MCO functions. QM audits generally fall into two basic categories: *Routine Audits* and *Focused Audits*.

Routine Audits:

Routine audits are reviews that are completed on a regularly scheduled basis (i.e. quarterly, bi-annually, annually). Routine audits are considered “full audits” meaning they involve review of multiple standards related the specific LME/MCO functions that QM audits.

Focused Audit:

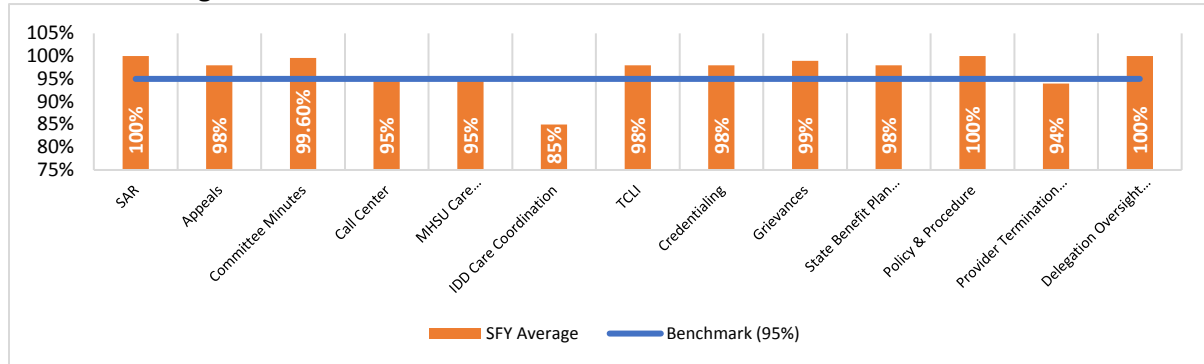
A Focused Audit concentrates on one or two specific accreditation standards, Partners BHM policies, procedures, program plans/descriptions, Department of Health and Human Services (DHHS) and/or Division of Health Benefits (DHB) contract requirements

A *Focused Audit* may be conducted for the following reasons:

- Review items which scored below the 95% benchmark during the annual audit or items identified as out-of-compliance during EQR, Block Grant Audits or accreditation reviews. These focused audits will be conducted at least 2-3 times during the fiscal year outside the annual audit or until the item score meets or exceeds the 95% benchmark for at least 2 audits.
- At times, the QM department may determine that a one-time focused audit needs to be completed based on concerns/trends noted by QM supervisors, Management Team and/or Department Directors, performance data, or in preparation for national accreditation, IMT or EQR reviews. These audits may be clinical or non-clinical in nature based on the area of concern and/or need.

Goal(s): Maintain a 95% audit compliance with accreditation, EQR and contractual standards/requirements for each area audited. (*Internal Process*)

Table 11. Average Score for Routine and Focused Audits Combined



*Data from the QM Audit Trend Reports

Status/Evaluation:

- Partners achieved a 100% average audit score for the following:
 - SAR Processing (Utilization Management)
 - Policy and Procedure (Legal)
 - Delegation Oversight (Member Services/Utilization Management)
- The average audit score met or exceeded (but totaled less than 100%) the audit benchmark of 95% for the following audits:
 - Appeals (Utilization Management)
 - Committee Meeting Minutes (Administration)
 - Call Center (Member Services)
 - MHSU Care Coordination (Care Coordination/Clinical)
 - Transition to Community Living Initiative (TCLI) (Care Coordination/Clinical)
 - Credentialing (Provider Network)
 - Grievances (Legal)
 - State Benefit Plan Eligibility (Utilization Management)

Identified Issue(s)/Barrier(s):

- Call Center (Member Services):** Score for February 2019 was 85% due to Call Center staff not asking caller if they want call information shared with their Primary Care Physician (PCP). Not all staff were asking the PCP question for emergent calls or when caller was calling on behalf of a member as they may not know if member has a PCP.
- IDD Care Coordination:** Overall audit score of 92% for September 2018 audit. Low scoring items were completion of the *Beneficiary Responsibilities* form for members on the Innovations Waiver (85%) and the monthly/quarterly face to face contact with member requirement (90%).
- Credentialing:** Although the overall audit score for credentialing was consistently above the 95% benchmark, review of audits from April 2018 through November 2018 indicated scores below the benchmark for three (3) of six (6) audits for approving recredentialing of a provider within three years of the initial credentialing. A barrier to completing recredentialing within the time frame is providers submitting the recredentialing information in time to complete all the verifications needed before presenting to the Credentialing Committee.

- **Provider Termination Letter Audit:** The overall audit score was 85% for the May 2019 audit. This was no provider termination letter present in members' files for six (6) of forty-one (41) files reviewed. It was determined that a temporary staff person had failed to save and upload the letters to member files prior to mailing the letter out.

Intervention(s):

- **Call Center (Member Services):** A Plan of Action (POA) was implemented in February 2019. Updates were made in the Alpha call portal to prompt staff to document the PCP question more clearly. Additional staff training on changes was also completed during regularly scheduled staff meetings. Call Center scored 100% on follow-up audit in May 2019. The POA will remain active through at least Q1 of SFY 2020.
- **IDD Care Coordination:** A POA was implemented in September 2018. A self-audit process was implemented for Care Coordinators to review their records to make sure all forms are completed and uploaded in a timely manner and that face to face contacts are completed and documentation in Alpha is completed within the required time frames. The item score for the face to face contact requirement has shown steady improvement, showing a score of 100% in both the March 2019 and June 2019 audits. The item score for the Beneficiary Responsibilities form has shown more fluctuation in improvement. The POA will remain active through at least Q1 of SFY 2020.
- **Credentialing:** A POA was implemented in December 2018. Changes were made to the application review process to tighten up the timelines for completing primary/secondary source verifications. As of the May 2019 audit, improvement has been shown. The POA will remain active through at least Q1 of SFY 2020.
- **Provider Termination Letter Audit:** A POA was implemented in May 2019. New letters were mailed out to the affected members and the process for completing and mailing letters has been revised. A follow-up audit was completed in July 2019 with a 100% score. The POA will remain active through at least Q1 of SFY 2020.

External Quality Review (EQR):

The External Quality Review (EQR) is conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the North Carolina Department of Health and Human Services' (NC DHHS) Division of Health Benefits (DHB) to evaluate LME/MCOs' compliance with state and federal regulations. Partners' review for SFY 2019 was completed October 2018.

Goal(s): Will improve on the previous year's overall compliance rating. (*Internal Goal*)

Table 12. Compliance Scores for EQR- Three (3) Year Trends

	SFY 2017	SFY 2018	SFY 2019
Overall Compliance Score	93%	95%	98%
Administration	91%	91%	95%
Provider Services	88%	91%	99%
Enrollee Services	89%	89%	94%
Quality Improvement	94%	94%	94%
Utilization Management	90%	98%	100%
Grievances and Appeals	95%	80%	90%
Delegation	100%	100%	100%
Program Integrity	96%	100%	100%
Financial Services	100%	100%	100%

**Data from NCEQR Compliance Report*

Status/Evaluation:

- Partners' overall compliance score for the SFY 2019 review showed a three (3) percentage point increase to the SFY 2017 score.
- Partners SFY 2019 EQR results indicate 98% of the standards were met and 2% partially met.
- Partners scored 100% in the following areas:
 - Utilization Management
 - Delegation
 - Program Integrity
 - Financial Services
- Partners showed improvement of five (5) or more percentage points in the following areas:
 - Provider Services (+8)
 - Enrollee Services (+5)
 - Grievances and Appeals (+10)

Identified Issue(s)/Barrier(s):

- Partners rated "Partially Met" or "Not Met" for the following EQR Standards:
 - The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data submission. (Administration)
 - The PIHP has a process for handling abandoned records, as required by the contract. (Provider Services)
 - Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including:
 - Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request). (Enrollee Services)
 - The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract. (Enrollee Services)
 - The procedure for filing an appeal. (Appeals)
 - Timeliness guidelines for resolution of the appeal as specified in the contract. (Appeals)
 - The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines. (Quality Improvement)

Intervention(s):

- Partners identified issue in Alpha that was preventing all the required encounter data elements to be submitted to DMA. A helpdesk ticket was submitted to Alpha which was resolved 12/12/18.
- *Policy 4.11 Record Retention and Disposition* was updated to include the process for handling abandoned records.
- An “**Accepting New Patients**” field was added to the Provider directory and was added to search parameters of the online search tool.
- A list of post-stabilization provider locations was added to the website to allow for easy changes.
- Policy and procedure 13.04U, *Clinical UM Appeals* was revised to state, “Partners shall ensure that punitive action is not taken against a provider who requests or supports an enrollee’s appeal”.
- Policy and procedure 13.04U, *Clinical UM Appeals* was revised to state, “when Partners extends the appeal resolution timeframe, reasonable efforts will be made by Partners to give the enrollee prompt oral notice of the delay and written notice of extension will be mailed to appellant within two calendar days”.
- Initiated a committee process whereas the Clinical Advisory Committee [CAC] assesses and selects specific clinical practice guidelines deemed high risk or high priority. Audit outcomes regarding provider compliance with clinical guidelines will be reviewed quarterly in CAC and QIC as a standing quarterly agenda item.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

URAC Accreditation:

One of the qualifications for being a LME/MCO in North Carolina is to obtain and maintain accreditation with a nationally recognized accrediting organization. Partners BHM chose accreditation with URAC. Partners was originally accredited by URAC in 2012 for three years. Partners completed the re-accreditation April 2018.

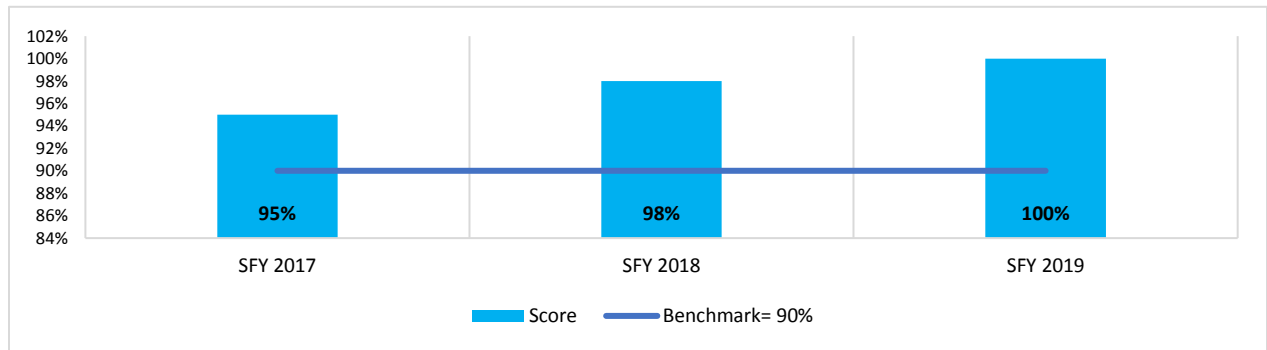
No accreditation monitoring took place during SFY 2019. Partners is currently in the process of obtaining National Committee for Quality Assurance (NCQA) accreditation, which is required to become a NC Tailored Plan. Accreditation review is expected to be completed by the end of SFY 2020.

Annual Personnel File Audit:

One of the responsibilities of the Human Resources department is to assure that Partners personnel, benefit, and training files follow regulatory guidelines and URAC standards. Auditing of these files is one method of assuring compliance with these guidelines and standards.

Goal: At least 90% of Partners’ personnel files will meet URAC standards. (CORE 25-32)

Table 13. Personnel File Audit Results- Three Year Trend



**Data from URAC Performance Dashboard Report*

Status/Evaluation:

- Partners exceeded the 90% benchmark for SFY 2019 by 10 percentage points.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified by Human Resources department.

Intervention(s):

- No interventions were required due to 100% score.

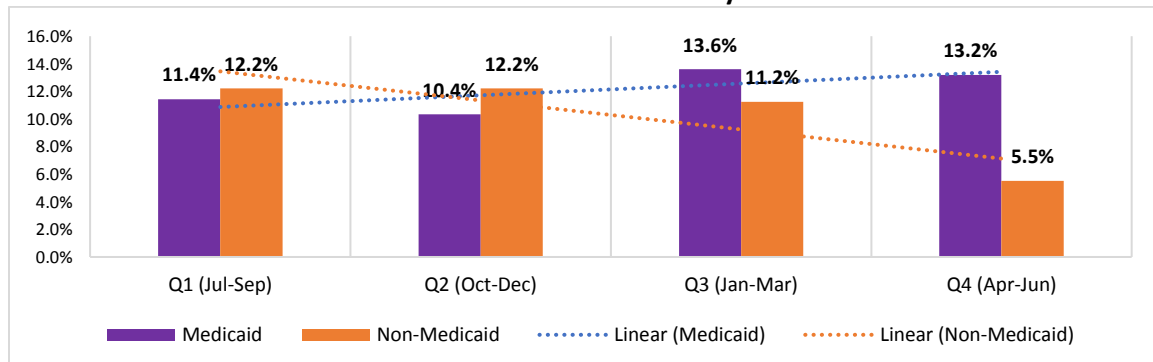
Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes. Goal will continue through SFY 2020 as audit of personnel files is a URAC requirement.

B. CLINICAL PROGRAM

Mental Health Substance Use (MHSU) Performance Measures

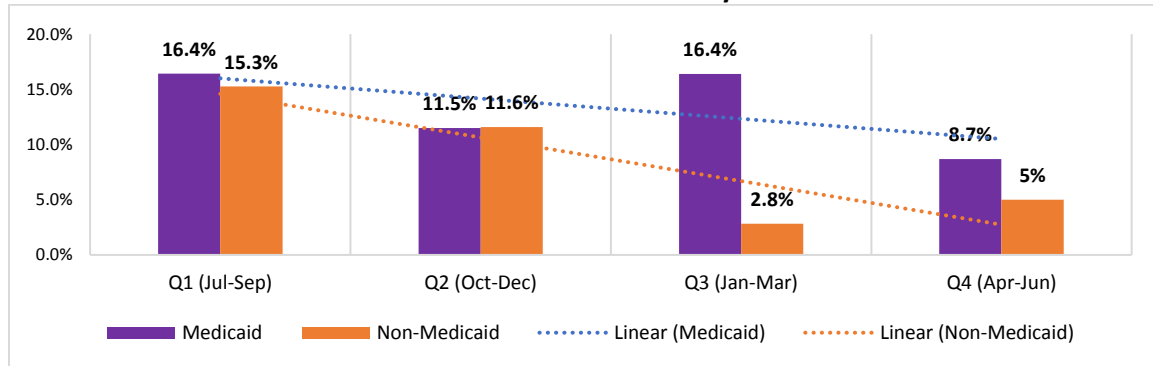
Goal(s): Demonstrate a decrease in the percentage of readmission within 30 days for both the mental health and substance use populations. (DMH/DHB Performance Measure)

Table 14a. % of MH Admissions Readmissions within 30 Days



**Data from LME/MCO Monthly Monitoring Report*

Table 14b. % of SU Admissions Readmissions within 30 Days



**Data from LME/MCO Monthly Monitoring Report*

Status/Evaluation:

- Average of 12.1% readmission rate for MH Medicaid
- Average of 10.3% readmission rate for MH Non-Medicaid
- Average of 13.2% readmission rate for SU Medicaid
- Average of 8.7% readmission rate for SU Non-Medicaid
- The readmission rate for MH Medicaid demonstrated an upward trend during SFY 2019.
- The readmission rate for SU Medicaid has demonstrated a downward trend during SFY 2019.

Identified Issue(s)/Barrier(s):

- Members not engaging in outpatient treatment after hospitalization.
- Not obtaining timely follow-up appointments after inpatient discharge.

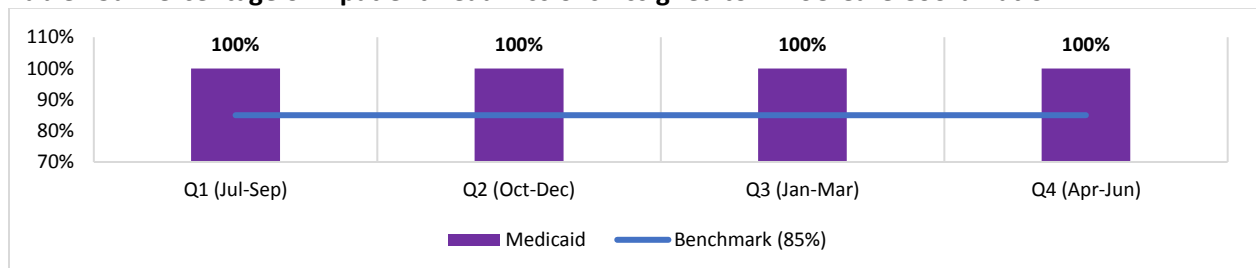
Intervention(s):

- While there are not currently interventions in place specifically to address readmission rates, there are interventions in place to address timely follow-up (7 days) after inpatient discharge. If Partners can improve the timeliness of follow-up appointments to get members engaged as quickly as possible after discharge, readmission rates should show a corresponding decrease.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Goal: Ensure 85% of MHSU Medicaid inpatient readmissions are assigned to care coordination (*DHB Performance Measure*)

Table 15a. Percentage of Inpatient Readmissions Assigned to MHSU Care Coordination



**Data from LME/MCO Monthly Monitoring Report*

Status/Evaluation:

- Partners exceeded this goal by 15 points for four (4) of four (4) quarters of SFY 2019 with a score of 100%

Identified Issue(s)/Barrier(s):

- No issues/barriers were identified as Partners exceeded the 85% benchmark.

Intervention(s):

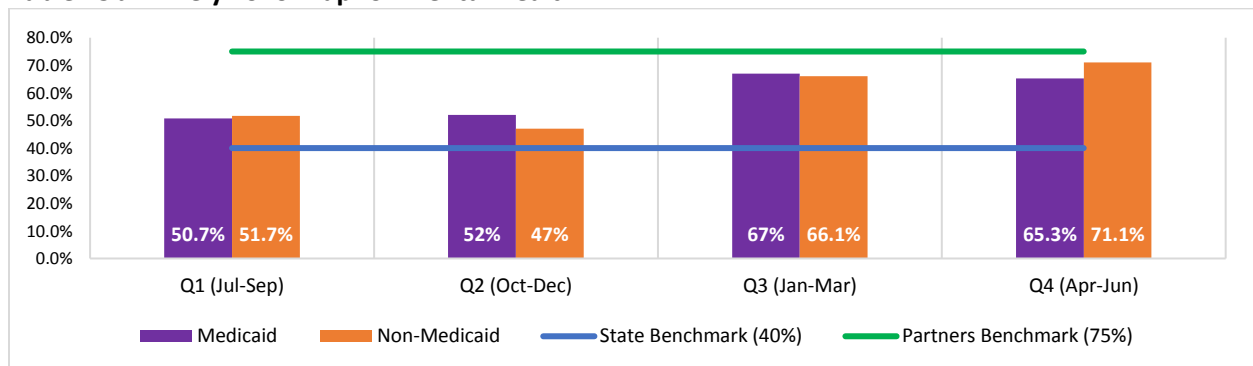
- No interventions implemented as score was 100%.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes. As this is a contract performance measure, Partners will continue goal into SFY 2020.

Goal(s):

- 40% of Individuals will have a timely follow-up visit with a community mental health provider within seven (7) days of discharge from either a community-based hospital, State psychiatric hospital or facility-crisis center. *(DHHS/DHB Super Measure)*
- 75% of Individuals will have a timely follow-up visit with a community mental health provider within seven (7) days of discharge from a community-based hospital, state psychiatric hospital or facility-based crisis center. *(Strategic Plan Goal 1.A, 1.B)*

Table 15b. Timely Follow-up for Mental Health ¹



**Data from Strategic Plan Progress Report*

¹Results are subject to change due to claims lag and claims processing that may result in changes to claim status.

Status/Evaluation:

- Partners exceeded the 40% State benchmark for four (4) out of four (4) quarters of SFY 2019 for both Medicaid and Non-Medicaid.
- Although the 40% State benchmark was met, Partners' internal benchmark of 75% was not met during SFY 2019.

Identified Issue(s)/Barrier(s):

- Limited availability of follow-up appointments within the seven (7) day time frame.
- Limited means of identifying and engaging discharged members so that potential for first appointment follow-up is increased.
- Gaps in coordinated care between hospital and community treatment.
- Delayed notification of the LME/MCO regarding discharges prior to discharge date.

- Access to the correct member contact information to communicate with the member about follow-up appointments.

Intervention(s):

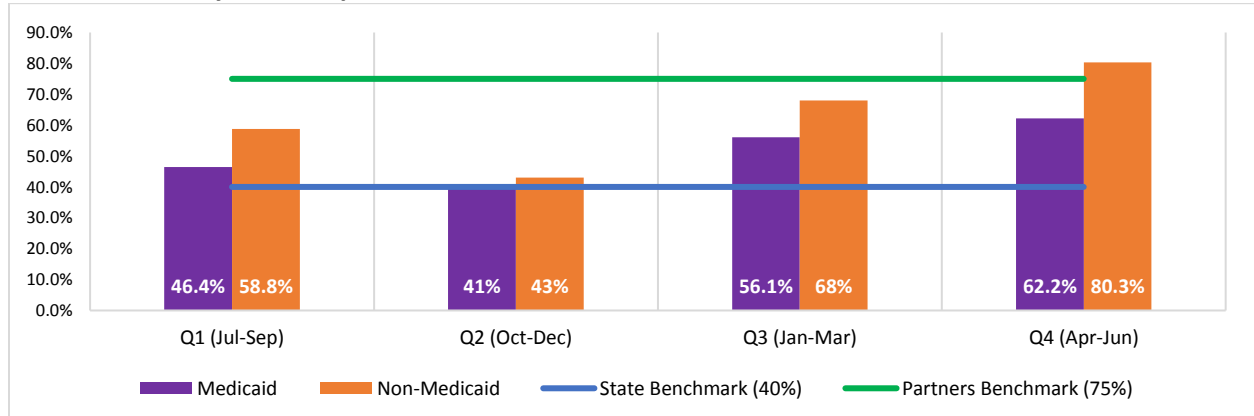
- A quality improvement project (QIP) has been implemented to assist Partners in achieving the internal benchmark and maintain progress with the State benchmark.
- The Interventions for the QIP include:
 - Development of process to partner providers with hospitals to facilitate timely follow-up.
 - Development of procedure for Care Coordination Staff and/or Peer Supports to connect with member while they are inpatient to ensure on-going communication.
 - On-going meetings with provider to discuss barriers and processes for timely follow-up.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Goal(s):

- 40% of Individuals will have a timely follow-up visit with community substance use services provider within seven days of discharge from a community-based hospital, state psychiatric hospital, facility-based crisis center, detox or State ADATC program. (*DHHS/DHB Super Measure*)
- 75% of Individuals will have a timely follow-up visit with a substance use services provider within seven (7) days of discharge from a community-based hospital, state psychiatric hospital, facility-based crisis center, detox or State ADATC program. (*Strategic Plan Goal 1.C, 1.D*)

Table 15c. Timely Follow-up for Substance Use¹



**Data from Strategic Plan Progress Report*

¹Results are subject to change due to claims lag and claims processing that may result in changes to claim status.

Status/Evaluation:

- Partners met the 40% State requirement for all four (4) quarters of SFY 2019.
- Partners met the 75% internal benchmark for Non-Medicaid in Q4.
- Partners did not meet the 75% internal benchmark for all four (4) quarters for SFY 2019 for Medicaid. Partners also did not meet the 75% internal benchmark for Q1-Q3 for Non-Medicaid.

Identified Issue(s)/Barrier(s):

- Limited availability of follow-up appointments within the seven (7) day time frame.

- Limited means of identifying and engaging discharged members so that potential for first appointment follow-up is increased.
- Gaps in coordinated care between hospital and community treatment.
- Delayed notification of the LME/MCO regarding discharges prior to discharge date.
- Access to the correct member contact information to communicate with the member about follow-up appointments.

Intervention(s):

- A quality improvement project (QIP) has been implemented to assist Partners in achieving the internal benchmark and maintain progress with the State benchmark.
- The Interventions for the QIP include:
 - Development of process to partner providers with hospitals to facilitate timely follow-up.
 - Development of procedure for Care Coordination Staff and/or Peer Supports to connect with member while they are inpatient to ensure on-going communication.
 - On-going meetings with providers to discuss barriers and processes for timely follow-up.

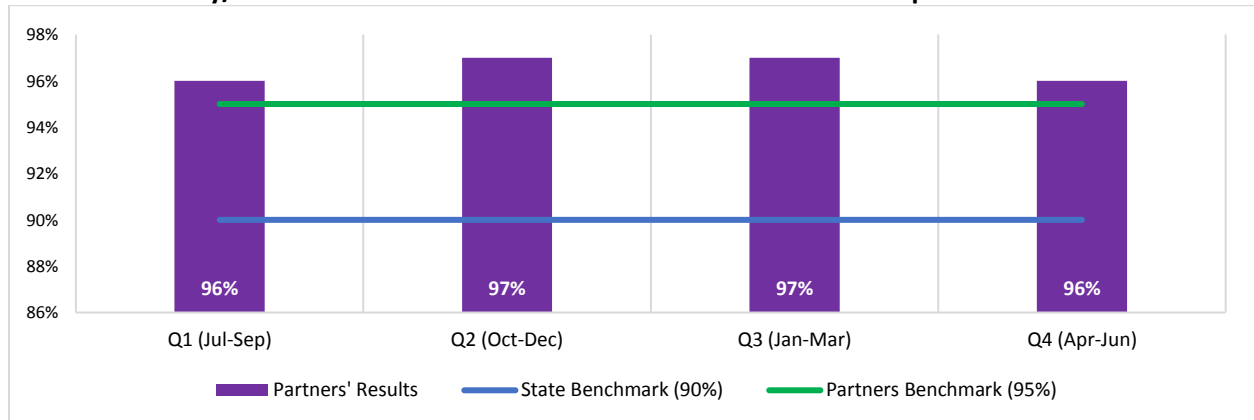
Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Innovations Waiver Performance Measures

Goal(s):

- 90% of Members under the 1915c Innovations waiver who received at least one service under the wavier during SFY 2019 received a primary care or preventative health service. (*DHB Super Measure*)
- 95% of Members under the 1915c Innovations waiver who received at least one service under the wavier during SFY 2019 received a primary care or preventative health service. (*Strategic Plan Goal 1.F*)

Table 16. Primary/Preventative Health Care for Innovations Waiver Participants



**Data from Strategic Plan Progress Report*

Status/Evaluation:

- Partners exceeded the 90% State measure benchmark for four (4) out of four (4) quarters for SFY 2019.
- Partners also exceeded the 95% strategic plan benchmark for all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No barriers were identified as benchmarks were exceeded.

Intervention(s):

- No interventions were required as benchmarks were exceeded.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Transition to Community Living Initiative (TCLI) Performance Measures

The State of North Carolina entered a settlement agreement with the United States Department of Justice (DOJ) in 2012. The purpose of this agreement was to make sure that persons with mental illness can live in their communities in the least restrictive settings of their choice. The NC Department of Health and Human Services is implementing the agreement through the Transition to Community Living Initiative (TCLI).

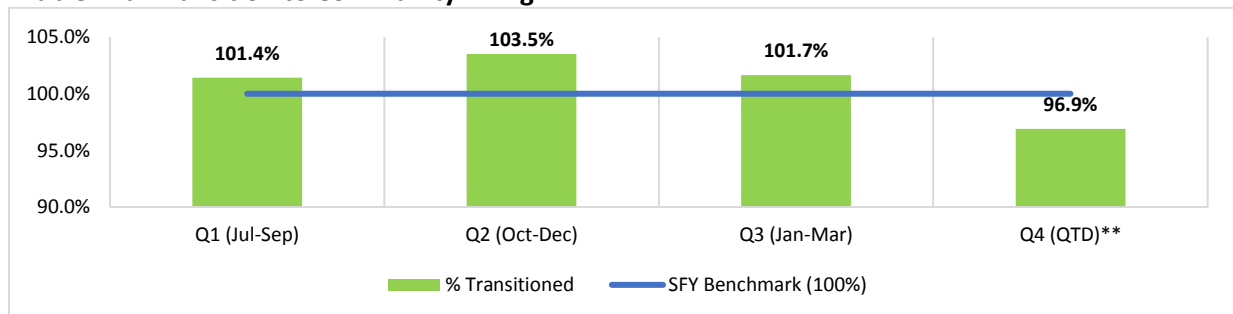
The Transitions to Community Living Initiative has six primary components:

- **In-Reach and Transition:** Providing or arranging for frequent education efforts and discharge planning targeted to individuals in Adult Care Homes (ACHs) and state psychiatric hospitals.
- **Diversion:** Providing informed choice regarding housing options to individuals with Serious Mental Illness (SMI) or a Serious and Persistent Mental Illness (SPMI) considering admission to an ACH.
- **Housing:** Providing community-based supportive housing with tenancy supports.
- **Supported Employment:** An evidence-based practice to assist individuals in preparing for, identifying, and maintaining integrated, paid, competitive employment.
- **Assertive Community Treatment:** An evidence-based treatment and support model of services offering intensive customized, community-based services for people with mental illness.
- **Quality Management:** using data to evaluate progress and outcomes.

Housing Measures:

Goal: Will transition at least 5.1 (15.3 per quarter) individuals to community living per month for a total of 61 by the end of SFY 2019. *(TCLI Performance Measure)*

Table 17a. Transition to Community Living



*Data from Transition to Community Living Initiative (TCLI) Dashboard

**Q4 data only includes April-May as June data not available at the time of this report. As such, the acronym QTD (Quarter to Date) has been added to indicate this is the percentage we have as of the end of the fiscal year, June 30, 2019, but could change significantly once June 2019 data is received.

Status/Evaluation:

- Partners was exceeding the benchmark for SFY 2019 until Q4. As this drop came at the end of the fiscal year and June 2019 data has not been received from the State as of the date this report was completed, there has not been time to complete any analysis or develop interventions to address the issue.

Identified Issue(s)/Barrier(s):

- Members or their family members/guardian do not want to move into the community.
- Members do not have adequate support to remain in the community.
- Members have health issues that necessitate skilled nursing facility care.

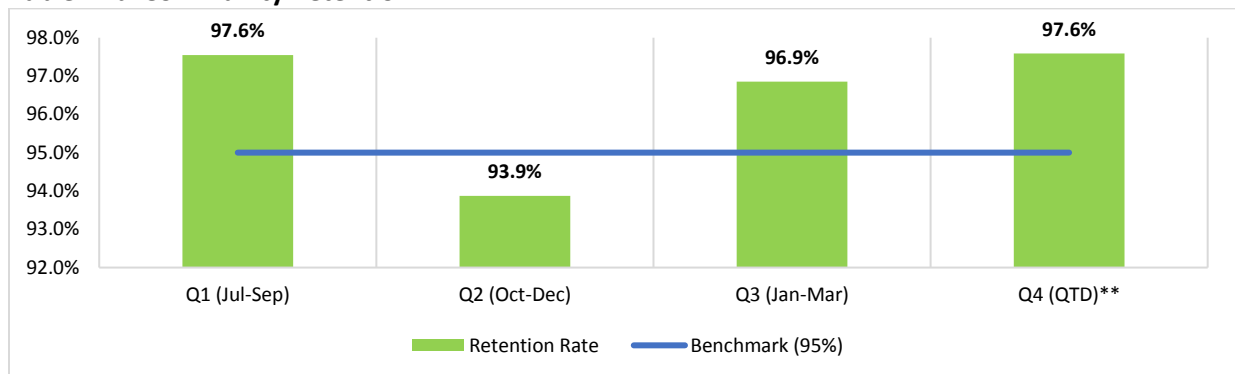
Intervention(s):

- No interventions have been implemented at this time as data for June 2019 has not been received. Once data is received and analyzed Partners can proceed with developing interventions to address percentage decrease if no improvement is shown.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Goal(s): 95% of individuals transitioned will remain in the community for SFY 2019 (*TCLI Performance Measure*)

Table 17b. Community Retention



*Data from Transition to Community Living Initiative (TCLI) Dashboard

**Q4 data only includes April-May as June data not available at the time of this report. As such, the acronym QTD (Quarter to Date) has been added to indicate this is the percentage we have as of the end of the fiscal year, June 30, 2019, but could change significantly once June 2019 data is received.

Status/Evaluation:

- Except for Q2 Partners met this benchmark for SFY 2019.

Identified Issue(s)/Barrier(s):

- Members who have been in adult care homes for a long period of time have difficulty transitioning back into the community.
- Members may have medical issues that necessitate a higher level of care.

Intervention(s):

- Partners has assigned two staff to focus on housing retention as of May 2019.

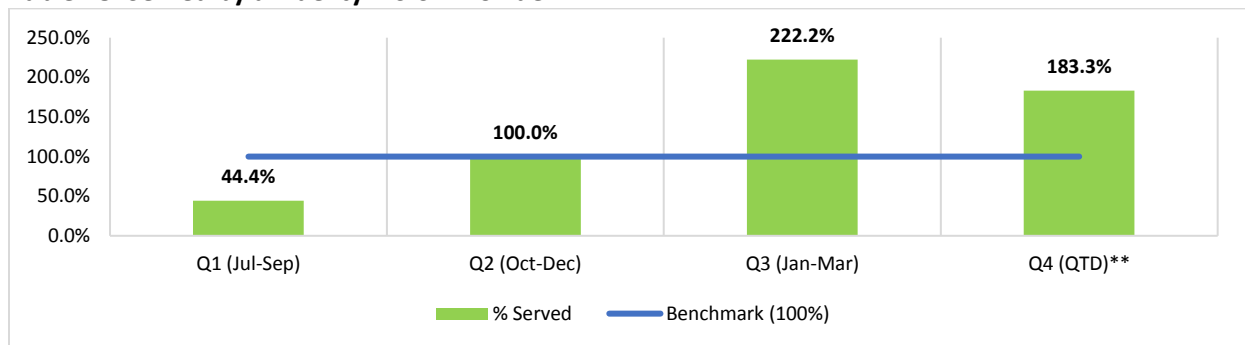
- Embedded Care Coordinators within TCLI to be involved earlier in the transition process to establish rapport with the provider and member to help monitor the tenancy and services.
- Care Coordinators work with providers twice monthly to discussion concerns, problems, and interventions with TCLI members.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Supported Employment (SE) Measures:

Goal: 100% of Individuals at risk of adult care home entry newly served by a Fidelity IPS- Supported Employment (SE) provider. *(TCLI Performance Measure)*

Table 18. Served by a Fidelity IPS-SE Provider



*Data from Transition to Community Living Initiative (TCLI) Dashboard

**Q4 data only includes April-May as June data not available at the time of this report. As such, the acronym QTD (Quarter to Date) has been added to indicate this is the percentage we have as of the end of the fiscal year, June 30, 2019, but could change significantly once June 2019 data is received.

Status/Evaluation:

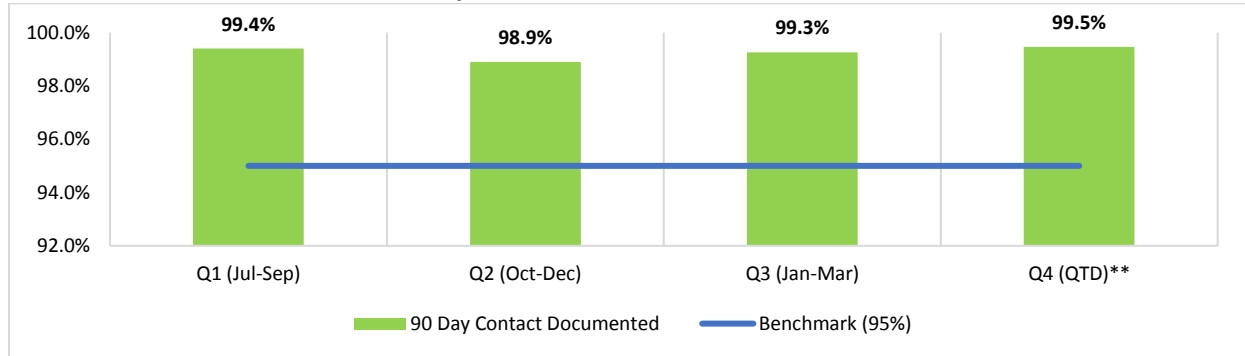
- Partners has been meeting or exceeding this goal since Q2 SFY 2019. Interventions that were implemented earlier in SFY 2019 will be continued to ensure compliance with State requirements.
- **Issue(s)/Barrier(s):**
 - Not enough Fidelity IPS-SE providers.
 - Members not wanting to participate in supported employment.
- **Intervention(s):**
 - The staff for each IPS-SE provider met with the Partners' TCLI Staff on April 17, 2019 to discussed referrals and IPS-SE process.
 - Partners awarded a Request for Proposal (RFP) to A Caring Alternative (ACA) to provide Fidelity IPS-SE. ACA started to provide this service as of February 2019.
 - Partners has worked with IPS-SE Fidelity Providers to establish a monthly goal of Five (5) new individuals entering IPS-SE.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

In-Reach and Transition Measures

Goal: 95% of individuals in “In-Reach” status will have an In-Reach contact in last 90 days. *(TCL/ Performance Measure)*

Table 19a. In-Reach Contact in 90 Days



*Data from Transition to Community Living Initiative (TCL) Dashboard

**Q4 data only includes April-May as June data not available at the time of this report. As such, the acronym QTD (Quarter to Date) has been added to indicate this is the percentage we have as of the end of the fiscal year, June 30, 2019, but could change significantly once June 2019 data is received.

Status/Evaluation:

- Partners met this goal for all four (4) quarters of SFY 2019

Identified Issue(s)/Barrier(s):

- No issues or barriers identified as Partners met this goal.

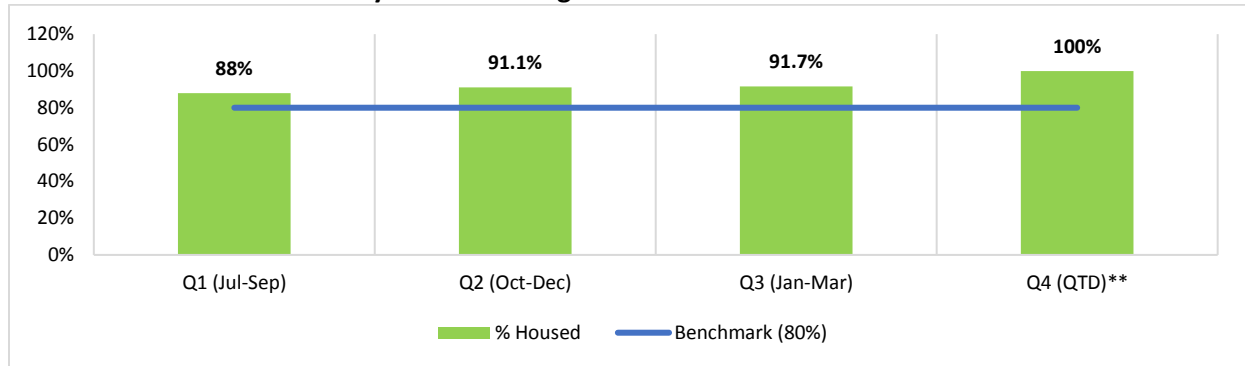
Intervention(s):

- No interventions in place as goal was met.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Goal: 80% of individuals in transition status are housed within 90 days after housing slot is issued. *(TCL/ Performance Measure)*

Table 19b. Transitioned 90 Days After Housing Slot Issued



*Data from Transition to Community Living Initiative (TCLI) Dashboard

**Q4 data only includes April-May as June data not available at the time of this report. As such, the acronym QTD (Quarter to Date) has been added to indicate this is the percentage we have as of the end of the fiscal year, June 30, 2019, but could change significantly once June 2019 data is received.

Status/Evaluation:

- Partners met the goal for all four (4) quarters of SFY 2019, although Partners fell below the benchmark for the month of March 2019.

Identified Issue(s)/Barrier(s):

- Lack of appropriate housing in the community.
- Members may have health issues that slow down transition.

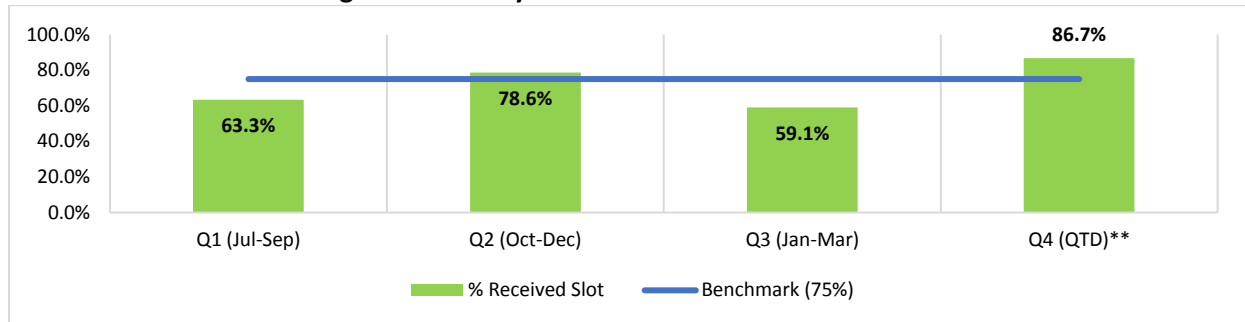
Intervention(s):

- TCLI Staff will review each case every 30 days to identify any barriers/concerns to the individuals moving within 90 days.
- Establish time frames for each move.
- TCLI supervisor will monitor days to transition monthly.
- Staff will evaluate members' medical conditions to ensure that is not a barrier to transition.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Goal: 75% of individuals who agree to transition to the community receive housing slots within 30 days.
(TCLI Performance Measure)

Table 19c. Received Housing Slot in 30 Days



*Data from Transition to Community Living Initiative (TCLI) Dashboard

**Q4 data only includes April-May as June data not available at the time of this report. As such, the acronym QTD (Quarter to Date) has been added to indicate this is the percentage we have as of the end of the fiscal year, June 30, 2019, but could change significantly once June 2019 data is received.

Status/Evaluation:

- Partners met goal during Q2 and Q4 of SFY 2019.
- Partners did not meet the goal during Q1 and Q3 of SFY 2019.

Identified Issue(s)/Barrier(s):

- Housing slots not requested in a timely manner.
- Members, guardians and service providers not clear on the TCLI process.

Intervention(s):

- TCLI staff will review when members agree to transition and ensure agreement is documented in the TCL database (TCLD).
- TCLI staff will track and ensure housing slots are requested within established time frames.
- Educate members, guardians and adult care homes on the transition process.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

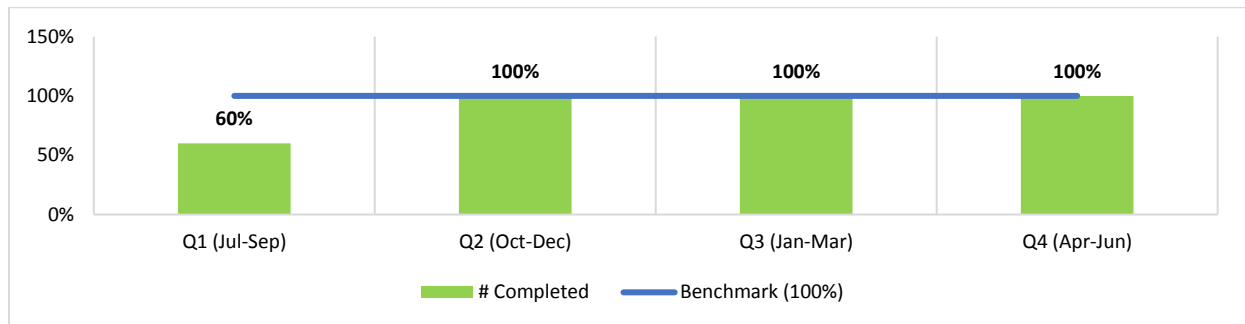
Whole Person Integrated Care

Partners Behavioral Health Management has developed a community health program called Whole Person Integrated Care. This model is based on three main elements: **whole person, integrated care, and community health.**

Partners has implemented the Whole Person Integrated Care model at its integrated Care Centers in Burke, Gaston and Iredell counties.

Goal: A minimum of 100 *Social Determinants of Health Assessments* will be completed by each of the Whole Person Care Centers by 12/31/18. (*Strategic Plan Goal 2.A*)

Table 20a. Social Determinants of Health Assessments



*Data from Strategic Plan Progress Report

Status/Evaluation:

- This goal was completed by the due date.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goal was completed by due date.

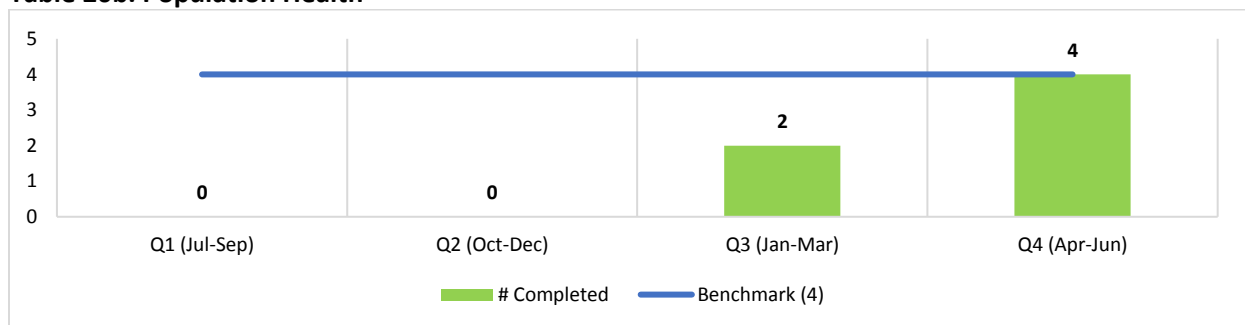
Intervention(s):

- No interventions were implemented as goal was completed by due date.

Goal(s) to Continue for Next Fiscal Year (Yes/No): No. Goal completed.

Goal: By 6/31/19 at least four (4) Wellness Collaboratives will use results of *Social Determinants of Health Assessment* results to develop an action plan to at least one (1) social determinant of health. (*Strategic Plan Goal 2.B*)

Table 20b. Population Health



*Data from Strategic Plan Progress Report

Status/Evaluation:

- This goal was met by the due date.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goal was completed by due date.

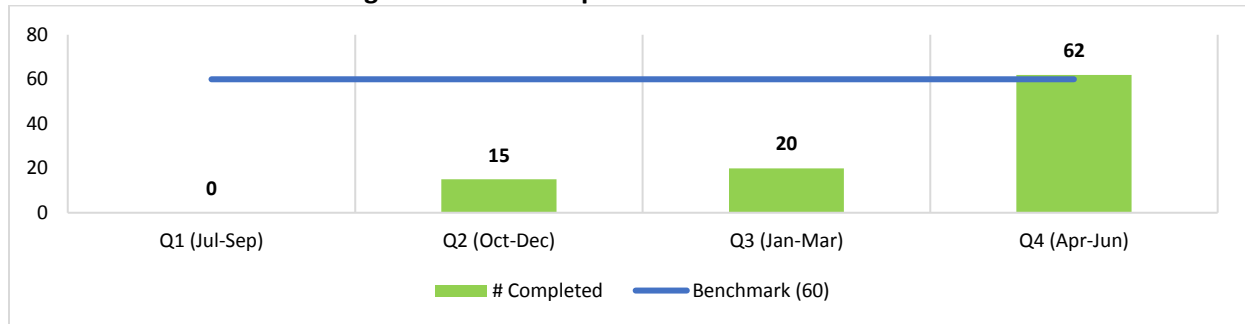
Intervention(s):

- No interventions were implemented as goal was completed by due date.

Goal(s) to Continue for Next Fiscal Year (Yes/No): No. Goal completed.

Goal: A minimum of 60 providers will adopt protocols for sharing/exchanging both behavioral and physical health information. *(Strategic Goal 3.A)*

Table 20c. Whole Person Integrated Care Principles



**Data from Strategic Plan Progress Report*

Status/Evaluation:

- This goal was met.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goal was completed.

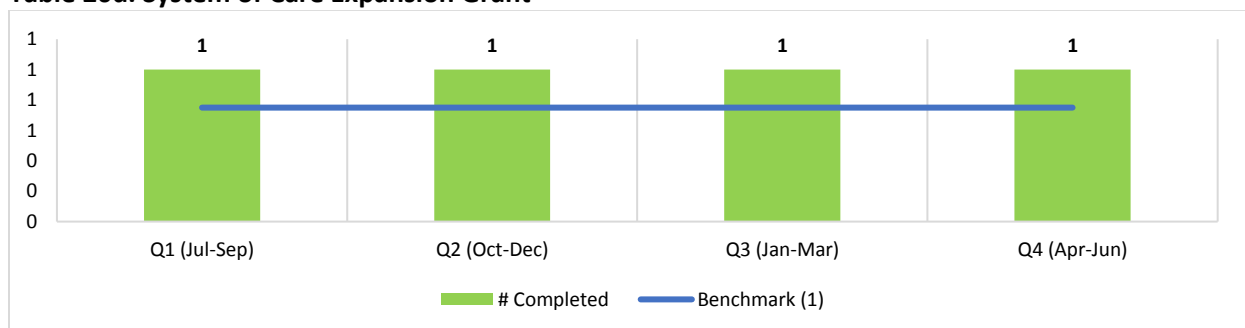
Intervention(s):

- No interventions were implemented as goal was completed.

Goal(s) to Continue for Next Fiscal Year (Yes/No): No. Goal completed.

Goal: Implement System of Care Expansion Grant and Whole Person Care in one pediatric practice in Gaston County. *(Strategic Plan Goal 3.B)*

Table 20d. System of Care Expansion Grant



**Data from Strategic Plan Progress Report*

Status/Evaluation:

- This goal was met.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goal has been completed.

Intervention(s):

- No interventions were implemented as goal was completed.

Goal(s) to Continue for Next Fiscal Year (Yes/No): No. Goal was completed.

C. COMPLAINTS, APPEALS, AND QUALITY OF CARE

Grievances

Grievances (also called complaints) are defined as “an expression of dissatisfaction about matters involving the MCO or MCO Provider Network”. Grievances are expressions of dissatisfaction about any matters other than an “action” (summarized as UM decisions to deny, reduce, suspend or terminate any requested services). Grievances or complaints can be received by any staff member at Partners.

Complaints may be received via telephone, mail, email, Access to Care web address, or in person. All Grievances and complaints are entered into the AlphaMCS System by the staff receiving the grievance or complaint.

The Legal Department of Partners is responsible for assignment of complaints to appropriate staff/departments for resolution, tracking, monitoring, and ensuring completion of all complaints received.

Grievance Categories & Examples:

- **Quality of Care:** *A member has filed a complaint that a condition was misdiagnosed.*
- **Access:** *A member filed a complaint that participating practitioners lacked available appointments.*
- **Attitude/Service:** *A Member complained that a practitioner was rude and used abusive language.*
- **Billing/Financial:** *Out of Network services where members are balanced billed or disputes of deductibles and copayments.*
- **Quality of Practitioner Office Site:** *A member sought out-of-network care because the participating practitioner’s offices lacked wheelchair accessibility. The organization identified other practitioners with wheelchair access, but the member appealed to go out of network.*

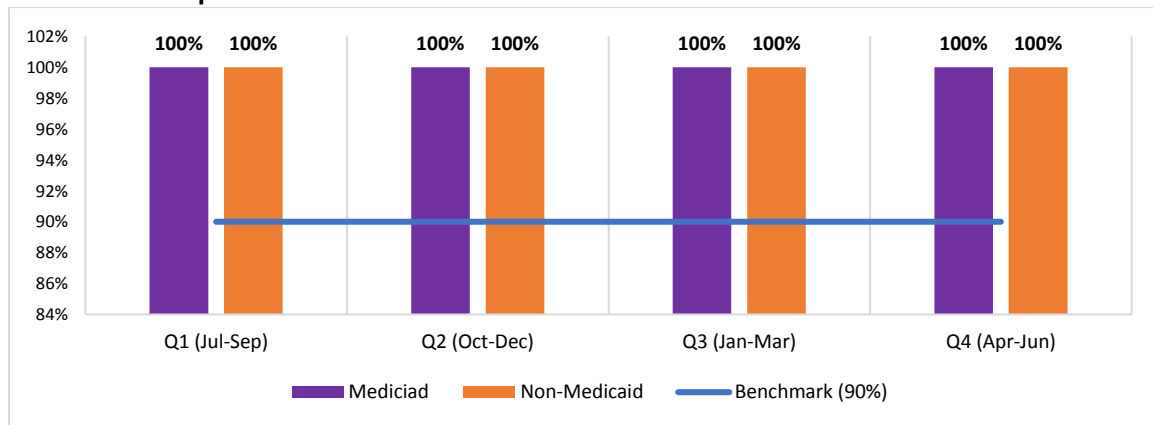
Table 21a. Grievance Totals for SFY 2019

	SFY 2019 #	% of Total
Total Grievances Received	112	100%
<i>Quality of Care</i>	67	59.8%
<i>Access</i>	24	21.4%
<i>Billing/Financial</i>	16	14.3%
<i>Attitude/Service</i>	5	4.5%
<i>Quality of Practitioner Office Site</i>	0	0%

**Partners Annual Grievance Report*

Goal(s): At least 90% of all grievances are resolved within 30 calendar days of receipt. (*URAC Standard: Core 35d; State Performance Measure*)

Table 21b. Compliance with Grievance Resolution Time Frame



**Data from LME/MCO Monthly Monitoring Report*

Status/Evaluation:

- Partners exceeded this goal's benchmark all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goal was met.

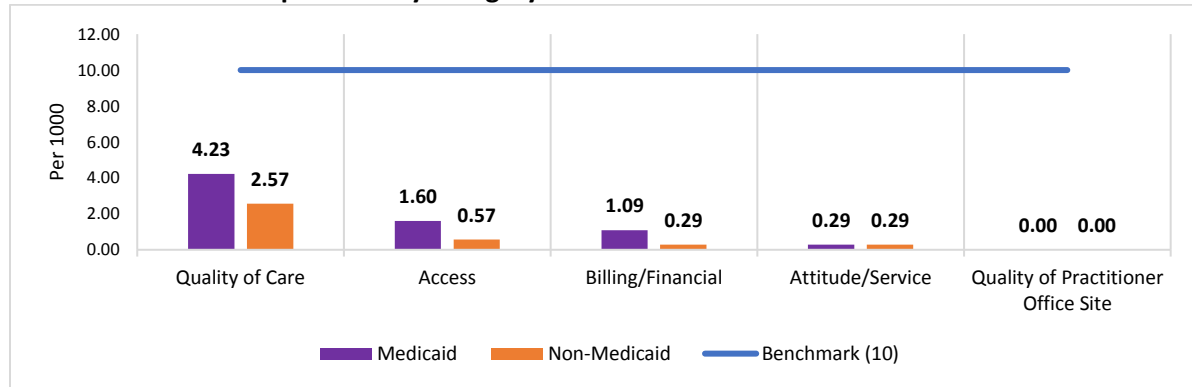
Intervention(s):

- No interventions were implemented as goal was met.

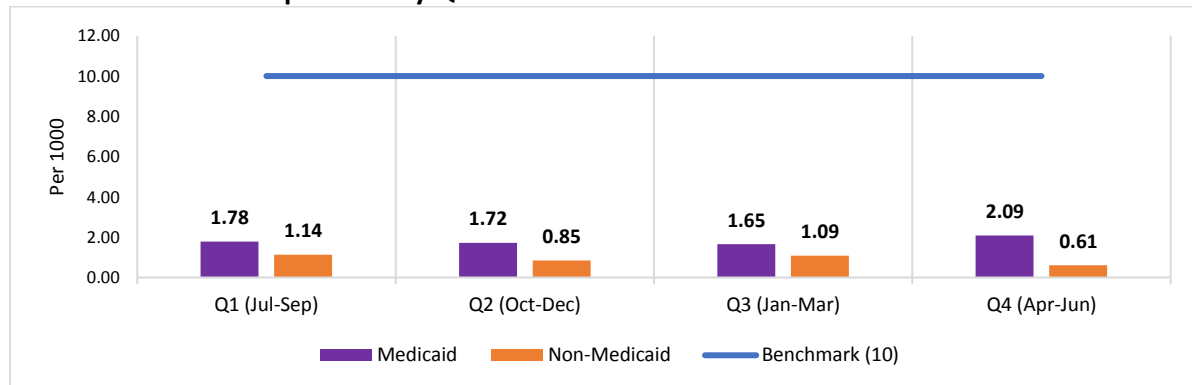
Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Goal(s):

- Achieve a rate of 10 grievances or less per 1000 active members. (NCQA Standard QI6)

Table 21c. Grievances per 1000 by Category

*Data from SFY Annual Grievance Report

Table 21d. Grievances per 1000 by Quarter

*Data LME/MCO Monthly Monitoring Report

Status/Evaluation:

- Partners met goal of 10 grievances or less per 1000 active members for both the Medicaid and Non-Medicaid populations.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goal was met.

Intervention(s):

- No interventions were implemented as goal was met.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes. Goal will continue as is required by NCQA.

Appeals Process

When UM staff review an authorization request and the decision is that of a denial, reduction, suspension or termination, the member/legally responsible person has the right to appeal or ask for a review of the decision. Timeframes and other requirements for the appeal process are in accordance with the requirements of the NC DHHS, Division of Mental Health, Developmental Disabilities, Substance Use Services (DMH/DD/SAS), Division of Health Benefits (DHB), and URAC.

Table 22a. Appeals Received

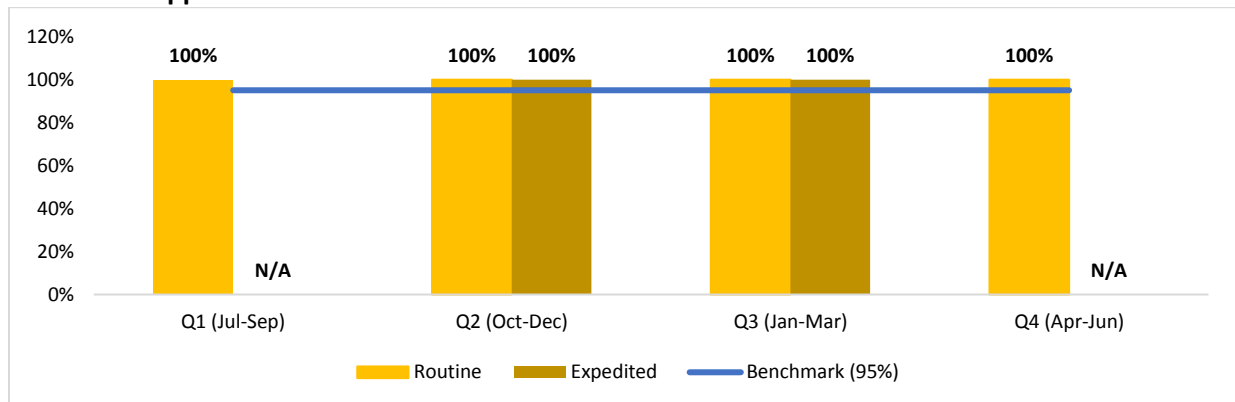
	Medicaid	Non-Medicaid
Appeals Requests Received	336	12

**Data from LME/MCO Monthly Monitoring Report*

Goal(s):

- 95% of all *Routine* appeals are completed and written notification of the appeal decision is issued within 30 calendar days of receipt of the request for appeal (*HUM 39*)
- 95% of all *Expedited* appeals are completed with verbal notification of the appeal decision to the requesting party within 72 hours of the request followed by written confirmation within 3 calendar days. (*URAC Standard: HUM 38*)

Table 22b. Appeals Process Timeframes



**Data from URAC Dashboard*

Status/Evaluation:

- Partners met the goal for routine appeals all four (4) quarters of SFY 2019.
- Partners met the goal for expedited appeals during the two (2) quarters (Q2 and Q3) in which expedited appeals were received. There were no expedited appeals processed during Q1 or Q4 as indicated by "N/A" on the above graph.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goals were met.

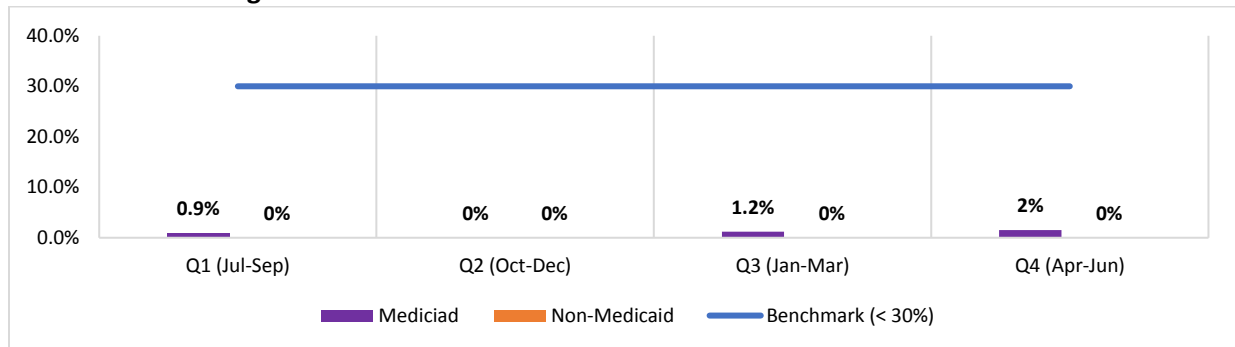
Intervention(s):

- No interventions were required as goals were met.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes. Goals will continue through SFY 2020 as they are a URAC requirement.

Goal(s): 30% or less of initial SAR decisions are overturned upon member appeal. (URAC Standard: HUM 34)

Table 22c. Percentage of Initial SAR Decisions Overturned



*Data from LME/MCO Monthly Monitoring Report

Status/Evaluation:

- Goal was met for all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goal was met.

Intervention(s):

- No interventions were required as goal was met.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes.

Health & Safety

Partners seeks to ensure member safety and implements policies and procedures to ensure that staff understands how to manage member interactions or adverse incidents where members may be at risk. Additionally, Partners, through the QM Consumer Rights Team, tracks all reports of adverse incidents to ensure that interactions are handled appropriately, and follow-up is completed to help ensure safety. The Quality of Care (QOC) Committee reviews and analyzes these reports to identify trends and opportunities for improvement.

Goal(s): Ensure that all adverse incidents are reported by providers as required by the North Carolina Administrative Code (NCAC) and appropriate investigation and follow-up is completed by Partners. (DHHS Requirement)

Table 23. Incident Reporting & Investigation Statistics

	SFY 2019 Total
Level II Critical Incident Reports received	2220
Level III Critical Incident Reports received	245
Level II and Level III Incidents that resulted in Partners on-site investigation	2
Level II and Level III Incidents that resulted in DHSR Investigation	24

*Data from Fiscal Year Monitoring Data Report (QM-Member Rights)

Table 23b. Results of Level II and Level III Investigations

	Q1 (Jul-Sep)	Q2 (Oct-Dec)	Q3 (Jan-Mar)	Q4 (Apr-Jun)
Results of Partners' On-site Investigations				
No Action by Provider Required	1	0	0	1
Corrective Action Plan by Provider Required	0	0	0	0
Provider Network Sanctions	0	0	0	0
DHSR Investigations				
No Action by Provider Required	4	1	2	2
Corrective Action by Provider Required	2	2	3	3
Type A1/A2 Penalty and Corrective Action Required**	3	0	0	1
Type B Penalty and Corrective Action Required***	0	1	0	0
Suspension of Admissions Issued	0	0	0	0
Revocation of Licensure	0	0	0	0

*Data from Fiscal Year Monitoring Data Report (QM-Member Rights)

** **Type A1 Violation** means a violation by a facility of applicable laws and regulations governing a facility which results in death or serious physical harm, abuse, neglect, or exploitation. **Type A2 Violation** means a violation by a facility of applicable laws and regulations governing the licensure of a facility which results in substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur.

*** **Type B Violation** means a violation by a facility of applicable laws and regulations governing a facility which is detrimental to the health, safety, or welfare of any resident, but which does not result in substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur.

Status/Evaluation:

- Partners met goal for SFY 2019
- No onsite investigations conducted because of a Level II or III incident report resulted Partners requesting corrective action from the provider for SFY 2019.
- When a provider is licensed by DHSR, Partners is required to defer any investigation, corrective action or penalties to DHSR.
- Incident reports are reviewed in the Quality of Care committee each month.

Identified Issue(s)/Barrier(s):

- No issues or barriers to goal were identified.

Intervention(s):

- No interventions were implemented as no issues or barriers were identified.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Quality of Care Concerns

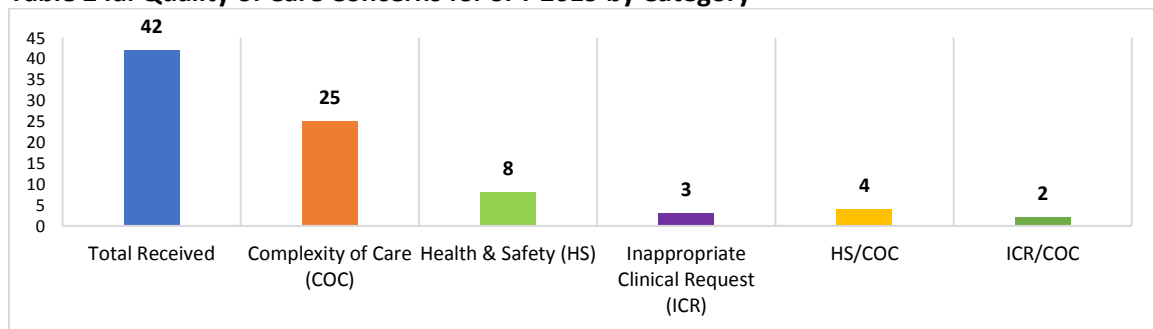
Quality of Care Concerns typically fall into one or more of the following three categories:

- **Health and Safety Concerns** include abuse, neglect, or reported risk of harm to self and others that has not been addressed adequately by the provider and directly impacts the safety of an individual. Health and Safety Concerns are considered incidents which are sent to the Provider Monitoring Team in the Quality Management Department for investigation within twenty-four hours of receipt of the notification and involves oversight of the Chief Medical Officer. Imminent health and safety conditions are also sent directly to Partners Chief Medical Officer.
- **Complexity of Care Concerns** involves inappropriate or inadequate treatment and/or lack of appropriate referrals of members which impact the member's care and well-being. The member's treatment needs are not limited to behavioral health; they could also include the need for housing, medical care, transportation, or natural and community resources. This type of QOCC could be identified when the member needs additional specialized treatment, psychological testing, or a psychiatric assessment to better develop a treatment plan. Complexity of Care Concerns may also identify gaps in Partners BHM array of service.
- **Inappropriate Clinical Request Concerns** are identified when the provider does not demonstrate minimal standards of care and/or demonstrates a lack of knowledge regarding the diagnosis, the requirements related to the service being delivered, appropriate level of care, requests for authorization that exceeds benchmarks or timeframes without justification for such, and poor documentation that does not support the request for authorization. Concerns in these areas may be indicators of inadequate treatment in addition to fraudulent activity.

Goal(s):

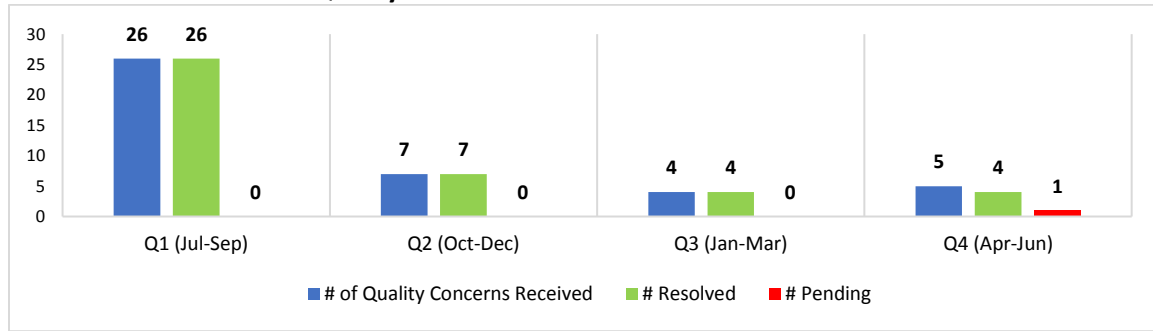
- Resolve quality of care concerns in a timely manner.
- Review all the QOC issues with the committee in a timely manner

Table 24a. Quality of Care Concerns for SFY 2019 by Category



*Data from QOC Referral Log

Table 24b. Resolution of Quality of Care Concerns for SFY 2019



*Data from QOC Referral Log

Status/Evaluation:

- Partners met goals for SFY 2019.
- 42 Quality of Care concerns were received during SFY 2019. One concern from June 2019 is still open at the time of this report writing.
- QOC concerns are staffed monthly with the QOC committee.

Identified Issue(s)/Barrier(s):

- No issues or barriers to goal were identified.

Intervention(s):

- No interventions were implemented as no issues or barriers were identified.

Goal(s) to Continue for Next Fiscal Year (Yes/No):

D. PROVIDER ACCESS AND AVAILABILITY

Network Composition

Table 25a. Provider Network Composition

Type	SFY 2019 Totals
Agencies (credentialed and contracted)	332
Licensed Independent Practitioners [LIP] (credentialed and contracted)	102
Associated Clinicians (active/credentialed)	2779
Out of Network Contracts Issued with Hospitals	5
Out of Network Contracts Issued with Physicians	9
Contracts Issued at Care Coordination Request	1

*Data from Healthcare Network Report

Table 25b. Network Composition- Practitioner Types

Psychiatrist	476
Clinical Psychologist	113
Licensed Clinical Social Worker	634
Licensed Professional Counselor	739

**Data from Partners Network Adequacy and Accessibility Analysis Report*

Table 25c. Network Composition- Facility Types

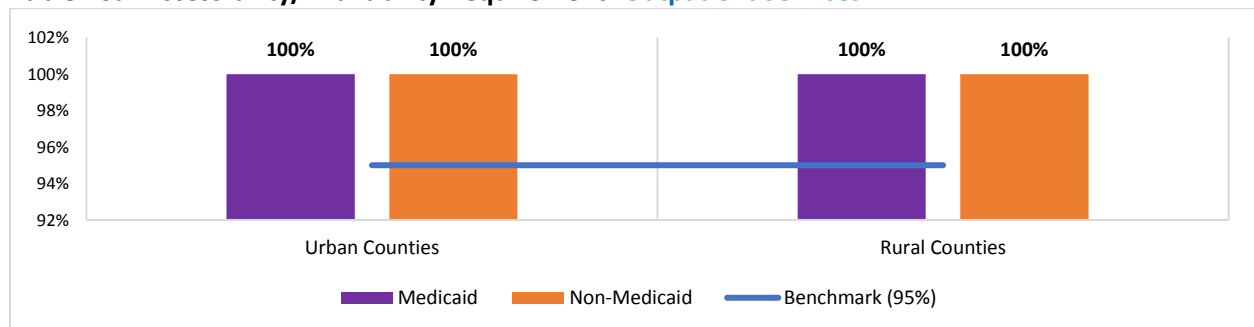
Inpatient Hospitals	9
Residential	141
Ambulatory Services	873

**Data from Partners Network Adequacy and Accessibility Analysis*

Access and Availability Standards

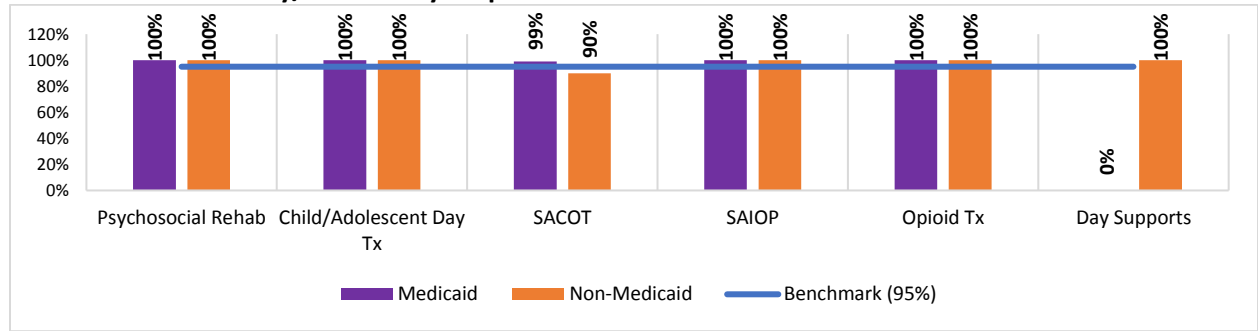
Goal(s):

- Ensure members have a choice of at least two (2) network providers within 30 miles/minutes of their home for urban areas and 45 miles/minutes for rural areas 95% of the time. *(North Carolina LME/MCO Access and Availability Requirement)*
- Maintain a provider network with at least one (1) Psychiatrist for every 2,000 members. *(North Carolina Access and Availability Requirement)*
- Maintain a provider network with at least one (1) Clinical Psychologist for every 10,000 members. *(North Carolina Access and Availability Requirement)*
- Maintain at least one (1) Licensed Clinical Social Worker for every 1,000 members. *(North Carolina Access and Availability Requirement)*
- Maintain at least one (1) Licensed Professional Counselor for every 1,000 members. *(North Carolina Access and Availability Requirement)*
- Maintain a provider network of at least one (1) inpatient hospital for every 10,000 members. *(North Carolina Access and Availability Requirement)*
- Maintain a network of at least one Residential Facility for every 7,500 members. *(North Carolina Access and Availability Requirement)*
- Maintain a network of one at least one Ambulatory/Crisis facility for every 1,000 members. *(North Carolina Access and Availability Requirement)*

Table 26a. Accessibility/Availability Requirement- Outpatient Services

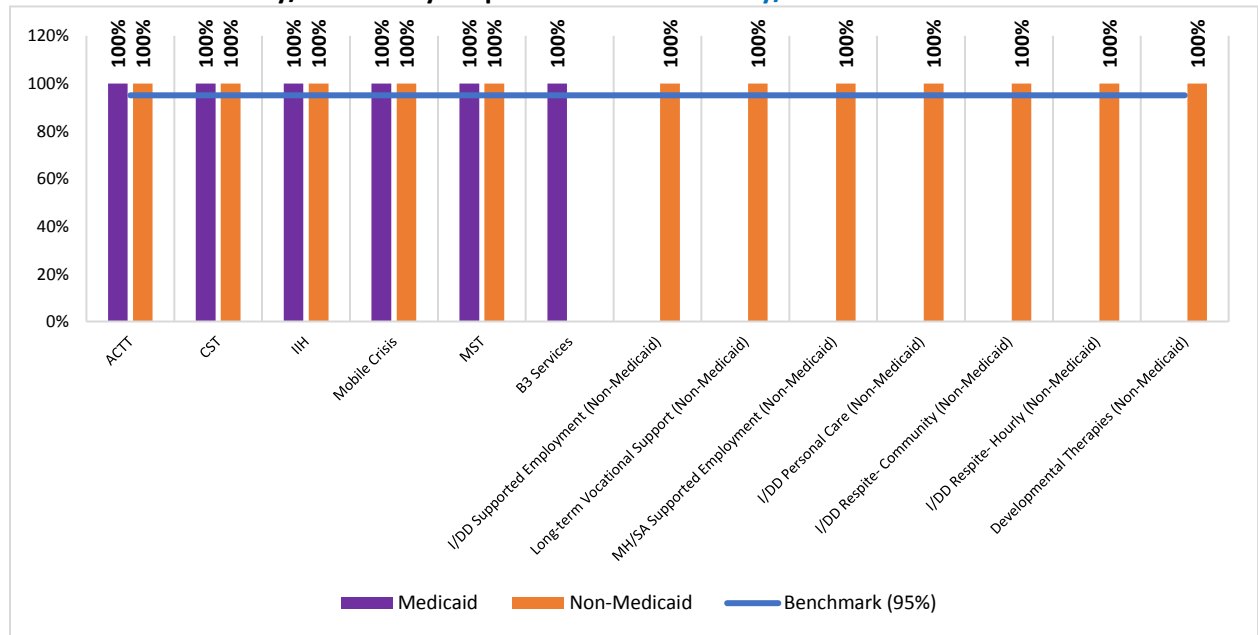
**Data from Partners Network Adequacy and Accessibility Analysis*

Table 26b. Accessibility/Availability Requirements- Location-Based Services



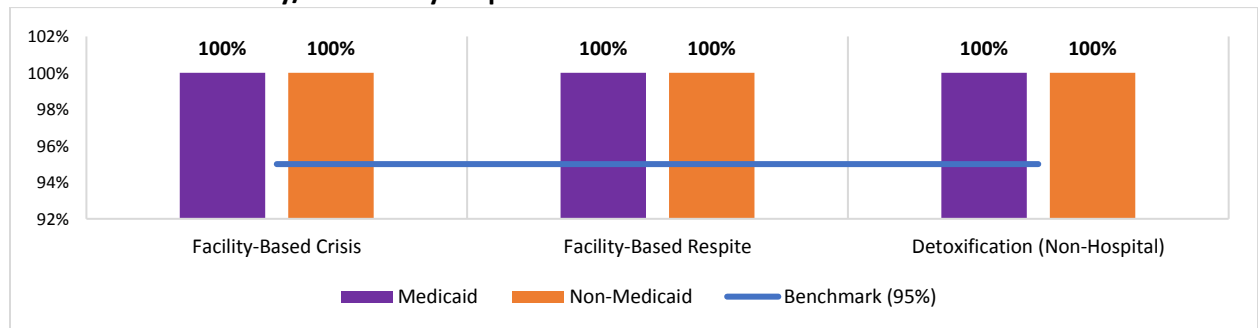
*Data from Partners Network Adequacy and Accessibility Analysis

Table 26c. Accessibility/Availability Requirements- Community/Mobile Services



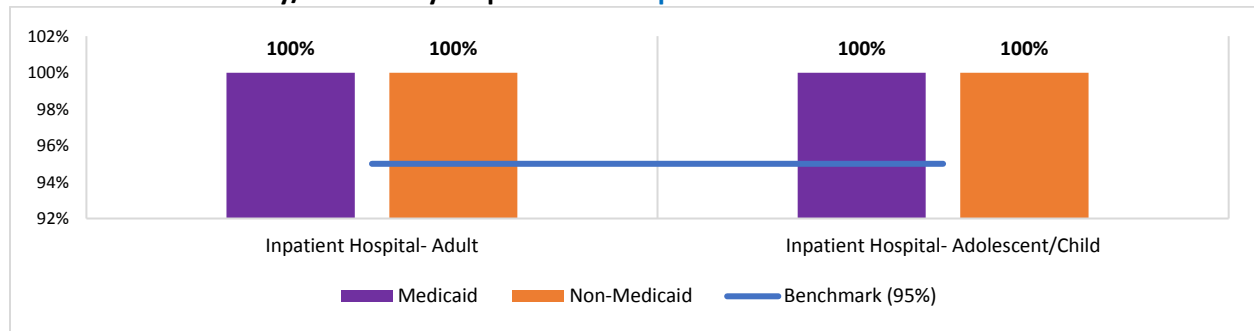
*Data from Partners Network Adequacy and Accessibility Analysis

Table 26d. Accessibility/Availability Requirements- Crisis Services



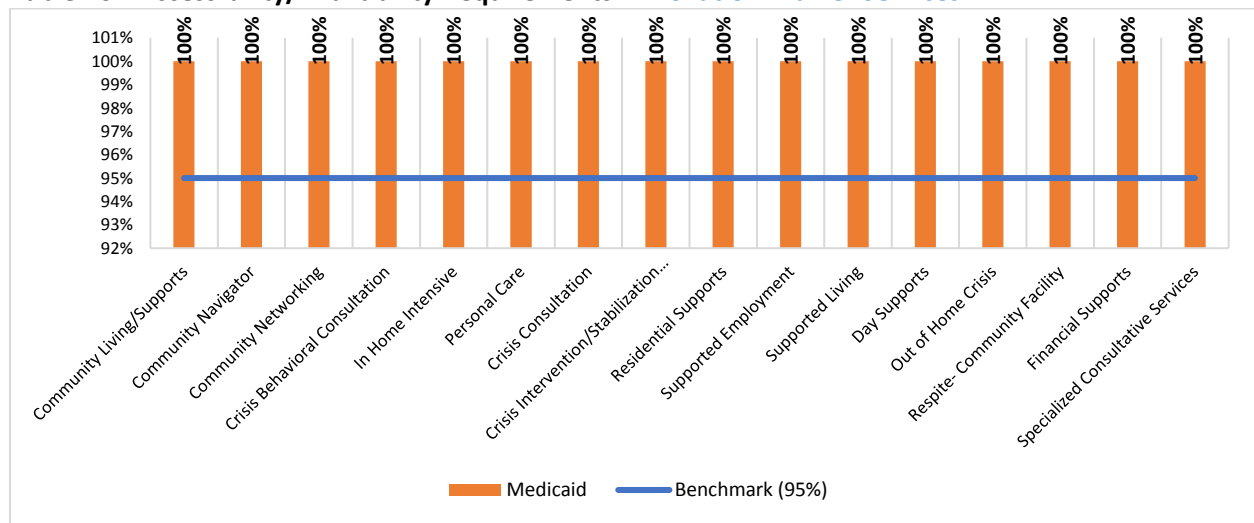
*Data from Partners Network Adequacy and Accessibility Analysis

Table 26e. Accessibility/Availability Requirements- Inpatient Services



*Data from Partners Network Adequacy and Accessibility Analysis

Table 26f. Accessibility/Availability Requirements- Innovation Waiver Services



*Data from Partners Network Adequacy and Accessibility Analysis

Table 26g. Practitioner Type Ratios

	Benchmark	Total Ratio
Psychiatrist	1:2000	1:472
Clinical Psychologist	1:10,000	1:1986
Licensed Clinical Social Worker	1:1000	1:354
Licensed Professional Counselor	1:1000	1:304

*Data from Partners Network Adequacy and Accessibility Analysis

Table 26h. Facility Type Ratios

Facility Type	Benchmark	Total Ratio
Inpatient Hospitals	1:10,000	1:24,938
Residential	1:7,500	1:1,592
Ambulatory Services	1:750	1:257

*Data from Partners Network Adequacy and Accessibility Analysis

Status/Evaluation:

- For SFY 2018 77% of Medicaid members, and 88% of Non-Medicaid members had access to two SACOT providers within 30/45 miles/minutes of their residence. For SFY 2019 this increased to 99% (+22 points) for Medicaid, and 90% (+2) for Non-Medicaid.
- Substantial efforts were to increase the supports available to the special populations. Partners was able to increase jail/prison services via a diversion grant and participates annually in the Veteran Stand Down. Additionally, an internal task force has been developed to analysis the language and interpretive service needs for our catchment area.

Identified Issue(s)/Barrier(s):

- Those in the northern counties of the catchment area are still experiencing obstacles and barriers to receiving substance use services, but progress has and continues to be made. Affordability of services and the stigma surrounding substance use is a concern.
- The feeling or belief that treatment does not work was a top influencer in a decision to stop seeking treatment reported by members and providers.
- Lack of support from family/friends was reported as a top service barrier by members, providers, and community stakeholders.
- Additionally, a perception gap was identified on whether members are informed about the different services available to them between members and providers & community stakeholders.
- Mental health services for substance use members are needed. When asked what would improve quality of life in their community 41% of SUD members said mental health services; 43% of SUD members reported their mental health was always or often not good in the past month.

Intervention(s):

- Partners will facilitate 12 community-based activities that will assist in identifying and reducing barriers to treatment.
- Increase member engagement by implementing three identified strategies for improving transportation solutions.
- Develop transportation options in Surry and Yadkin counities by identifying three transportation resources available to members.
- Increase IAFI providers treating the specialty population (sexually trafficked youth) to serve all nine counties.
- Increase the availability and capacity of residential level II services for youths.
- Increase access to Psychologists to provide mobile evaluations.
- Decrease the percentage of SUD members who report their mental health as always or often not good to 33% or less.
- Develop a dual Diagnosis (IDD/MH/SU/ASD 3-4 bed residential group home that serves adults.
- Develop a dual Diagnosis IDD/MH/SU Level III residential treatment facility serving females ages 9-12.
- Develop on Therapeutic Foster care (TFC) home specializing in IAFI serving children ages 9-12
- Develop at least 1 transitional housing program for adults diagnosed with substance use disorders in Partners Norther Region (Iredell, Surry, Yadkin)
- Increase the number of SACOT providers to close service needs gap in Surry and Yadkin Counties.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Credentialing

Partners is required to credential and re-credential all Applicants meeting required qualifications for participation in the closed Provider Network of Partners, including but not limited to Licensed Practitioners, Licensed Independent Practitioners, Agencies (including Group Practices and Licensed Facilities such as Psychiatric Residential Treatment Facilities), and Hospitals and/or Health Systems.

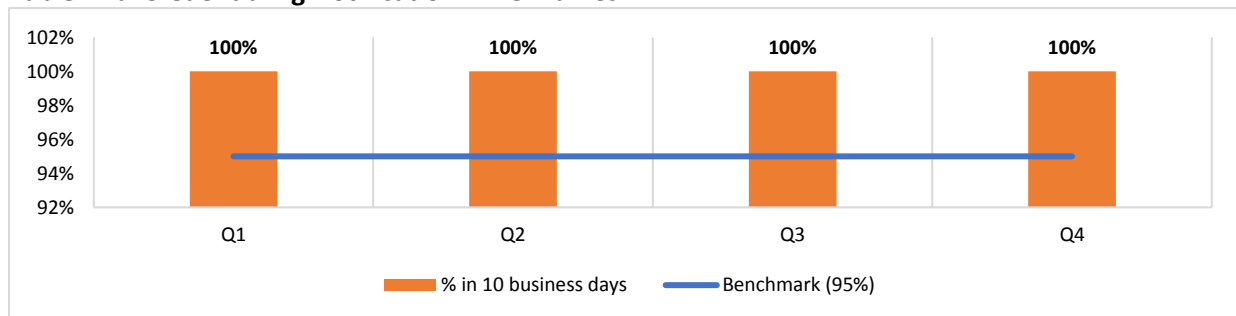
Table 27a. Credentialing/Contract Status

	SFY 2019 Totals
Initial Credentialing Completed	
Agency	60
LIP	808
Re-credentialing Completed	
Agency	86
LIP	660
Credentialing Denial	11
Credentialing Revoked	30
Withdrawal of Credentialing	23
Contracts Terminated for Cause	2
Contracts Terminated without Cause	1
Voluntary Contract Termination	20
Non-Renewal of Contract	5

**Data from Healthcare Network Report*

Goal: Written notification of credentialing decision is sent within 10 business days of the credentialing determination 95% of the time. (URAC Standard: HNM-CR 13)

Table 27b. Credentialing Notification Time Frames



**Data from URAC Performance Dashboard Report*

Status/Evaluation:

- Partners met the credentialing notification goal all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goal was met.

Intervention(s):

- No interventions were implemented as goal was met.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes. Goal will continue through SFY 2020 as it is a URAC requirement.

Provider Disputes

To respect providers' rights while simultaneously protecting members, Partners maintains a formal process consistent with its written agreements to address alleged violations of the agreement by participating providers. This "Dispute Resolution Process" is available to any participating provider who wishes to initiate it. Disputes fall into one of the following categories:

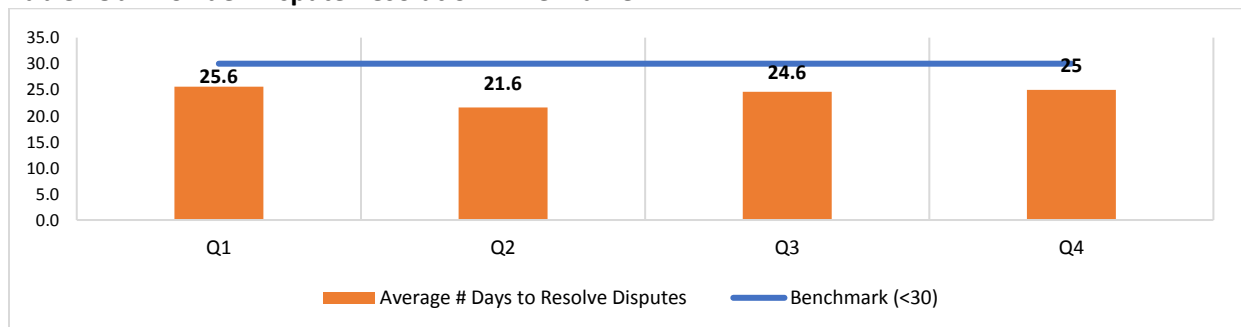
- **Clinical Disputes:** Involving professional competence or conduct issues.
- **Administrative Disputes:** Involving administrative issues.

Table 28a. Provider Disputes

	Totals for SFY 2019
Administrative Disputes	
<i>Filed</i>	29
<i>Resolved</i>	27
Clinical Disputes	
<i>Filed</i>	4
<i>Resolved</i>	3

**Data from Healthcare Network Report*

Goal(s): Provider disputes are resolved within 30 days of the provider's initiation of the dispute. (URAC Standard: HNM 14e)

Table 28b. Provider Dispute Resolution Time Frame

**Data from Healthcare Network Report*

Status/Evaluation:

- Partners met the goal of provider dispute resolution in 30 days or less for all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goal was met.

Intervention(s):

- No interventions were implemented as goal was met.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes. Goal will continue through SFY 2020 as it is a URAC requirement.

Access to Care Call Center Performance Measures

Partners has the responsibility of offering individuals who live in Partners' catchment area 24/7/365 access to services. Partners fulfills these responsibilities through the Member Services Call Center. The call center fields various calls and performs screening, triage and referral. Partners' call center does not perform health education, except in the context of screening, triage and referral when personnel are assisting the member with provider choice.

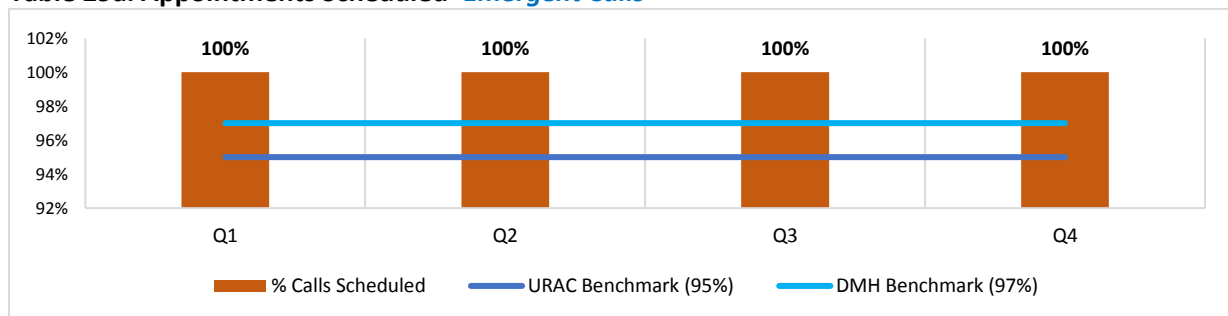
Partners strives to provide timely access to routine, urgent and emergent behavioral healthcare for its members. URAC Health Call Center guidelines and the Division of Health and Human Services (DHHS) contracts provide specific requirements for ensuring that timely appointments are provided to members.

Screening, Triage & Referral

Goal(s):

- 95% of *Emergent* calls are scheduled to be seen by a provider within two (2) hours. (*URAC Standard: HCC 16*)
- 97% of *Emergent* calls are scheduled to be seen by a provider within two (2) hours and fifteen (15) minutes. (*DMH Requirement*)

Table 29a. Appointments Scheduled- *Emergent Calls*



**Data from URAC Performance Dashboard*

Status/Evaluation:

- Partners scored 100% all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goal was met.

Intervention(s):

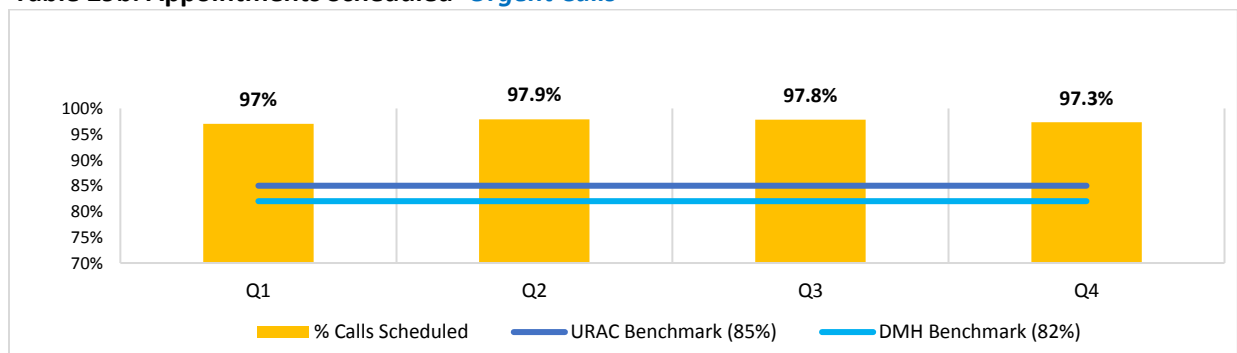
- No interventions were implemented as goal was met.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes. Goals will continue through SFY 2020.

Goal(s):

- 85% of *Urgent* calls are scheduled to be seen by a provider within forty-eight (48) hours. (*URAC Standard: HCC 16*)
- 82% of *Urgent* calls are scheduled to be seen by a provider within forty-eight (48) hours. (*DMH Requirement*)

Table 29b. Appointments Scheduled- *Urgent Calls*



**Data from URAC Performance Dashboard*

Status/Evaluation:

- Partners met both timely scheduled Urgent appointment goals for all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goals were met.

Intervention(s):

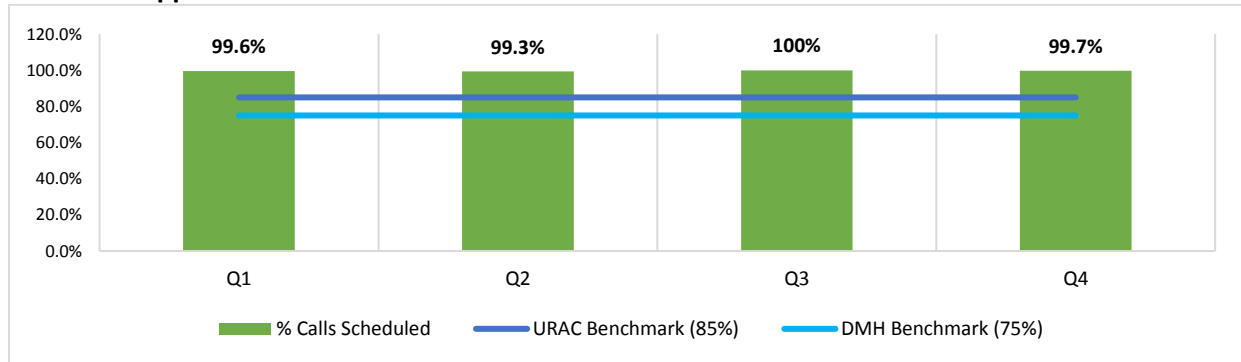
- No interventions were implemented as goals were met.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Goal:

- 85% of *Routine* calls are scheduled to be seen by a provider within fourteen (14) calendar days. (*URAC Standard: HCC 16*)
- 75% of *Routine* calls are scheduled to be seen by a provider within fourteen (14) calendar days. (*DMH Requirement*)

Table 29c. Appointments Scheduled- *Routine Calls*



* Data from URAC Performance Dashboard

Status/Evaluation:

- Partners met both timely scheduled Routine appointment goals for all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goals were met.

Intervention(s):

- No interventions were implemented as goals were met.

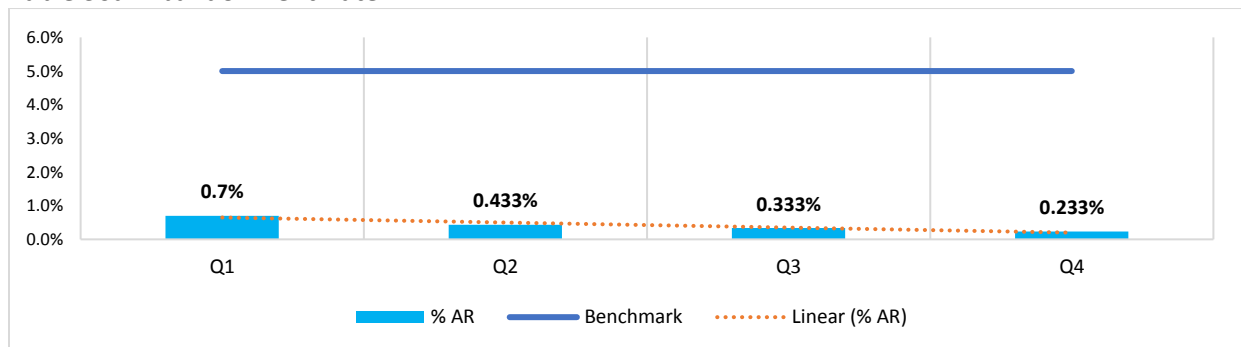
Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Abandonment Rate:

Abandonment Rate (AR) is the percentage of calls offered to the automatic call distribution (ACD) system, that are terminated by the caller prior to being answered by a live staff person.

Goal(s): Partners will maintain an abandonment rate of 5% or less. (*URAC Standard: HCC 11c; DMH Requirement*)

Table 30a. Abandonment Rate



*Data from Member Services- Access to Care Department Performance Report

Status/Evaluation:

- Partners met goal for all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goals were met.

Intervention(s):

- No interventions were implemented as goals were met.

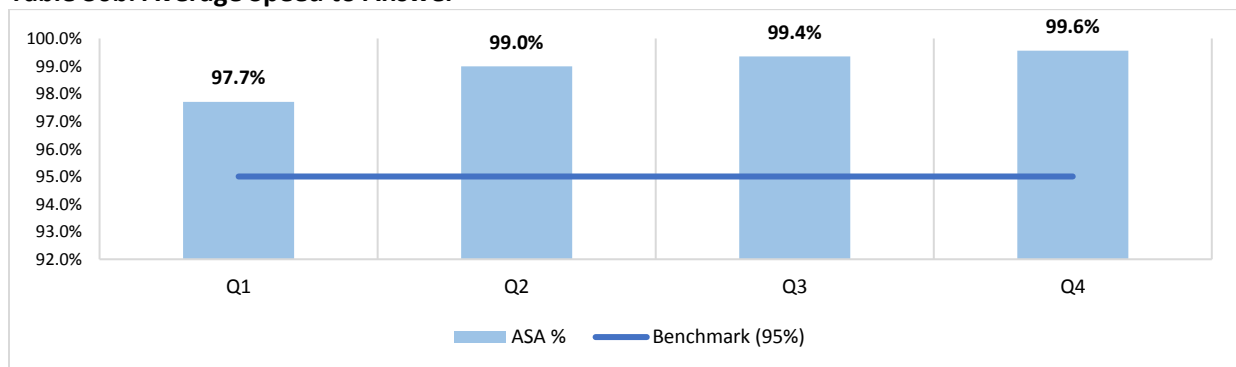
Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Average Speed to Answer:

Average Speed to Answer (ASA) is the average delay in minutes and seconds that inbound telephone calls encounter waiting in the telephone queue before being answered by a live staff person.

Goal: 95% of calls to Access to Care line will be answered within 30 seconds or less. (*URAC Standard: HCC 11b; DMH Requirement*)

Table 30b. Average Speed to Answer



**Data from LME/MCO Monthly Report*

Status/Evaluation:

- Partners met goal for all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goals were met.

Intervention(s):

- No interventions were implemented as goals were met.

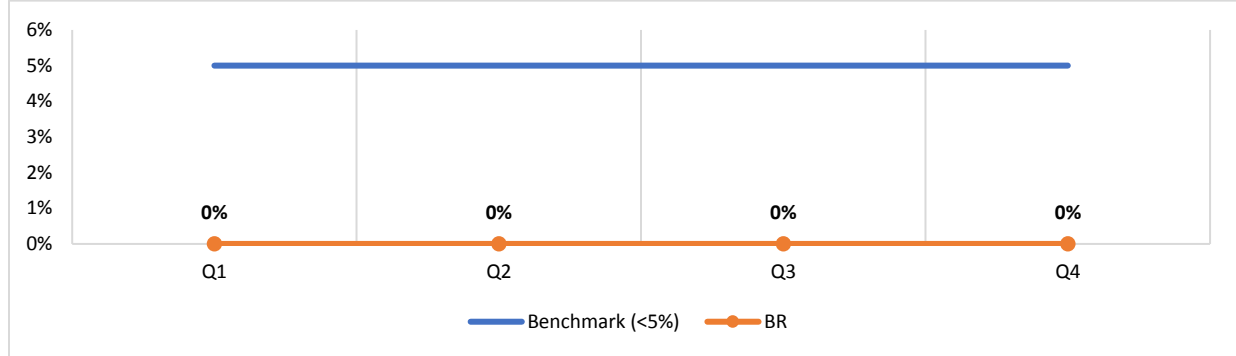
Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Blockage Rate:

Blockage Rate (BR) is the number of times a member calling into the call center experiences a busy signal.

Goal: Partners will maintain a blockage rate of 5% or less. (*URAC Standard: HCC 11a*)

Table 30c. Call Blockage Rate



**Data from URAC Performance Dashboard*

Status/Evaluation:

- Partners met goal for all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goals were met.

Intervention(s):

- No interventions were implemented as goals were met.

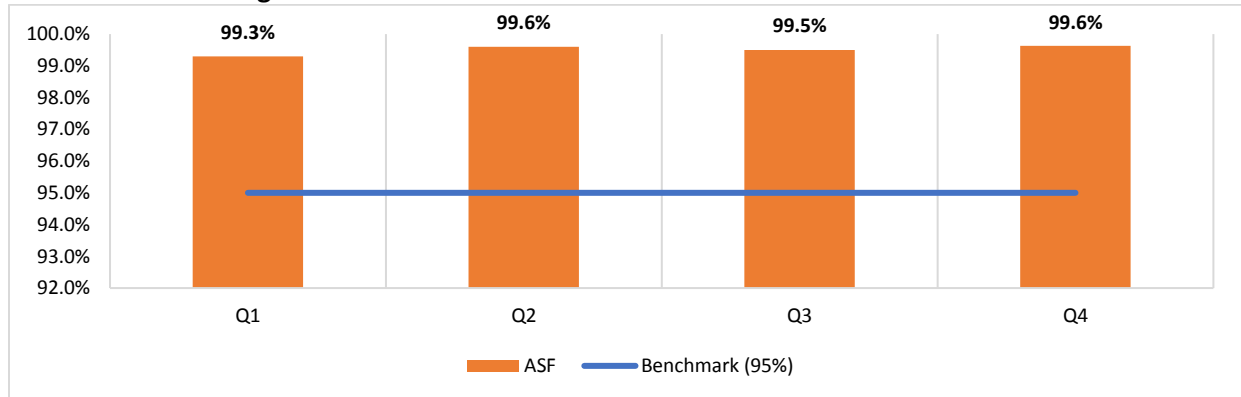
Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Answering Service Factor:

Answering Service Factor (ASF) is the percentage of calls offered to the automatic call distribution (ACD) system that are answered by the call center.

Goal: Partners will maintain an answering service factor of 95% or above. (DMH Requirement)

Table 30d. Answering Service Factor



**Data from Member Services- Access to Care Department Performance Report*

Status/Evaluation:

- Partners met goal for all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goals were met.

Intervention(s):

- No interventions were implemented as goals were met.

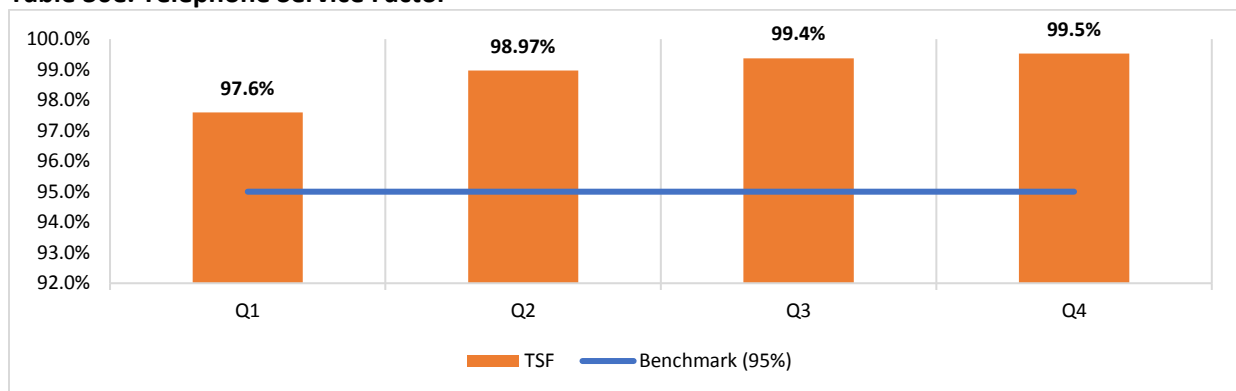
Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Telephone Service Factor:

Telephone Service Factor (TSF) is the percentage of all calls answered by the call center that were answered in 30 seconds or less.

Goal: Partners will maintain a telephone service factor of 95% or above. (*DMH Requirement*)

Table 30e. Telephone Service Factor



**Data from Member Services- Access to Care Department Performance Report*

Status/Evaluation:

- Partners met goal for all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goals were met.

Intervention(s):

- No interventions were implemented as goals were met.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Access to Care Inter-Rater Reliability Testing (IRR)

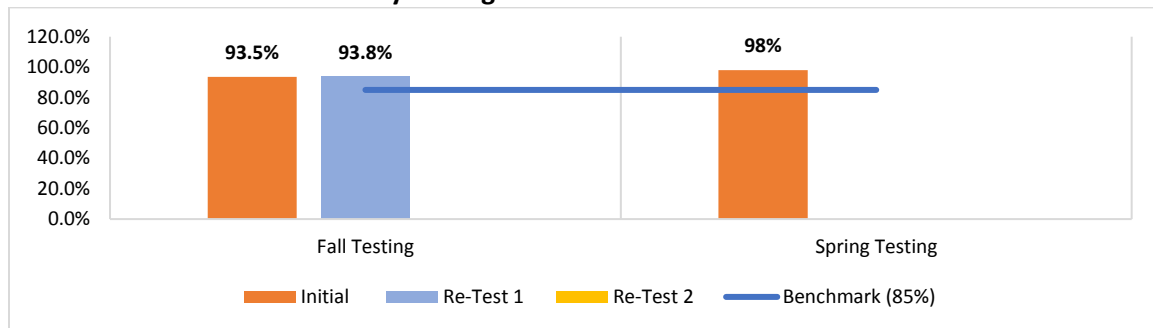
It is the policy of Partners that Access to Care will measure and maintain inter-rater reliability (IRR). IRR is an assessment, test or study performance measurement tool involving a comparison of responses for

a control group with a set standard and assures consistency in judgment and the decision-making process. All Access to Care staff are to make timely and consistent decisions per approved criteria and URAC standards. Inter-Rater Reliability testing will be conducted Spring and Fall each year.

Goal:

- Maintain an 85% or greater average test score (*URAC Standard: Core 29b*)
- Improve Average IRR score from 91.1% (Spring 2018) to 94%. (*OQAP*)

Table 31a. Inter-Rater Reliability Average Test Scores



**Data from Member Services-Access to Care Inter-Rater Reliability Results*

Table 31b. Inter-Rate Reliability- Staff Scoring within Specified Range

	Fall Testing	Spring Testing
% of staff met/exceeded 85% benchmark	69.6%	100%
% of staff scoring 100%	39.1%	73.9%
% of staff scoring below 85%	30.4%	0%

**Data from Access to Care Inter-Rate Reliability Results*

Status/Evaluation:

- Partners met the average score goals for SFY 2019.
- 100% of call center staff participating in the Spring IRR testing met or exceeded the 85% test score benchmark.
- 73.9% of call center staff participating in the Spring IRR testing scored 100%.

Identified Issue(s)/Barrier(s):

- 30.4% of call center staff participating in the Fall IRR testing did not meet the 85% test score benchmark.

Intervention(s):

- Call center staff that scored below 85% on the initial test were retested. As the staff who took the retest all scored above 85%, no remediation training was required.

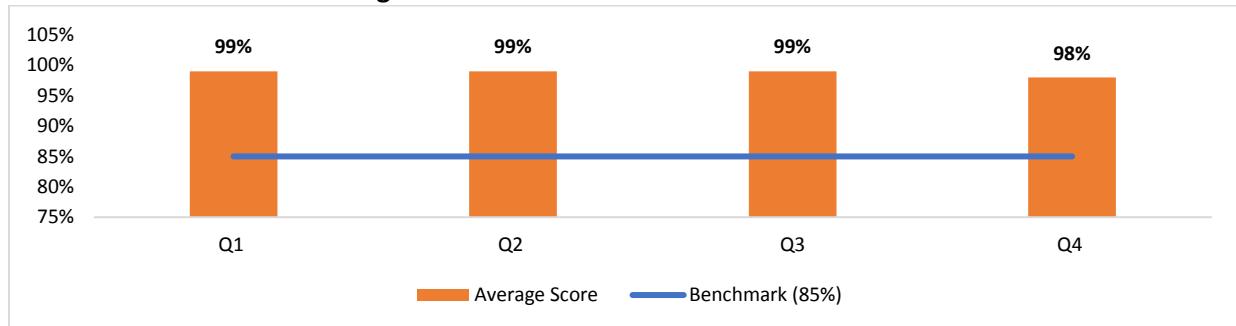
Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Access to Care Silent Call Monitoring

The purpose of silent call monitoring is to ensure that quality service is being given per telephone screenings and interactions with members, potential members, and their families or significant others. Silent call monitoring also ensures that all telephone interactions are conducted in a professional manner and allows provision of supervision and direction to call center staff in a timely manner.

Goal: Maintain an average score of 85% for silent call monitoring (*URAC Standard: Core 29b*)

Table 32. Silent Call Monitoring of Access to Care Staff



**Data from Member Services- Access to Care Department*

Status/Evaluation:

- Partners met goal for all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goals were met.

Intervention(s):

- No interventions were implemented as goals were met.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

E. CONTINUITY AND COORDINATION OF BEHAVIORAL HEALTH SERVICES

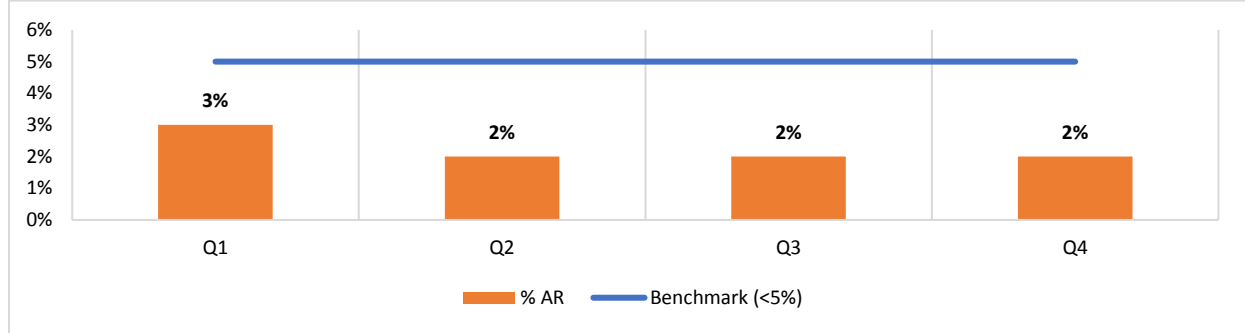
Utilization Management (UM) Performance Measures

Abandonment Rate:

Abandonment Rate (AR) is the percentage of calls offered to the automatic call distribution (ACD) system, that are terminated by the caller prior to being answered by a live staff person.

Goal: Utilization Management will maintain an abandonment rate of 5% or less. (*URAC Standard: HUM 2*)

Table 33a. Abandonment Rate



** Data from URAC Performance Dashboard*

Status/Evaluation:

- Partners met goal for all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goals were met.

Intervention(s):

- No interventions were implemented as goals were met.

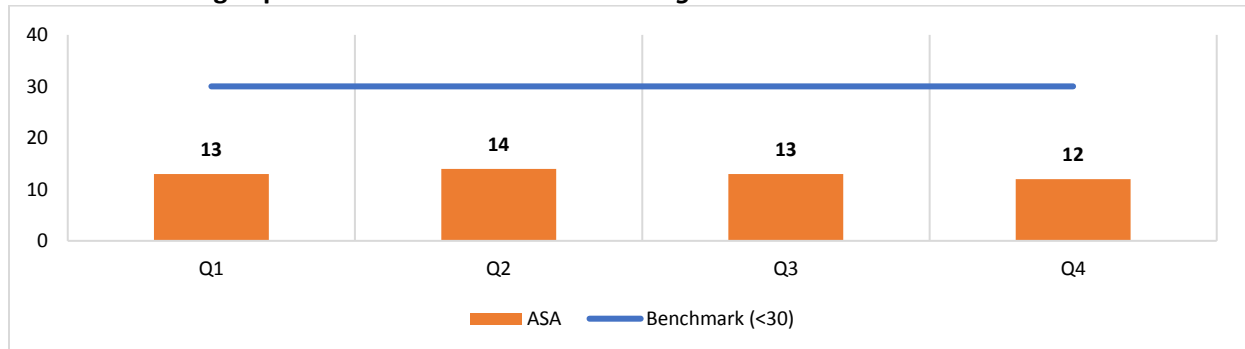
Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Average Speed to Answer:

Average Speed to Answer (ASA) is the average delay in minutes and seconds that inbound telephone calls encounter waiting in the telephone queue before being answered by a live staff person.

Goal: Utilization Management will maintain an average speed to answer of 30 seconds or less. (*URAC Standard: HUM 2*)

Table 33b. Average Speed to Answer- Utilization Management



** Data from URAC Performance Dashboard*

Status/Evaluation:

- Partners met goal for all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goals were met.

Intervention(s):

- No interventions were implemented as goals were met.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes**Standard Authorization Request (SAR) Processing**

Requests for mental health (MH), substance use (SU) or intellectual and developmental disability (IDD) services are made by the completion and entry of a Service Authorization Request (SAR) into AlphaMCS. Care Management staff have up to 14 days to process routine requests or 72 hours for an expedited request. All time frames for review are inclusive of decision and the peer review and mailing of *Notice of Action* letter to the member/legally responsible person if there is a denial of all or part of the request.

Table 34a. SAR Decisions- Routine & Expedited Combined

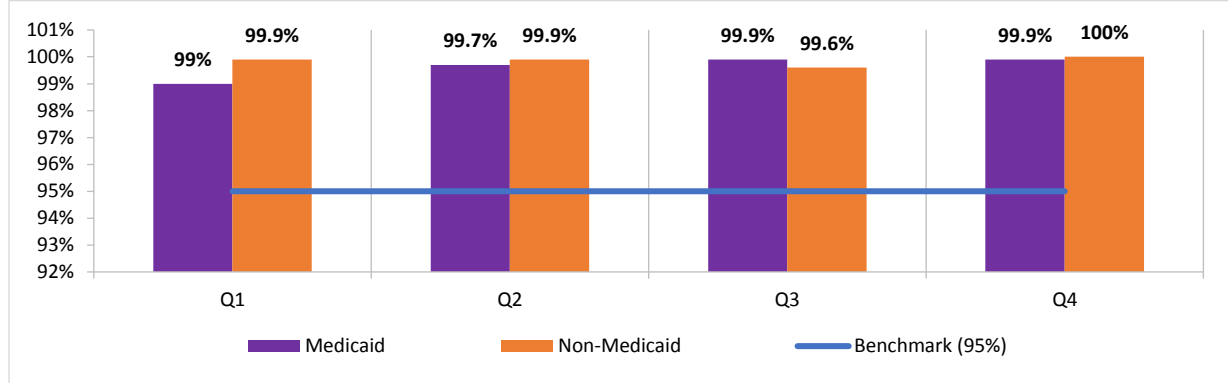
	SFY 2019
SARs Received	
<i>Medicaid</i>	42,119
<i>Non-Medicaid</i>	25,204
SARs Approved	
<i>Medicaid</i>	39,446
<i>Non-Medicaid</i>	24,956
SARs Denied for Administrative Reasons	
<i>Medicaid</i>	494
<i>Non-Medicaid</i>	112
SARs Denied for Clinical Reasons	
<i>Medicaid</i>	2,179
<i>Non-Medicaid</i>	136

**Data from LME/MCO Monthly Monitoring Report*

Goals:

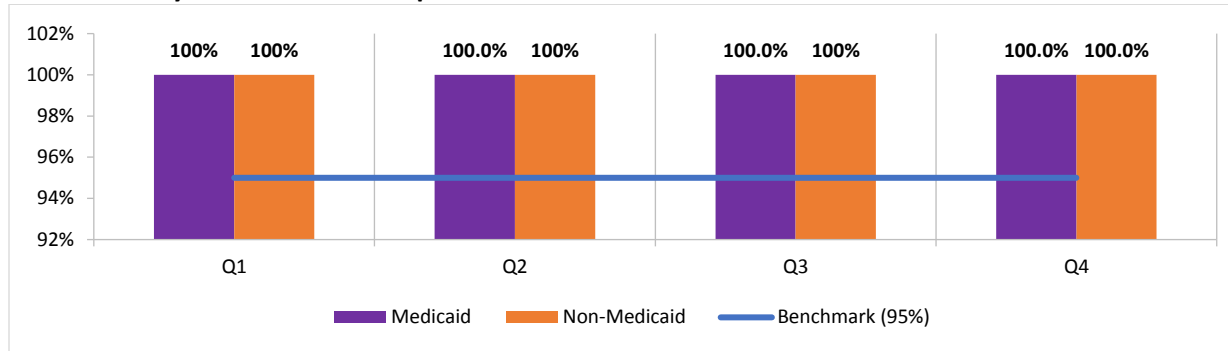
- 95% of all *Routine* SARS will be processed within 14 calendar days (*DHB/DHHS Contracts; URAC Standard: HUM 19-21*)
- 95% of all *Expedited* SARS will be processed within 72 hours (*DHB/DHHS Contracts; URAC Standard: HUM 19-21*)

Table 34b. Days to Decision for Routine SAR



**Data from LME/MCO Monthly Monitoring Report*

Table 34c. Days to Decision for Expedited SAR



**Data from LME/MCO Monthly Monitoring Report*

Status/Evaluation:

- Partners met goal for all four (4) quarters of SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goals were met.

Intervention(s):

- No interventions were implemented as goals were met.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

UM Inter-Rater Reliability Testing (IRR)

It is the policy of Partners Behavioral Health Management (Partners BHM) that UM will measure and maintain inter-rater reliability (IRR). IRR is an assessment, test or study performance measurement tool involving a comparison of responses for a control group with a set standard and assures consistency in judgment and the decision-making process. The UM department uses IRR testing to assess and ensure consistent application of clinical criteria for the authorization of services.

Goal: Maintain an 85% or greater average test score (*URAC Standard: Core 29b*)

Table 35. Inter-Rater Reliability Test Scores for UM

UM Inter-Rater Reliability Results		
Type	Date	Average Score
SAIOP	Oct 2018	80%
SAIOP Re-test	Dec 2018	100%
Inpatient Services	April 2019	89%
I/DD Services (Day Supports, Supported Employment, Residential Supports)	May 2019	100%

**Data from Utilization Management Department*

Status/Evaluation:

- Partners met goal for IRR testing for SFY 2019

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goals were met.

Intervention(s):

- No interventions were implemented as goals were met.

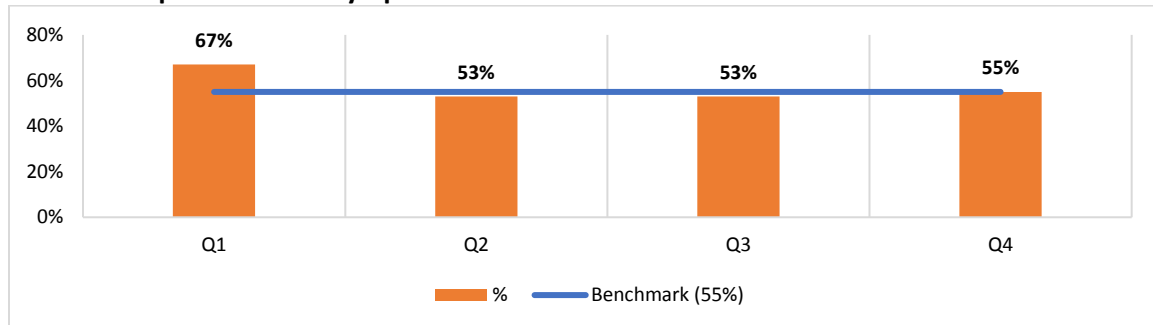
Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Treatment Effectiveness/Engagement Strategic Plan Goals

Treatment Effectiveness

Goal: 55% or more of MHSU members will identify treatment was “Very Helpful” with improving symptoms. *(Strategic Plan Goal 7.A)*

Table 36. Improvement of Symptoms



**Data from Strategic Plan Progress Report*

Status/Evaluation:

- Partners met this goal by Q4 SFY 2019.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goals were met.

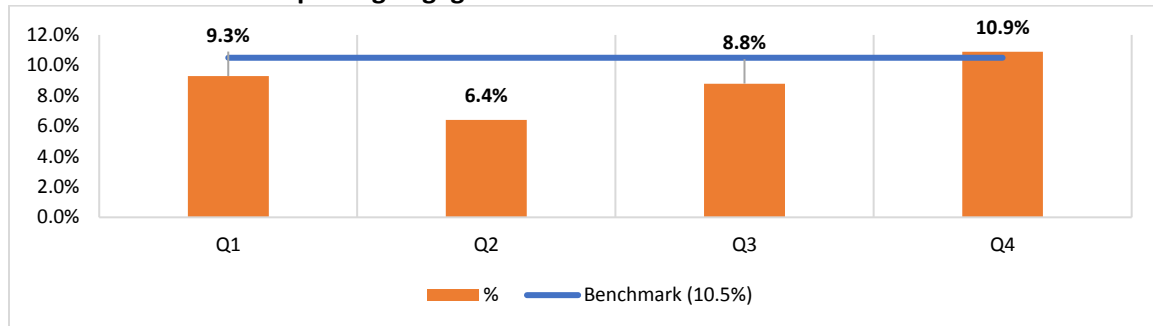
Intervention(s):

- No interventions were implemented as goals were met.

Goal(s) to Continue for Next Fiscal Year (Yes/No): No

Goal: The number of individuals receiving adult substance use services who report engagement as a barrier to treatment will decrease by 5 percentage points (from 15.5% to 10.5%). (*Strategic Plan Goal 7.B*)

Table 37. Individuals Reporting Engagement as A Barrier to Treatment



**Data from Strategic Plan Progress Report*

Status/Evaluation:

- Partners met goal Q1-Q3 but Q4 score showed a 2.1 percentage point increase from Q3

Identified Issue(s)/Barrier(s):

- As Q4 data has just recently been received and Partners was achieving goal prior to receipt of Q4 data, issues and barriers have yet to be identified.

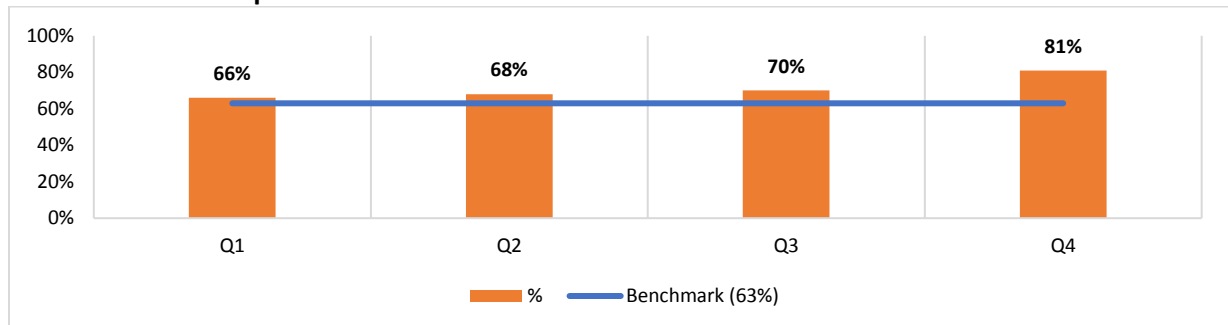
Intervention(s):

- Interventions have not been developed at this time as Partners was achieving goal prior to Q4.
- Partners is in the process of finalizing new, more specific engagement goals for the SFY 2020 Strategic Plan.

Goal(s) to Continue for Next Fiscal Year (Yes/No): No

Goal: All Licensed Independent Practitioners (LIP) will achieve 63% or higher on patient improvement score. (Strategic Plan Goal 7.C)

Table 38. Patient Improvement Score



**Data from Strategic Plan Progress Report*

Status/Evaluation:

- This goal has been met.

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified as goal was met.

Intervention(s):

- No interventions were implemented as goal was met.

Goal(s) to Continue for Next Fiscal Year (Yes/No): No

F. SATISFACTION

Partners' Member Experience Survey

Partner's Behavioral Health monitors performance areas affecting member satisfaction on an annual basis. One of the ways this monitoring is completed is through the administration of the *Partners' Member Experience Survey*.

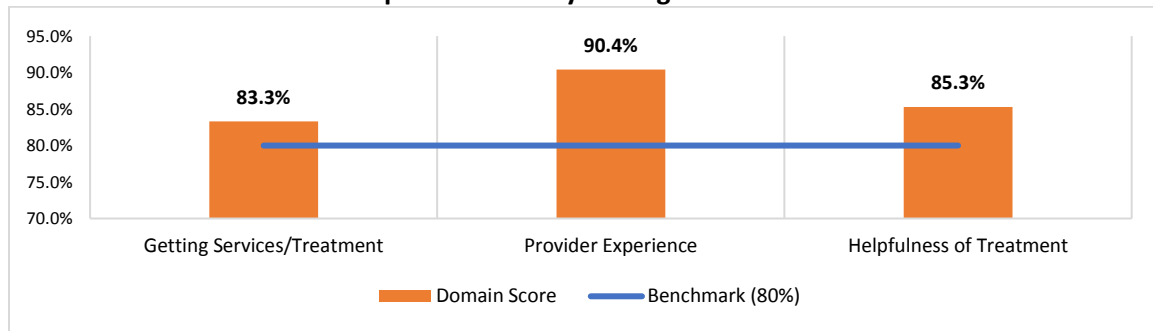
The objectives of this survey are:

- Annually evaluate member satisfaction with Partners
- Identify opportunities to improve member satisfaction
- Develop and implement solutions to improve member satisfaction

SFY 2019 was the inaugural year for this survey and was administered on behalf of Partners by The Mihalik Group (TMG), LLC during March 2019. Partners received the survey results during May 2019.

Goal: Achieve at least 80% score on the Member Experience Survey. (NCQA Standard: QI6.A2)

Table 39. Partners' Member Experience Survey Average Domain Score



**Data from Partners' Member Experience Survey Report*

Status/Evaluation:

- Overall, Partners' average score for each domain was above 80%. However, there were four (4) individual survey questions where Partners scored below the 80% benchmark.
- Partners had the best performance (i.e. scored 90% or above) for the following survey questions:
 - Q7. *Your Provider's office or location is easy to get to. (Provider Experience: 98.3%)*
 - Q9. *After your first appointment, your Provider was able to schedule a follow-up appointment as soon as you wanted. (Provider Experience: 93%)*
 - Q10. *Your Provider responded in a timely manner to your telephone calls. (Provider Experience: 96.4%)*
 - Q11. *Your privacy and dignity were maintained while you received services or treatment. (Provider Experience: 93.3%)*
 - Q12. *Your Provider was able to meet any special or cultural needs or choices that you had. (Provider Experience: 98.2%)*
 - Q13. *Your Provider worked with you to develop treatment goals and plan of action (Provider Experience: 94.8%).*
 - Q14. *Fees and payments were explained to you. (Provider Experience: 92.2%)*
 - Q15. *Privacy of information was explained clearly. (Provider Experience: 94.8%)*
 - Q16. *Provider's office staff were helpful. (94.9%)*
 - Q30. *The services or treatment I received helped me perform better at work or school. (Helpfulness of Treatment: 91.8%)*

Identified Issue(s)/Barrier(s):

- Partners did not perform as well (i.e. below 80%) for the following survey questions:
 - Q6. *Pleased with getting an appointment for services or treatment. (Getting Services or Treatment: 72.2%)*
 - Q21. *First appointment with provider was within 2 weeks. (Provider Experience: 73.6%)*
 - Q22. *Rating of Your Provider (Provider Experience: 79.7%)*
 - Q42. *At first appointment, waited less than 1 hour to see to be seen by the therapist. (Provider Experience: 78.4%)*
- The following issues were identified as possible barriers to meeting 80% survey benchmark:
 - Difficulty in tracking appointments that members make directly with the provider.
 - Members may not have reliable transportation to appointments.
 - Partners may be able to obtain an appointment with a provider within two weeks, but it is not with the provider of choice.
 - Lack of after-hours and weekend appointments to fit member's schedule.

Intervention(s):

- Partners received the final report from TMG May 2019 and results were presented to June 2019 QIC.
- A second, follow-up survey was sent out at the end of June 2019. This included follow-up questions for the timely appointment questions asked in the March Survey.
- Partners has decided to wait on the results of the follow-up survey before implementing any further action on the items scoring below 80%.

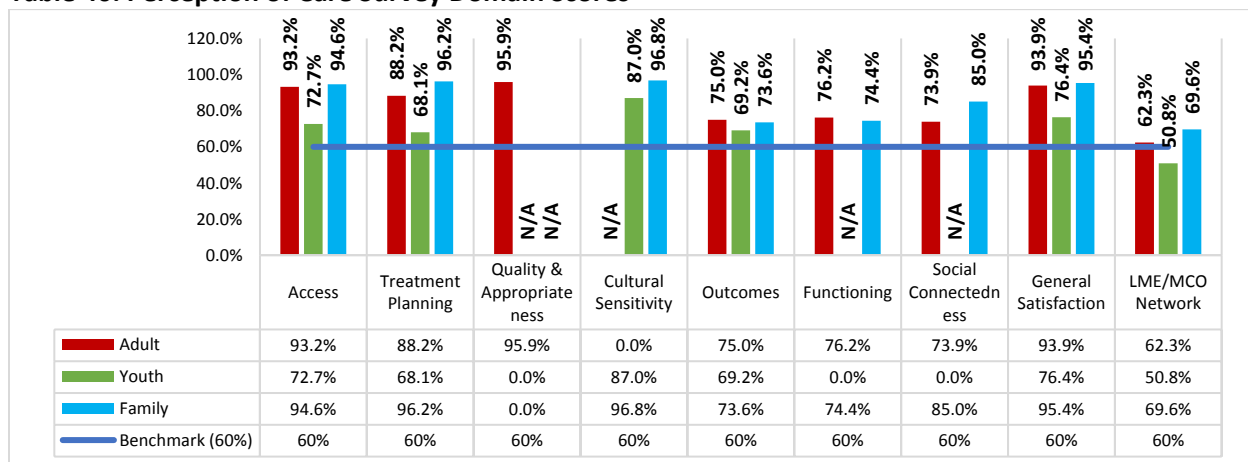
Goal(s) to Continue for Next Fiscal Year (Yes/No): No. While Partners will continue to work on interventions to address issues identified in the March 2019 and June 2019 survey, the survey itself is a one-time activity.

Consumer Perception of Care (POC) Survey

The *North Carolina Mental Health and Substance Abuse Consumer Perception of Care Survey* is administered by the North Carolina Department of Health and Human Services (DHHS), in partnership with the Local Management Entities/Managed Care Organizations (LME/MCO) on an annual basis. The survey provides information on the quality of care in each LME/MCO catchment area, based on the perceptions of individuals and families who have received Medicaid or State-funded mental health and/or substance use services. The Calendar Year (CY) 2018 survey was administered between May 7, 2018 and June 5, 2018. Results were reported out to the MCOs in March 2019.

Goal(s):

- Analyze survey results and develop measures to address identified quality problems. (*EQR Standard: IV.A.4*)

Table 40. Perception of Care Survey Domain Scores

*Data from DHHS Perception of Care Survey Report

N/A= Domain not included in survey indicated

Status/Evaluation:

- The highest scoring domains for each survey population were *Quality and Appropriateness* (Adult: 95.9%) and *Cultural Sensitivity* (Youth: 87%; Child: 96.8%).

- The lowest scoring domains for each survey population were *Social Connectedness* (Adult: 73.9%), *Treatment Planning* (Youth: 68.1%), and *Outcomes* (Child: 73.6%).
- Partners had the best performance (i.e. $\geq 90\%$ **or** highest score with no decrease in score **or** decrease of two (2) percentage points or less compared to previous survey **and** at least 10 usable responses) for the following survey questions:
 - *Staff respected Respondent's wishes regarding sharing treatment information. (Quality and Appropriateness- Adult: 96.5%)*
 - *Respondent participated in child's treatment. (Treatment Planning-Child: 100%)*

Identified Issue(s)/Barrier(s):

- Partners did not perform as well (i.e. below 60% **or** lowest score **or** showed a decrease of 10 or more percentage points from previous survey) for the following survey questions:
 - *Received a Consumer Handbook within 14 days. (LME/MCO Network- Adult: 40%; Youth: 38%; Child: 52%)*
 - *Know how to make a complaint. (LME/MCO Network- Adult: 51%; Youth: 40%)*
 - *Location of services convenient. (Access- Youth: 72.9%; -12.7 points)*
 - *Respondent got as much help as he/she needed. (General Satisfaction- Youth: 72.2%; -12.5 points)*

Intervention(s):

- Partners received the results of the survey from DHHS in January 2019. An analysis of the state results and Partners' raw data, including a comparison of Partners' results with Statewide results and Partners' trends for the past three (3) years, was completed by Quality Management. The analysis results were presented at the April 2019 QIC.
- After reviewing the State survey report and the survey analysis completed by QM it was determined that Partners would focus on the individual survey question "Know How to Make a Complaint" as this is an issue across survey populations for the past three survey years.
- Partners is in the process of developing and posting a webinar to Partners' website to educate the public on how to make a complaint.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes. Partners will continue analysis of survey data with a benchmark of 80% set for SFY 2020

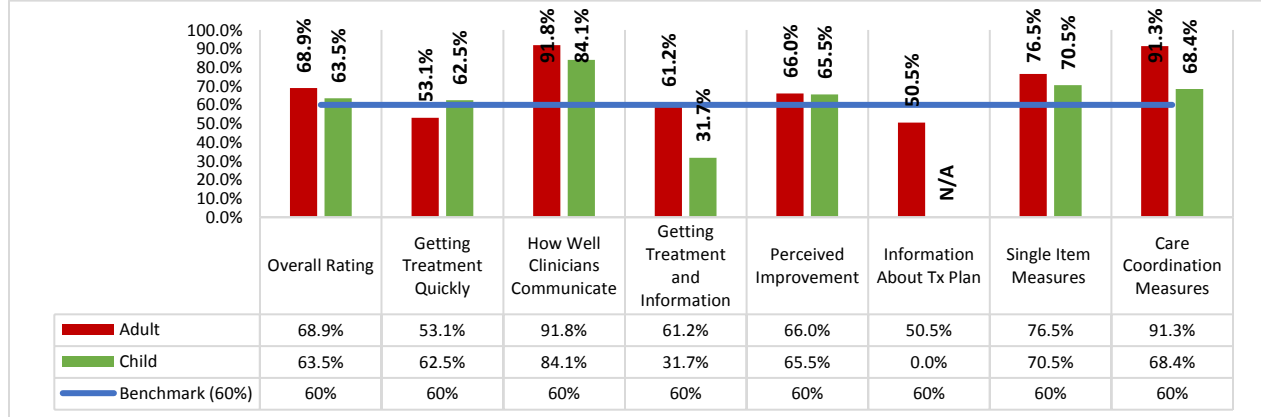
Experience of Care and Health Outcomes (ECHO) Survey

The *Experience of Care and Health Outcomes (ECHO)* for North Carolina Medicaid enrollees is a tool for assessing members' experiences with their health care. DataStat, Inc. conducted the survey on behalf of the State of North Carolina Division of Health Benefits (DHB) and the Carolinas Center for Medical Excellence (CCME). The SFY 2019 survey was administered between August 8, 2018 and October 10, 2018. The survey results were reported out to the MCOs in January 2019.

Goal(s):

- Analyze survey results and develop measures to address identified quality problems. (*EQR Standard: IV.A.4*)

Table 41. ECHO Survey Domain Results



*Data from CCME Adult ECHO Survey Report

N/A= Domain not included in survey indicated

Status/Evaluation:

- Partners had an overall rating of 69.9% for the Adult ECHO survey and 63.5% for the Child ECHO survey.
- Partners scored below the 60% benchmark for the following survey domains:
 - Getting Treatment Quickly (Adult: 53.1)
 - Getting Treatment Information (32%)
 - Information about Treatment Plan (50.5%)

Identified Issue(s)/Barrier(s):

- Partners scored below the 60% benchmark or showed a significant decrease in score from the previous survey for the following survey questions:
 - Usually/Always got help by telephone. (Getting Treatment Quickly: Adult= 35.3%, Child 33.3%)*
 - Helpfulness of customer service. (Getting Treatment & Information from the Plan: Adult= 33.3%; Child= 25%)*
 - Much better/a little better ability to deal with social situations compared to 1 year ago. (Perceived Improvement: Adult= 58.3%)*
 - Much better/a little better ability to accomplish things compared to 1 year ago. (Perceived Improvement: Adult= 58.3%)*
 - Told about self-help or member run programs. (Information About Treatment Options: Adult (44.4%)*
 - Talk about including family and friends in treatment. (Single Item Measure: Adult= 46.7%)*
 - Total about other ways to get treatment after benefits are used up. (Single Item Measure: Adult= 50%; Child= 57.1%)*
 - Care Coordinator usually/always asks how best to support member. (Care Coordination Measure: Child= 64.5%/-20.1 percentage points)*

Intervention(s):

- Partners received the results of the survey from DHB in January 2019. An analysis of the state results and Partners' raw data, including a comparison of Partners' results with Statewide results

and Partners' trends for the past three (3) years, was completed by Quality Management. The analysis results were presented at the April 2019 QIC.

- After reviewing the State survey report and the survey analysis completed by QM it was determined that Partners would focus one survey question for each survey population (Adult/Child):
 - **Adult:** *Told about self-help or member run program. (Information About Treatment Options)-* Partners scored 44.4% on this question, which is a 5.6 percentage point decrease from 2017 to 2018.
 - **Child:** *Care Coordinator usually or always asks how best to support me and my child. (Care Coordination Measures)-* Partners scored 68.4% for this question, which is a 20.1 percentage point decrease from 2017 to 2018.
- Members Services-Access to Care has been assigned the Adult Population focus area and MHSU Care Coordination has been assigned the Child Population focus area.
- The assigned departments are working on the development of strategies for improvement.

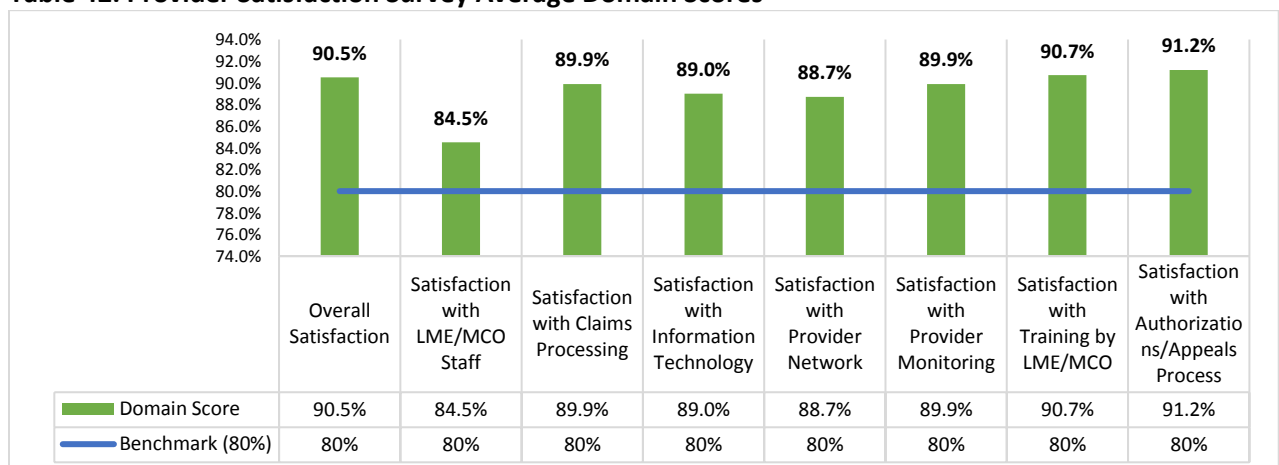
Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes. Partners will continue analysis of survey data with a benchmark of 80% set for SFY 2020

Provider Satisfaction Survey

The *DHHS Provider Satisfaction Survey* is administered on behalf of the North Carolina Department of Health and Human Services (DHHS), Division of Health Benefits (DHB) by the Carolinas Center for Medical Excellence (CCME) on an annual basis. The purpose of the survey is to assess perceptions of the LME/MCOs in North Carolina by service providers participating in the 1915(b) (c) Medicaid Waiver program. The SFY 2019 survey was administered between October 29, 2018 and December 10, 2018. The survey results were reported out to the MCOs in January 2019.

Goal(s): Achieve a score of at least 80% all survey areas. (*DHB Recommendation*)

Table 42. Provider Satisfaction Survey Average Domain Scores



*Data from NC Medicaid Provider Satisfaction Survey Report

*Data from Partners Provider Satisfaction QM Analysis Report

Status/Evaluation:

- Partners' *Overall Satisfaction* score improved by 0.9 percentage points from SFY 2018 to SFY 2019.
- Partners showed the best performance (i.e. above 90% with no significant decrease in score compared to previous survey) for the following survey questions:
 - *Claims are processed in a timely and accurate manner. (Satisfaction with Claims Processing: 93.9%)*
 - *Authorizations for treatment are made within the required timeframes. (Satisfaction with Authorizations & Appeals Process: 95.5%)*
 - *The authorizations issued are accurate. (Satisfaction with Authorizations & Appeals Process: 97.7%)*

Identified Issue(s)/Barrier(s):

- Partners did not perform as well (i.e. below 80% or lowest scoring survey question) for the following survey questions:
 - *LME/MCO staff referring members whose clinical needs match the services of the provider. (Satisfaction with LME/MCO Staff: 76.3%)*

Intervention(s):

- Partners received the results of the survey from DHHS in January 2019. An analysis of the state results and Partners' raw data, including a comparison of Partners' results with Statewide results and Partners' trends for the past three (3) years, was completed by Quality Management. The analysis results were presented at the May 2019 QIC.
- QM is currently working with the applicable departments to develop strategies for improvement.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes

Client Satisfaction Survey

The *Client Satisfaction Survey* is administered annually by Partners BHM. The purpose of the survey is to assess the satisfaction of the North Carolina Department of Health and Human Services (DHHS), and the Division of Health Benefits (DHB) regarding Partners BHM's contractual performance.

Goal(s): Complete a satisfaction survey with DHHS and DHB on an annual basis. (*URAC Standard: Core 12*)

Table 43. Client Satisfaction Survey Result

	SFY 2019
Q1. Partners met <i>DMH</i> contract standards	100%
Q2. Partners met <i>DHB</i> contract standards	100%
Q3. Partners staff treated client with courtesy and respect	100%
Q4. Partners staff responsive to client's questions and/or needs	100%
Q5. Extremely Pleased/Pleased with Partners' contractual performance	100%

**Data from the Client Satisfaction Survey Results*

Status/Evaluation:

- Partners scored 100% for all survey questions

Identified Issue(s)/Barrier(s):

- No issues or barriers were identified.

Intervention(s):

- No interventions were implemented as survey score was 100%.

Goal(s) to Continue for Next Fiscal Year (Yes/No): Yes. Survey is a URAC requirement, so it will continue at least until NCQA accreditation is complete.

III. Summation

Review of Partners' Quality Management Program showed the following:

Key Accomplishments:

- Partners continues to improve its overall compliance score for the External Quality Review. The overall score increased by three (3) percentage points with a score of 98% for SFY 2019 review.
- Partners exceeded the 40% State benchmark for the *Timely Follow-up for Mental Health* super measure all four (4) quarters of SFY 2019 for both Medicaid and Non-Medicaid populations.
- Partners exceeded the 40% State benchmark for the *Timely Follow-up for Substance Use* super measure for all four quarters of SFY 2019 for both the Medicaid and Non-Medicaid populations.
- Partners exceeded the 90% of Innovations Waiver members receiving a primary or preventative health service for all four (4) quarters of SFY 2019 as well as exceeding the 95% target for the Strategic Plan.
- Partners exceeded the *95% of members in "In-Reach" status will have an In-Reach contact every 90 days* TCLI performance measure for all four (4) quarters of SFY 2019.
- Partners exceeded the 80% members in transition status are housed within 90 days after housing slot is issued TCLI performance measure for all four (4) quarters of SFY 2019.
- Partners scored 100% for all four (4) quarters of SFY 2019 for the resolution of grievances within 30 calendar days requirement.
- Partners resolved 100% of *Routine* appeals within 30 calendar days of appeal request for all four (4) quarters of SFY 2019.
- Partners resolved 100% of *Expedited* appeals within three (3) calendar days of appeal request for two (2) of the two (2) quarters in which expedited appeals requests were received for SFY 2019.
- Partners scheduled *Emergent* calls within two (2) hours 100% of the time for all four quarters of SFY 2019.
- Partners processed *Expedited* SARs within 72 hours 100% of the time for all four (4) quarters of SFY 2019.
- Partners scored 90.5% in overall satisfaction for the SFY 2019 Provider Satisfaction Survey.

Strategies and Objectives for SFY 2019-2020:

- Achieve NCQA accreditation by the end of SFY 2020.
- Obtain QIC approval of QA/QI Work Plan and implement by the end of October 2019.
- Ensure continued compliance with current accrediting body [URAC] while working toward NCQA accreditation and Tailored Plan readiness.

- Track HEDIS and clinical measures proactively and develop improvement plans as needed to increase rates.
- Achieve Strategic Plan goal of *75% of members will have a timely follow-up appointment within seven (7) of discharge from an inpatient facility* by the end of SFY 2020 for both MH and SUD populations.
- Achieve an overall/general satisfaction score of at least 80% for the following surveys:
 - ECHO Survey
 - Perception of Care (POC)
 - Provider Satisfaction
 - Partners Member Experience Survey