

ALAMANCE-CASWELL-ROCKINGHAM
LOCAL MANAGEMENT ENTITY

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LOCAL BUSINESS PLAN



2007-2010

**Alamance / Caswell / Rockingham Local Management Entity
Local Business Plan
2007-2010**

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Introduction

Development of the Plan

The Alamance-Caswell-Rockingham (ACR) LME worked with citizens, stakeholders, consumers, families, providers, staff and the LME Leadership Team representing three counties to develop the Local Business Plan for 2007-2010 as required by House Bill 2077, 122C-115.2. Input was obtained through surveys, community forums, input sessions with major groups and a LBP Review Team comprised of representation of the community's stakeholder panel. The stakeholder representatives that provided input into this process included but were not limited to:

- *local hospitals*
- *law enforcement agencies*
- *school systems*
- *private psychiatrists*
- *local providers*
- *consumer focused advocacy groups*
- *faith-based programs*
- *local judicial systems*
- *community college systems*
- *Departments of Social Service*
- *Health Departments*
- *LME Board Members*
- *Division of Mental Health, Developmental Disabilities and Substance Abuse Services.*

The ACR LME Board of Directors and staff thank our community for their interest and input. Please keep in mind, this document is an ongoing work in progress.

LME Commitment

ACR is committed to continuing quality improvement and systemic evolution based on the changing circumstances of our community and the status of the system transformation. Strategic objectives identified in this document will be reviewed annually and as needed for appropriateness and effectiveness. The LME will make changes to this document as needed. Stakeholder input will be solicited to make adjustment to the plan. For complete review of the plan on-line, visit the LME's web page at: www.acmhdds.org.

ACR LME Mission Statement:

“To assist individuals and families affected by mental illness, developmental disabilities, or substance abuse to develop their maximum potential for growth and maturity in dealing with everyday life.”

The ACR Leadership Team supports the transformation process. We will continue to clarify organizational purpose and function while remaining responsive and accountable to our local stakeholders. The LME has set strategic objectives based on internal and external review and recommendation. Our focus is on initiating and managing these changes in the most timely, efficient and effective manner possible over the next three years. Business rules and practices that improve current operations and solidify and enhance performance are currently being identified and implemented by the LME.

Through this process the LME will ensure that services provided are:

- Consumer Driven
- Community Based
- Prevention Focused
- Recovery Oriented
- Best Practice
- Cost Effective

ACR developed the LBP in accordance with the LBP process laid out by the State in Communication Bulletin #68, DHHS NC State Plan 2006 – Blueprint for Change and in conjunction with the LME's long-range goals.

GOVERNANCE AND ADMINISTRATION LME FUNCTIONS

1. Mission

The LME Governance and Administrative Unit provides information, guidance and support to the LME Board. It also works with its community, stakeholders, providers and staff to further the agency's commitment to the provision of the highest quality services possible within the resources available.

2. Purchaser Standards

Per the 2004-07 Performance Contract, the LME adheres to and complies with all rules and regulations related to Governance and Administrative functions.

3. Current Operations

LME:

The Alamance-Caswell-Rockingham Local Management Entity (LME) is the local government agency charged with the responsibility for overseeing the public mental health, developmental disabilities and substance abuse services system for a three county catchment area. This area consists of 257,135 covered lives and is located between the Triad and Triangle regions in north central North Carolina. The counties are a mix of rural and urban communities.

LME Board:

The consolidated LME Board was officially implemented July 1, 2006 by a legally binding Joint Resolution that was approved by all three Boards of County Commissioners. The Joint Resolution addresses community-wide issues as well as the unique needs of each county. The Board has 20 members with representation based on population from each of the three counties. A member of each respective Board of Commissioners represents their county. These commissioners, in turn, appoint the other Board members from each of their communities.

The LME Board meets monthly with a planned recess in July. All meetings are advertised and open to the public. The Board receives an information packet approximately one week prior to the scheduled meeting containing the minutes from the previous meeting and materials slated for review, discussion, and action. The Board is currently reviewing an updated set of by-laws that will support more efficient Board operations. Changes include the addition of a Vice-Chair and Secretary and further define procedures for leadership and operations.

LME Committees:

Board members are assigned to each of the following sub-committees: Human Rights, CFAC, Personnel, System of Care, Finance, and Executive. These committees meet on a similar schedule to the Board. They discuss relevant issues, develop positions and make recommendations to the full Board. Each committee has a designated chair and an agency staff liaison. The liaison assists in the preparation of agenda and supplies relevant information for their review. The Chief Executive Officer (CEO) serves as an ex-officio member on all Board committees.

CFAC meetings are held on a regular basis to discuss and review governance and administrative issues and provide feedback. The LME Board and staff value the feedback of community stakeholders regarding organizational performance and work to implement recommendations.

CEO:

The Board hires an Area Director to serve as the Chief Executive Officer (CEO). The CEO is responsible for implementation of Board policy. The CEO is also responsible for maintaining a close working relationship between the LME and county governmental officials, and stakeholders in all three counties. The CEO is the lead liaison with the Division of MH/DD/SA, DMA and DHHS. The CEO provides the primary vision for the LME, implementation of the mission, leadership to the Executive Leadership Team and LME staff, the setting LME goals and objectives, policy development and operationalizing plans and organizational goals. The CEO position sets, drives and focuses all discussions related to the local behavioral healthcare system.

In addition to the CEO, the unit includes Human Resources (1 FTE), switchboard (1.0 FTE) and reception (1.0 FTE) and general support staff (1.0 FTE). Human Resources (HR) is located in this unit as opposed to Business Management in the cost model. It provides oversight and coordination of all personnel activity. It acts as liaison to the Office of State Personnel, establishes performance standards and provides oversight of the performance evaluation process. HR provides assistance to staff and their families in multiple areas including employment benefits.

Executive Leadership Team:

The Executive Leadership Team (ELT) is comprised of the CEO, COO, UR/STR/Crisis Manager, UR/STR Lead Staff, QI/Provider Relations Manager, IT/Reimbursement Manager, Contracts Manager, and the LME Administrative Assistant. Jointly, the CEO and the Team oversees the operations of the LME and supervises the activities associated with the divisions of the Local Business Plan. This ELT meets on a bi-weekly basis.

Human Resources:

The HR Manager also reviews and restates agency policy for the Board's review and approval as well as and maintaining policy and procedure manuals. The position also acts as the agency representative on several task forces and committees in the community.

HR ensures that the most qualified and appropriate staff are hired and maintained within the LME. Training and licensure requirements are coordinated and documented by the Human Resources unit. The LME recruits personnel using community boards, ESC, newspapers and other local government sites for posting positions. Qualifications are verified by Human Resources and the Office of State Personnel. All personnel are trained in pertinent rules and regulations.

4. Strategic Objectives

- The CEO will continue to engage and increase involvement with political stakeholders and governmental officials in all three counties and at the State level in order to advocate for the advancement of mental health, developmental disabilities, and substance abuse services. The CEO will attend Commission and Legislative Oversight Committee meetings as well as interfacing with decision makers at both the local and State level.

Target Date: 7- 2007 and on-going

Responsible: Executive Officer

Stakeholders: Board, CFAC, Providers, Stakeholders, and the community

- The LME will identify and implement a plan to reduce the financial strain of honoring its historic commitments to health care benefits provided to retired employees of the former Area Program. This plan will release additional funds to relieve the excessive multi-tasking of senior staff by adding additional positions.

Target Date: 7-2007

Responsible: CEO, COO, CFO, Board Executive and Finance Committee

Stakeholders: Board, CFAC, Providers, Stakeholders, and the community

- The LME continues to reorganize departments in order to improve operations. LME leadership will engage in continual organized training regarding issues associated with managing the transition from a publicly provided system to a managed care environment; focus on optimizing the oversight of the capitated financial reality and its implication for services available; drive towards more accurate and timely information available to all staff making these decisions; and move towards best practice standards to ensure the most effective treatment outcomes.

Target Date: Ongoing, 7-2007, as resource allows

Responsible: CEO, COO, CFO, HR manger

Stakeholders: Board, CFAC, Providers, Stakeholders, and the community

- The LME will ensure that staff is enabled and empowered to deliver and sustain customer service excellence to those in the community. A clear and consistent plan for communicating values, mission, purpose and progress. The LME staff

will be trained in the values and mission of the LME and kept up-to-date on changes at the Division level, internally and within the community.

Target Date: 7-2007

Responsible Party: CEO, COO, Personnel Director and LME Managers

Stakeholders: Board, CFAC, Providers, Stakeholders, and the community

- The LME will provide additional emphasis, education and training on the importance of financial-based decisions to the LME Board of Directors. Provide financial information at a more summary level; convert from a cash-based to an accrual-based method of accounting to more effectively manage trend data; first draft of accrual reporting presented at the February Board meeting; and full transition of the accounting system will take effect by July 1, 2007.

Target Date: 7-2007

Responsible: CEO, CFO, COO, Finance Committee

Stakeholders: Board, CFAC, Providers, Stakeholders, and the community

- The LME will optimize integration of the managed care system to more smoothly represent services requested, authorized, and the associated funds encumbered. The LME has conducted an internal review of the IT system and identified areas to improve access to timely information and data reporting. The LME will focus on development of user-friendly desktop-based service reports for managers. Additional training efforts will be implemented.

Target Date: 5-2007 and 12-2007

Responsible: CEO, CFO, COO, IT Director, UR Director, Contracts Manager, Service Manager

Stakeholders: State Division, Board, CFAC, Providers, Stakeholders, and the community

- The LME will identify, define, and develop policies and procedures related to the role of the LME in the community. That information will be distributed across the community via website, e-mail and memo. The LME is working with a URAC consultant to identify all policies and procedures needed in order to be URAC accredited. Once policies and procedures have been identified, the LME will develop and implement.

Target Date: 12-2008

Responsible: CEO, COO, QI Manager, LME Managers, QI Committee, CFAC and Board

Stakeholders: Consumers, Providers and Stakeholders

- The LME will assist in the transition of community psychiatry from a publicly managed effort to a contractual management agreement in order to control financial liability that is primarily borne by local communities represented by the LME.

Target Date: 7-2007

Responsible: Executive Officer and Finance Committee

Stakeholders: Board, CFAC, Providers, Stakeholders, and the community

- The LME will develop a 5 year strategic plan to integrate the LBP, Crisis Implementation Plan, and Qualified Provider Development Plan. This plan will set long-term goals and objectives for the LME and the community while focusing on national trends in behavioral healthcare. This plan will include:
 - * Implementing Best Practice services within the community:
 - Adult Mental Health: implement a Recovery Model training collaborative, establish Peer Bridger activities, and expand and support Peer Drop In Center;
 - Developmental Disabilities: redirect funding to supported employment and community activity and employment transition programs; expand supervised apartment and independent housing resources;
 - Adult Substance Abuse: implement Integrated Dual Diagnosis treatment continuum, expand vocational/employment, housing options and resources;
 - Child and Adolescent Mental Health: redirect funds from Residential Level III to Intensive In-Home service and MST
 - * Developing and ensuring a comprehensive crisis continuum of services that will include a centralized facility based crisis service;
 - * Developing a Jail Diversion Program (pre and post booking); and
 - * Developing a Provider Performance Report that will be available to consumers and the community;

Target Date: 7- 2010 and on going through 7-2012

Responsible: CEO

Stakeholders: Board, CFAC, Providers, Stakeholders, and the community

5. Resource Allocation

The LME Governance, Management and Administrative functions are comprised of 5.25 FTE's. The positions include, CEO (1 FTE), Human Resources Director (1 FTE), Administrative Assistant (1 FTE) Switchboard/reception (2 FTE) and a portion of the QI Director's time in policy development activities (.25 FTE). The actual staff salaries and benefit cost of the administrative functions are \$333,689 as compared to the Cost Model's appropriation of \$382,845. The expense associated with the governance responsibilities falls within the allowable 30% variation.

6. Business Rules:

Rules that Enhance:

1. Reporting all data within the required timeframes in order to comply with the LME Performance Agreement requirements with the State.

The LME finds this to be an important element of responsibility. Systems have been put in place in the contract and with the Qualified Provider Development Plan to ensure that data is received by the LME in a timely fashion and disciplinary actions are taken if not. At this time, the LME does not always have access to data in a timely manner and providers often delay reports. Also, since providers self-report some data, the validity of the data is unclear.

2. The LME empowers consumers to have a voice, their opinion to be respected and their issues responded to by the LME in a manner that promotes education, open communication and some type of resolution.

The LME will continue to work with CFAC and consumers to ensure that their voices are heard and the input is considered. The LME will implement the suggestions and recommendations made by consumers, their families and advocates.

3. The LME is to provide guidance and direction to the community on behavioral healthcare and best practice issues.

The LME will educate the community on behavioral healthcare and best practice issues. The LME is waiting for the Division to provide additional information on best practice/evidenced based practice before the LME proceeds with training.

Rules that Inhibit:

1. The LME is not currently staffed in certain areas that would make it eligible to get accreditation by a national accrediting organization.

Monies have been spent and the LME began implementing the modules for the accreditation of the managed care components of the LME prior to the downsizing of the LME related to the Value Options changes. However, while engaged in this process the requirements for accreditation changed. The policies and procedures development process, contracts with consultant and the staff time associated with the implementation of these policies were put on hold to a large degree. The process is now starting again with additional fees paid and new modules obtained.

2. Hospital diversion and downsizing dollars are not allocated to the local programs to the degree needed to support services at the local level in order to maintain individuals in the community.

Appropriate incentives are not offered to LMEs to assist with the cost of maintaining individuals in the community as opposed to institutions. Some funds have been allocated recently to support crisis services. The hope is that similar funding will be made available in the future.

3. The LME has been focused on responding to current issues to the detriment of broader, forward-focused, proactive strategic planning efforts.

Staff has been issue-oriented, devoting it's time to reacting to the issues and challenges facing the LME. There has not been a focus on internal quality management, customer service (within the LME) and being proactive. A future focus will be to become more proactive and focused on the success of the community, providers and consumers and ensuring their wellbeing and satisfaction.

Business Management / IT

1. Mission:

To support the operations of the LME and its Provider Network through efficient and effective use of public resources. Strong financial management, planning and reporting as well as effective use of up-to-date information technology to promote and maintain a stable, viable entity and network within the resources available.

2. Purchaser Standards:

The LME has reviewed the Business and IT standards of the 2004-2007 Performance Contract and will ensure full compliance with all listed elements as well as any other business requirements, State or Federal.

3. Current Operations:

The Business Management Department is comprised of two Units: Finance/Accounting and Information Management/Claims Adjudication. Both unit managers report directly to the CFO/COO. This Department has senior staff experienced in the NC Mental Health system across multiple Mental Health programs.

These departments have undergone significant changes in the past 3 years – that have had major impact on operations. In that timeframe, the department implemented a new finance software package, a new Voice-Over-IP telephone system, fax server system and developed and implemented a managed care/authorization/claims adjudication system. This was accomplished while dealing with the challenges of divestiture, provider network development and support, LME consolidation as well as organizational changes related to LME funding reductions. At this time, these systems are operational and in the process of being institutionalized across the organization.

Finance/Accounting

The staff is assigned to financial reporting, budget, general ledger, bookkeeping, accounts payable, payroll, purchasing, annual audit, contracts generation and fiscal management.

The department has transitioned from a service provider orientation to claims and service management entity. The LME was forced to transition bookkeeping functions from a county-based and supported system to find a new, stand-alone finance reporting system on short notice. This process revealed issues the department had with appropriate staffing levels and expertise. While a great challenge, those issues were

addressed and the LME has moved forward to an even stronger position in accounting and financial reporting functions. As a result of this conversion, the LME now has much greater access to timely information designed to meet specific operational needs.

More recently, the finance department has developed more simplified and user-friendly reports to staff, the Finance Committee and Area Board. Previous reports were very detailed, but were less practical for the typical user. New, broader, simplified income statement and balance sheet reports have been developed and presented. In addition, reports have been developed which target key indicators such as year-to-date IPRS utilization and service authorization encumbrances.

The next phase in the transition of the system is to move from a cash reporting basis of accounting to full accrual. Various reports have been developed to support this effort which gives the LME a more powerful way to review and respond to fiscal trends throughout the year. This allows for greater ability to encumber and forecast. This leads to a stable outlook of operations for staff, the Finance Committee, Area Board, CFAC and various local leaders. This transition should be in place by July 1, 2007

One of the greatest fiscal challenges the LME faces is in the management and control of specific IPRS funds where the community and provider network drive for service beyond available resources. Specifically, CTSP, MRMI and ADD are stretched thin. With the implementation of the managed care system, the finance department, through its contracts management section, now has the ability to run, review and analyze timely service data. The contracts management module has been implemented, requiring that all services by provider and service type be loaded into the system in order to be authorized and adjudicated. This function ensures a provider is endorsed for the service, and that funds are available before the services are appropriately authorized. Moving forward, this function, coupled with identified contract maximums, ensure that only funding available within the current year IPRS budget is utilized.

The LME is in the process of developing contract maximums for all providers. The contracts will be in place in time to ensure that prior fiscal year liability is limited to a prudent, controlled amount and that funds are spread evenly throughout the fiscal year. The LME anticipates a 25 percent utilization for the carry-over from FY 07 into FY 08, a transition year with a 17 percent target in FY 2009. Although both processes will be in place prior to that time, full system utilization of the contracts management module and the contract maximum go into effect on April 30, 2007.

In addition, contracts management will move towards a one-twelfth (1/12th) monthly allocation for provider payments. This process was implemented with two of the LME's largest providers in FY 07 and will be fully implemented for all providers effective July 1, 2007. This type of contract/payment dynamic will allow for a more consistent and planned cash-flow for the LME and between the LME and its providers. This process should help stabilize provider cash-flow, allowing them to build a more precise, sustainable operational budget within IPRS funds available to support their operations. These payments will be reconciled with actual claims activity on a monthly and quarterly basis.

A significant issue the LME has faced has been the lack of timely reporting of services by providers. In the past, the LME has been dependent for its fiscal forecasting on timely submission of provider claims. Providers have not followed a timely, consistent process. This has impacted the LME's ability to effectively project and plan for use of various funds. In order to secure the process, the LME has enacted a 60-day reporting clause which requires providers to report claims within 60 days of service delivered. This will allow for greater fiscal planning for services in the community. This effort is coupled with a similar effort on the authorization side of operations. Authorizations that have not been utilized within a similar timeframe will be administratively recouped, allowing for a more precise encumbrance process. Authorizations that have not been utilized will be recouped and reassigned to support community service needs.

Service Funds Management

Service Funds Management as defined in the Cost Model applies to management and control of LME funding, county funding and IPRS, as well as Medicaid funds.

LME funds are designated and reviewed by finance unit staff as well as the Finance Committee and Board. Various reports provide detailed information about utilization of those funds. Operational and staffing decisions are made based upon management data. In the coming year, the staff will continue to develop additional reports to more precisely target specific LME operational issues.

County funds are also managed through the finance unit. These funds are used to pay for non state-funded services critical to the community. These include support of community psychiatric services, transportation and medications. In addition, County funds are used for target-population eligible services where there are not enough State or Federal funds to support community needs.

The third area of service funds management - and the greatest challenge - is management of IPRS funds billed by the provider network. For some funds, there is significantly more demand than there are dollars to support. The LME is working very aggressively to bring these services within line with funds available. At the same time, other funds are underutilized. In the next year, the LME will be working to better utilize these resources. Management of these dollars are shared through multiple departments namely Information Management/Claims Adjudication, Finance, Contracts Management and UR/STR. Ongoing training and communication, key to the integration, synthesis and success of these critical areas, has begun and will occur on a scheduled basis.

The LME has developed and has been implementing an authorization and claims adjudication system that overlays and strengthens its packaged claims system. The system was developed in a combined design effort by the IT, finance, managed care, and contracts management units along with UR/STR consultants hired to help implement the LME's managed care operations. This system has been wrapped up in a lengthy development cycle as more and more functions were added. What initially started as a temporary, stop-gap process developed into a multi-faceted system designed to support operations across multiple areas. At different points-in-time various

components of the system were implemented. However, due to UR/STR staff shortages, changing requirements, training issues and a focus on fiscally supporting providers, full utilization of system functions were postponed. These functions are now up and running with a focus on optimizing training and utilization, as well as ensuring the quick and easy flow of decision-making data.

Most recently, the LME has completed a critical review of the IT software system to determine if the system will continue to meet the needs of the LME into the future. At this time, the current system has been assessed to meet the needs of the LME but additional attention will be focused on the system becoming more user-friendly. The LME Management Team will continue to assess the system operations on an on-going basis.

The system has been designed to account for all elements of the Service Funds Management Function specific to the LME. Once providers are endorsed and approved to deliver services a contract is generated. The contract spells out specifically what services are approved and at what rate. The implementation of contracts maximums that control expenditure will be added. This function is already in place but needs to be switched on with the upcoming year's budget. Once the contract is approved, provider specific data is loaded into the contracts module. At that point an authorization can be given. Authorizations are given and keyed by UR staff based upon the benefit package for each service. The benefit packages are under constant review and are currently undergoing intense scrutiny in order to ration funds where services are pressed and to increase services where there are surpluses.

We currently accept multiple means of claim submission - 837, direct keying, submission of the State spreadsheet or receipt of a paper claim. Electronic claims are then uploaded. At that point, the claim cycles through an electronic adjudication process that verifies all clean-claim elements as well as cross-references between target-pop, diagnosis and service code. This is the real strength of our system. The system electronically screens for all these items thereby reducing the need for staffing and eliminating many potential human-error issues. The next level of review is the authorization adjudication. The individual service is screened to ensure there is a valid authorization for the specific service for that provider, for that timeframe and that the units have not already been drawn down.

If any claim is denied for any of the above elements they are accumulated on reports that are faxed out through the fax server the next morning. All of this information is housed in an electronic format on our fax server. This timeframe ensures that we remain within the 18 day required window for denials. The denial fax details by specific claim every denial and the denial reason.

Once a claim has been passed through the adjudication cycle it is uploaded into the claims system for billing. At that point, the claim is submitted to EDS. Also built into the system is a prompt-pay component. This process is designed so at the 30-day point a remittance advice is generated for payment. This report details specific services being claimed on the particular invoice. A check is provided and the claims detail is mailed with the check.

This system and process has been under intense development over the past two years. Although it has taken time to develop, the LME is now seeing full capability and management information that allows us to target decision-making across all IPRS services. The LME can then determine who is getting what service at what cost and supports a more precise plan for utilization of service dollars.

Information Management/Claims Adjudication

This unit is a critical element in almost all LME functions, especially as we move forward in optimizing LME functions. Understandable, timely, usable data are critical to efficient operations of the LME. The unit is responsible for both traditional IT functions as well as claims adjudication/reimbursement. The LME has spent considerable time, effort and funding over the past years in the development and support of these operations.

The IT unit manages all of the hardware, software and communications operations of the LME. Support of most data reporting requirements is located in this department. Over the past two years, the unit has implemented a new Voice-Over-IP telephone system (allowing for better telephone data-tracking), a new managed care/authorization/claims adjudication system and a multi-choice electronic claims submission process.

In addition, the department is well-staffed with programmers and report writers. As a result of our effort to develop internal systems, we have hired qualified staff giving us additional capability as we move ahead to respond to changing information needs and data requirements.

This unit is also responsible for the reimbursement/claims adjudication function. This function is technologically driven through the entire process from claims receipt through adjudication, to claims submission and provider payment requests and Remittance Advice (RA) generation. The department also works the standard first and third (1st/3rd) party claims issues, as well as working all claims failures and denials.

4. Strategic Objectives:

- Secure IPRS funding through capped contracts and internal system controls. The LME has experienced a two-year cycle of over-utilization of CTSP and MRMI funding. In addition, the LME has had a mixed operation on the Adult Developmental Disability (ADD) side by combining both capped and fee-for-service operations, leading to early claiming of service. This has resulted in an over-utilization of those funds and has rolled budgets into the next fiscal year beyond what is appropriate. With implementation of more precise and concise system reporting we have identified the issues, services and consumers to target. Examples of actions currently being taken are reduction of Room and Board services for the CTSP population (within State guidelines) and reduction of layering of IPRS dollars on top of CAP and ICF/MR payments. We are currently

redesigning our benefit package to align services within available funding as opposed to more of a focus on medical necessity. In pressed funds we are attempting to keep consumers in a basic level of service, albeit a reduced one. Our current action plan is: 1) reduce funding as much as reasonable within the current year, giving providers advance notice of action to be taken, 2) restrict May and June 07 services claimed in July and August to a 25 percent budget maximum with a target of 17 percent for the FY 08 – FY 09 carryover, and 3) move forward into FY 08 with budgets and maximums in place as well as a implementing a revised benefit package that operates within funding available.

Responsible: UR/STR, Provider Relations, IT and Finance

Stakeholders: Providers, Consumers and families

Target Date: 7-2007

- The LME will improve network operations including:
 - * Decrease duplication of effort/ decrease re-keying time
 - * Improve information sharing across systems
 - * Standardize user training
 - * Policy and procedure redevelopment
 - * Increase software/systems reliability and up-time to 95%
 - * Improve response time for desktop support

Responsible: IT and Finance

Stakeholders: Providers

Target Date: 7-2007

- The LME will implement a plan to separate the Chief Operations Officer (COO) and Chief Finance Officer positions. The CFO will focus on the daily operational oversight of fiscal functions and reporting, as well as trend analysis. The Finance Officer position has been posted and interviews are beginning. Concurrently, this will allow the Chief Operating Officer to focus on broader daily operational issues and coordination and optimization of the LME functions across departmental lines.

Responsible: CEO,, COO, CFO, HR and Finance Committee

Stakeholders: Providers, Consumers and families

Target Date: 7-2007

- The LME will implement dollar maximum contracts. This will help to secure LME fiscal operations and stabilize community services within funding available. In addition, one twelfth (1/12th) monthly payments will be implemented to all providers within those capped amounts. This will allow for a more stable cash-flow within the LME, between the LME and providers and within the provider organization. This also allows for more accurate budget planning and staffing development in the provider network. The transition to this practice occurred with two large providers. The LME will transition the remaining providers by April 30.

Responsible: Provider Relations, IT and Finance

Stakeholders: Providers, Consumers and families

Target Date: 4-2007

- The LME will maximize effectiveness of IPRS funds by designing a more precise benefit package designed around population and funding availability in addition to service, as opposed to exclusively service. This will result in reduction in over-utilization and increases in areas of under-utilization.
 - Phase 1 – Areas of funding that have been highly utilized – this is currently being operationalized.
 - Phase 2 – Areas in which services may be utilized more appropriately and funding considered slightly pressed will be implemented by 7-2007.
 - Phase 3 – Underutilized areas will be reviewed and actions taken to develop additional services and providers in these areas.
 - Responsible:** UR/STR, Provider Relations, IT and Finance
 - Stakeholders:** Providers, Consumers and families
 - Target Date:** 9-2007

- The LME will shift from a cumbersome, centralized data reporting capability to a decentralized, desktop-oriented process. This will put additional information and reports on managers desktops allowing access to retrieve relevant information, as needed. Currently, IT is getting input from managers on data needed.
 - Responsible:** Provider Relations, UR/STR, IT and Finance
 - Stakeholders:** Providers, CFAC, Board, stakeholders and families
 - Target Date:** 9-2007

- The LME will implement a full accrual accounting system. This will allow for a more stable and balanced reporting process. Board reports have already been implemented and the staff working towards full system implementation is by the beginning of the next fiscal year.
 - Responsible:** Finance
 - Stakeholders:** Providers and Board
 - Target Date:** February, 2007/July 1, 2007

- The LME will move to discontinue all paper-based claims reporting processes and move to an entirely electronic submission process. All providers will begin using the Division spreadsheet, begin direct keying claims into the system or move to generating their own 837.
 - Responsible:** Provider Relations, IT and Finance
 - Stakeholders:** Providers
 - Target Date:** 7-2008

- The LME will continue to hone fiscal and IT reports allowing better forecasting of service and fiscal trends. IT continues to develop critical reports with all requested reports being generated by April 30, 2007. This is a continual process and additional reports will be forthcoming, as needed.
 - Responsible:** Finance, IT and UR/STR
 - Stakeholders:** Providers, CFAC, and Board
 - Target Date:** 4-2007

- The LME is to develop a more definitive risk management process. The process is to include a more intense review of service/cost outliers as well as

safety/liability issues. An initial review of high cost outliers is currently occurring by the LME Management Team. The process will be fully implemented and a committee will be formed to review all areas related to risk on a regular scheduled basis in coming year.

Responsible: *QI, Provider Relations, UR/STR, IT and Finance*

Stakeholders: *Providers, CFAC, Board, Consumers and families*

Target Date: *7-2008*

- The LME will develop more ongoing communication and collaboration between the UR, Provider Relations, IT and finance departments. There will be a shift of focus from clinical necessity to balancing priority for service within available funding.

Responsible: *Provider Relations and Finance*

Stakeholders: *Providers, Consumers and families*

Target Date: *7-2007*

- The LME will develop a new website that is user friendly and meets the need of the community, stakeholders, providers and consumers. At this time, the LME has two different websites. The main website with general information and a provider specific website. LME staff is working to make both sites more user friendly. The LME is exploring the possibility of placing provider claims and denial information on-line. In addition, reporting and outcomes reporting will be posted.

Responsible: *Provider Relations, IT, SOC and Finance*

Stakeholders: *Providers, stakeholders, consumers and families*

Target Date: *7-2008*

- The LME will redevelop fiscal and IT policies and procedures to more accurately reflect current operations both internal and external to the LME.

Responsible: *Provider Relations and Finance*

Stakeholders: *Providers, Consumers and families*

Target Date: *3-2008*

- The LME will upgrade computer hardware and the latest stable operating systems. This will include the ability to access the network from any remote location by management staff.

Responsible: *IT and Finance*

Stakeholders: *LME staff and Providers*

Target Date: *7-2010*

5. Resource Allocation:

With the addition of staff in the past year, the Business Management Department is currently operating at 13.5 FTE's. The addition of the CFO position would increase that to 14.5. The HR function, although assigned to this area in the cost model reports to Governance Section at ACR. The actual staff salaries and benefit cost for the Business Management /IT Department is \$722,136 and the Cost Model indicates \$881,708. As

such, the department is within the 30 percent allowable variance for these functional areas.

6. Business Rules:

Rules that Enhance:

1. Implementation of 60 day claims reporting window.

This has an enormous impact on the ability to manage and project funding throughout the course of the year by allowing the LME to deal with claims on a much more timely basis. Over the past two years, the LME has grappled with providers submitting large numbers of claims for the entire year in June, July, August and September.

2. The LME has restricted its provider network for the balance of the fiscal year. The LME will define and revamp that network as we move forward.

The LME will ensure that dollars are available throughout the year and that providers are stable and funded to the extent available while continuing to provide choice to consumers regarding service providers.

3. Separation of the Medicaid MOA and IPRS contract.

Now that the LME has more authority over the IPRS contract language, the LME will implement contract maximums and 1/12th allocations. This will also have an impact on LME operations and planning as well as helping to stabilize provider budgetary operations.

Rules that Inhibit:

1. The LME only having access to IPRS claims information and Medicaid paid claims are not readily available to the LME.

The current fragmentation of the authorization and billing processes makes tracking accurate detail of services being provided in the community (i.e. utilization and # of individuals being served) difficult. We do not have an overview of what is occurring with our consumers. In addition, the lack of claims information makes keeping up with when consumers start and stop Medicaid benefits difficult, impacting our billing procedures, staffing and workflow.

2. The providers in the IPRS contract provider network do not have the technical capability to move forward with a more advanced billing system.

The implementation of an efficient, less costly claims/payment process has been significantly impacted by the number and size of the members of provider network. If we had a smaller network comprised of larger provider entities could afford to

operate systems and reporting procedures that would help automate many of our procedures.

3. The LME must respond to and coordinate multiple, fragmented reporting requirements, systems and data elements as required by the State. In addition, much of this information is self-reported by providers, making the dynamic even more difficult.

IPRS, NCTOPPS, COI, CDW, SNAP to the new Screening Form are all requirements. These requirements make service provision and LME operations more costly without necessarily providing valid and reliable data to base decisions upon. The LME must ensure completion by the providers. In some cases, the LME completes reports but the data is not returned in a timely manner and is not easily sorted, understandable or usable. The LME staff must spend a considerable amount of time hand sorting and recreating usable reports to send to providers. The LME would find it beneficial if the data could be provided by multiple means or a consolidated system developed that would allow for more efficient use of resources and better access to data.

PROVIDER RELATIONS AND DEVELOPMENT

1. Mission:

The Provider Relations Department strives to build and support a qualified provider community that meets the treatment and service needs of people with mental health, developmental disabilities or substance abuse issues. This is accomplished through a careful assessment of the needs of the consumer and community as a whole. This goal is supported through the collection and analysis of data as well as seeking input from consumers and their family members, community stakeholders, providers, CFAC, Area Board and staff.

2. Purchaser Standards:

Per the 2004-07 Performance Contract, the LME adheres to and complies with all rules and regulations related to Provider Relations and Development.

3. Current Operations:

The Provider Relations Department was established formally in early 2006. In July 2006, the Department merged with QI and Customer Service Departments. The department shares responsibilities in Provider Relations, QI and Customer Services and staff are cross-trained in areas related to each department.

Provider Relations provides the following functions:

- Endorsement of providers by a dedicated Endorsement Specialist, supported by an endorsement team comprised of QI staff and various other staff who complete the on-site reviews, documentation and follow-up.
- Contracts Coordination by a full-time Provider Liaison that handles contract and MOA provider issues, and works with Contract Managers to complete, update contracts and ensure compliance of all provider contracts.
- Provider recruitment and development of provider network. Qualified Provider Development Plan developed and implemented. Both IPRS and Medicaid providers recruited.
- Staff conducts gap analysis and addresses trends noted on an annual basis and as needed.
- Oversight, review and monitoring of provider credentials, both in and out of the catchment area. Oversee the LME Credentialing Committee.
- Credentialing, Endorsement, and disciplinary action of providers via the LME's Credentialing Committee.

- Technical assistance to providers related to contract adherence, licensure standards and State/Federal service requirements.
- Provider problem resolution and mediation both between providers and between providers and the LME.
- Provider Network training on issues related to compliance, QI, contract, or State regulations.
- Coordination of the LME Provider Forum and ongoing communication with providers on a regular and as needed basis.
- Marketing LME services and the overall role in the community. Development of brochures, website, and marketing materials, as well as public appearance and presentations.
- Assisting with care coordination functions when needed by a provider or through the complaint process. This responsibility will be shifted to another department (Care Coordination) in the future.

At this time, there are 6 FTE's in the Provider Relations Department. Responsibilities include CFAC, grant management, community education and collaboration, housing initiatives, disaster preparedness, health and wellness initiatives, and care coordination. In the future, a separate Care Coordination Department will be developed and those responsibilities and duties will be allocated to the new department. Staff which handle Customer Service issues will also be assigned to the appropriate departments.

4. Strategic Objectives:

- The LME will conduct data-driven gap analysis on an annual basis to identify needed services that are not offered by current providers, while focusing on the underserved communities within the catchment area.
Responsible Party: *Provider Specialist and QI Staff*
Stakeholders: *Providers, Community members, stakeholders, and families.*
Target Date: *3-2008*
** (LME has completed the gap analysis for 2007.)*
- The LME will develop and implement a Qualified Provider Development Plan to address gaps in services and provider issues.
Responsible Party: *Provider Relations Manager and Credentialing Committee*
Stakeholders: *Providers and LME*
Target Date: *3-2008*
** (LME has developed the Provider Recruitment Plan and Crisis Plan for 2007. The IPRS network became a closed network as of 3-2007)*
- The LME will hold a provider event in each community on at least an annual basis to include consumers and family members, community, stakeholders, staff and providers.
Responsible Party: *Provider Specialist and Liaison*

Stakeholders: Providers, Consumers, and Community Members
Target Date: 1-2008

- The Provider Relations Department will coordinate, facilitate and mediate between providers and the LME. Data will be collected and shared from the Access/ Finance Departments and given to the provider by Provider Relations in order to assure timely, accurate and consistent communication. This is to be done by internal education and on-going staffing throughout the LME.

Responsible Party: LME Managers and Provider Manager
Stakeholders: Providers and LME
Target Date: 7-2007

- The LME will establish a process to collect and distribute data on service provision and providers. The LME will make this information available to the community via the website and printed information on a quarterly basis. This process will be begin with the LME requesting input from the provider, stakeholder and CFAC on the type of data desired.

Responsible Party: LME Managers and Provider Manager
Stakeholders: Providers and LME
Target Date: 1-2008

- The LME will communicate in a timely manner with providers through the LME website, emails and telephone contact. Communication may be specific to providers based on content, services, geographic area, etc. When possible, providers will be asked for input and notified prior to any changes being implemented by the LME.

Responsible Party: Provider Relations, QI
Stakeholders: Community Stakeholders, Providers
Target Date: 7- 2007

- The LME will promote and develop the provider community while focusing on Rockingham County in order to expand services, meet capacity and address gaps in services. This will be done through collaboration with the current contract providers and the Medicaid provider community and then with non-contract providers. The providers recruited will be evidence-based, meet service definitions, and address the needs of the community as noted in the gap analysis. Gaps include lack of SA providers in all three counties, MI providers in Rockingham, and crisis services in all three counties.

Responsible Party: Provider Relations, CEO, COO
Stakeholders: Stakeholders, CFAC, Providers, Consumers
Target Date: 7- 2009

- The LME will partner with the residential child provider community to promote community collaboration and develop supportive services for children. This will be done by:
 - Recruitment and education of providers on Therapeutic Foster Care, MST, Intensive In-Home and Community Support Team across the three counties.

- Provide community education and training to providers to discuss step-down plans, treatment teams, expectations, and resources.

Responsible Party: *Provider Relations, CEO, COO*

Stakeholders: *Stakeholders, CFAC, Providers, Consumers*

Target Date: *7- 2009*

- The LME will establish a working relationship with stakeholders that include open communication, meetings, website information and information bulletins. Meetings are to be held on no less than a quarterly basis with active membership and participation. The LME will provide information on the LME's role in the community by developing *LME Information Packets* and providing *Welcome Packet* information to stakeholders in the community.

Responsible Party: *Provider Relations, CEO, COO*

Stakeholders: *Stakeholders, CFAC, Providers, Consumers*

Target Date: *7- 2008*

- The LME will educate and monitor providers regarding their role as First Responders to individuals receiving their services. First Responder training will be held by the LME on an annual and as needed basis. Follow-up will be provided when the LME, a hospital or Mobile Crisis are involved with a First Responder situation.

Responsible Party: *Provider Relations, CEO, QI*

Stakeholders: *Provider, DSS, Families of Children, Schools*

Target Date: *1-2008 and on-going*

- The LME will develop and implement training and protocol for supported employment development in the community while working in conjunction with the community of supported employment providers and Vocational Rehabilitation to educate providers **and community** on supported employment concepts.

Responsible: *QI staff*

Stakeholders: *Consumers*

Target Date: *1-2009*

<h2>5. Resource Allocation:</h2>

The Provider Relations Department will transition staff by July 2007 due to job reclassifications and departmental reorganizations. A Care Coordination Unit will be organized to include the Housing Specialist function. In addition, the CFAC Liaison will be moved from the Provider Relations Department to the Customer Service Department.

Once staff changes occur, the Provider Relations staffing will include 4.25 FTEs. This number includes a Support Staff (1 FTE), Provider Liaison (1 FTE), Endorsement Coordinator (1 FTE), Provider Data Specialist (1 FTE) and Manager (.25 FTE). The expense related to this department is \$216,466 and the Cost Model allowable expense is

\$551,368. The departmental cost is outside of the 30% allowable variance. Additional staff will be assigned as needed once the reorganization occurs.

6. Business Rules:

Rules that Enhance:

1. The LME to focus on rules, regulations and contract requirements and hold providers accountable for all areas out of compliance.

The LME strives to provide the necessary technical assistance and involvement with providers. At times, there is not a clear indication of the expectations of the LME and to what extent the LME is to provide training and technical assistance. The LME will needs clear direction from the State in order to interpret and enforce rules and service definitions. Consistency across LMEs would be helpful. Standardized documents for monitoring recommended.

2. LME is committed to having a communication distribution system that is verifiable for providers regarding endorsement, plans of corrections and contracts utilizing a system that may include certified or trackable mail, e-mails and other forms of verification to ensure fairness, timely notification and documentation of LME contact.

The LME wants to be fair and consistent in all procedures related to providers. Thus, the LME adheres to timeframes and hold all providers to the same standards. Ensuring that information is received and responded to according to set timeframes is essential. The Qualified Provider Development Plan and the Provider Recruitment Plan have both been developed and implemented to assist with this business rule.

3. The LME is committed to working with providers to assist with billing, denials, appeals and receiving payment through the LME in a timely and consistent manner.

The Provider Liaison works with each contract provider to increase understanding of and eliminate confusion about issues related to the LME computer system, the State system and authorization/claims issues. At all times, a provider may contact the Provider Liaison who will assist.

Rules that Inhibit:

1. The LME staffing does not allow for the provision of technical assistance to the provider community in the manner in which it is needed.

Providers with issues related to licensure or a basic understanding of providing services to the MH/DD/SA populations contact the LME for direction, guidance, assistance and instruction. The LME does not have guidelines for the level of technical assistance that will be provided. Requests include helping unlikely providers locate websites to assist in their decision to open a home. Others are asking the LME to assist with interviewing staff. The LME will need to work with other LME's to set

standards of what is acceptable and what is excessive when it relates to technical assistance. The LME will communicate with the State on expectations.

2. The LME has the reputation of a friendly and flexible organization that works to resolve issues to the benefit of the provider and not always within budget.

The LME has been overly flexible in resolving provider issues to the detriment of the LME. The LME has changed the approach in dealing with providers and is more focused on financial responsibility and budgetary limitations. Providers must adhere to the contract requirements.

3. The LME has determined that any endorsed providers that are willing and able will be allowed into the LME network.

The LME has found endorsing a providers but denying them access to the IPRS network difficult. At this time, the LME has closed the IPRS contract process until there is further need to expand in the service areas in which gaps were noted. The LME is concerned with the excessive interest of providers in level 3-4 residential facilities and other child residential programs. The LME has developed and implemented a Qualified Provider Development Plan that will assist with this issue.

Service Management

1. Mission:

To assist individuals and families affected by mental illness, developmental disabilities, or substance abuse to develop maximum potential for growth and maturity by ensuring adequate screening and triage for appropriate referral to service. Will monitor outcomes while managing care and service dollars through monitoring of person centered plans, performing risk management and care coordination activities in a manner that is responsive and in compliance to state and federal law as well as regulatory and accreditation standards.

2. Purchaser Standards:

Per the 2004-07 Performance Contract, the LME adheres to and complies with all rules and regulations related to Service Management.

3. Current Operations:

The Service Management Department was established formally in 2005.

Service Management is executed in the Utilization Review/ Screening Triage and Referral (UR/STR) unit at ACR LME which currently includes care coordination and crisis services.

Screening, Triage, and Referral:

The LME provides clinical screening, triage and referral services 24 hours per day, 7 days per week, 365 days per year to the citizens of Alamance, Caswell and Rockingham counties. A toll-free telephone number with TTY capability is available and staffed as a single point of entry to all services. The LME ensures that the direct care provider is able to accommodate for cultural and demographic differences, visual impairment, and other handicapped accessibility issues. If an identified or needed service is outside of the provider network, Utilization Management will work with the Provider Relations Department to identify and contract for services by a non-participating provider.

The Access Department, which includes the screening, triage and referral function, is structured within a call center operation. Calls are received in real-time. The Access Department standards for telephone access ensure that calls are answered within 5 rings (less than 6 rings) or 30 seconds and that no more than 5% of all calls are abandoned.

Utilization Review:

Utilization Management Specialists (UMS) and the Medical Director gather, only the necessary clinical information to complete reviews and make determinations regarding the service intensity of requests for authorization in a timely manner. Provider authorization requests are accepted by mail, telephone, or facsimile. The timeframe within which the determination must be made is dependent upon the clinical circumstances, including the urgency of the consumer's situation and clinical information received by the LME staff person.

There are two types of review functions: the Initial and concurrent review. The initial reviews are conducted prior to a consumer's admission or course of treatment. The concurrent reviews are performed to verify the need for the continuing authorization of existing services and the continued service intensity. The LME notifies the provider of all review decisions.

Medical Director:

The LME administration unit also provides clinical leadership and oversight, along with community integration and education provided by a part-time Medical Director. This position provides clinical direction, guidance and oversight to appropriate functions performed by the LME and the provider community. The Medical Director is the lead clinician working with Quality Improvement, Customer Service, and Service Management to ensure quality service by the provider community and clinical oversight both internally and externally, when necessary. The position is involved in the clinical appeals process, clinical consultation, 2nd opinions, and the review of UR decisions. The remainder of the Medical Director's time is spent supervising psychiatrist and providing direct service provision.

4. Strategic Objectives:

- The LME will develop a Care Coordination Unit by identifying appropriate staff through reallocation of existing staff or staff vacancies. The unit will conduct risk management functions such as providing care coordination for high cost and high risk consumers. This unit will include CAP, Hospital Liaison, Crisis Team, Housing Specialist and System of Care Coordination. The job responsibilities that will be relocated to this department are grants, housing, supported employment, crisis, System of Care, hospital follow-up, and CAP.

Responsible :UR/STR Manager, CEO, Personnel, & Finance

Stakeholders :CFAC, providers, grant sub-recipients

Target Date :1- 2008

- The LME will hire a devoted staff to oversee grants that have been awarded to the LME. This position will be certified through a State approved process and will be responsible for conducting the sub-recipient monitorings, reporting and management of documentation required in order to maintain the grants.

Responsible :UR/STR Manager, CEO, Personnel, & Finance

Stakeholders :CFAC, providers, grant sub-recipients

Target Date :7- 2008

- The LME will develop a care coordination system with providers and stakeholders in the community with emphasis on consumers in hospitals, justice systems, at-risk children, DSS (abuse, neglect and exploitation) and other emergency service organizations. This will be accomplished through the development of MOAs that outline roles and responsibilities of each entity, the process for information and data sharing and procedures to coordinate care by all parties.

Responsible : *UR/STR Manager, Provider Relations Manager, CEO*

Stakeholder : *Community Hospitals, Department of Social Services, Schools, Police, Sheriffs, Magistrates, Courts, Providers, Health Departments and RTS*

Target Date : *meet with Stakeholders at least quarterly*

- The LME will assure that consumers who are at most risk and in most need of services receive evidence based services. This will be accomplished by providing utilization management and when needed, care coordination to assess risk and to determine initial and continued need.

Responsible : *UR/STR Unit, Provider Relations, Finance, Care Coordinators, and IT*

Stakeholder : *Provider Council*

Target Date : *3- 2008*

- The LME will maintain 24/7/365 screening, triage, and referral unit that handles all calls coming into the LME. The LME will provide access information and data to staff in order to coordinate and authorize care after hours for all three counties. The LME will evaluate and establish the most appropriate and effective means of providing this service on a 24/7/365 basis.

Responsible : *UR/STR Unit, Provider Relations, Finance, Care Coordinators, and IT*

Stakeholder : *Provider Council*

Target Date : *4- 2008*

- The LME will implement the Crisis Plan as outlined by the fiscal and procedural guidelines of the Division and develop a diverse community crisis program that encompasses Alamance, Caswell and Rockingham Counties. The array of crisis services will include: First Responder, Mobile Crisis, Walk-In Crisis, and hospitalization (local, out of catchment area and state institutions).

Responsible: *UR/STR, Crisis, Provider Relations and Finance*

Stakeholders: *Hospitals, CFAC, Law Enforcement, Consumers and families*

Target Date: *7-2008*

- The LME will increase the quality of Person Centered Plans (PCP) through internal monitoring. PCP's are to be reviewed at a sampling rate of 10%. PCP that are out of compliance will be turned over to QI for a plan of correction to be issued. The LME will review all State funded PCPs to ensure that they are within standards. The LME will provide technical assistance to the provider agency and require corrections for PCP's that are not within standards.

Responsible: Customer Services, QI, UR/STR
Stakeholders: Provider, Consumer, Families
Target Date: 7- 2008 – ongoing

- The LME will monitor utilization of services through a reporting system that integrates authorization, reimbursement and claims data.

Responsible Person: CEO, IT, & Finance, UR/STR
Stakeholders: CFAC, Provider Council, LME Board
Target Date: 7- 2007

- The LME will implement a managed care system to reclaim unencumbered authorizations thereby ensuring the clearest fiscal picture possible and allowing the UR/STR Department to authorize the unencumbered authorizations. This will allow the LME to monitor and control the budget. This will also enable the LME to manage the funding appropriately and ensure that acceptable funding is available throughout the year.

Responsible: Reimbursement, Finance, IT, UR/STR
Stakeholders: CFAC
Target Date: 7- 2007

- The LME will modify its IPRS Benefit Package to assist/enable the UM Department to authorize appropriate services within available financial resources.

Responsible: Clinical Services, UR/STR, Finance, IT
Stakeholders: Providers, CFAC, consumers
Target Date: 7-2007-ongoing

- The LME will improve screening, triage and referral functions to meet performance indicators. The LME will ensure that providers are held accountable for meeting the timeframes the State has dictated for intakes and first appointments. Data will be collected from providers on each new record number assigned by the LME. On-site visits will be conducted in order to review the accuracy of the data.

Responsible: UR/STR, QI and Provider Relations
Stakeholders: Providers, CFAC, consumers
Target Date: 7-2007-ongoing

- The LME will develop and implement an LME Marketing Plan to provide external communication to the community to promote the LME's activities and responsibilities. Events coordinated by the LME will include: open houses, posters in the community, community forums, news releases, articles in local magazines, staff presentations at local interest groups, a LME website, mass mailings, welcome packets, and other means of reaching the community with information on the LME.

Responsible Party: Provider Relations, UR/STR, and QI
Stakeholders: Providers, CFAC, Hospitals
Target Date: 12- 2007

- The LME to evaluate and determine the feasibility of a jail diversion program in the community. The LME will provide training of law enforcement personnel (CIT) in the

area of crisis intervention and jail diversion. The LME will determine the counties in which the program would be the most successful and beneficial.

Responsible: UR/STR, Provider Relations

Stakeholders: Consumers, CFAC, hospitals, law enforcement and Providers

Target Date: 7-2009

- The LME will develop a crisis service continuum in the community that allows individuals in crisis to be maintained in the community, while keeping the community safe. The LME will work with the local hospitals and providers of crisis services to bid for grants, request additional funding, and encourage collaborations with all agencies in order to ensure the success of the crisis support in the community.

Responsible: UR/STR, Provider Relations

Stakeholders: Consumers, CFAC, hospitals, law enforcement and Providers

Target Date: 7-2010

- The LME will work to integrate behavioral healthcare services into the general healthcare system by facilitating training and making available information to local healthcare practitioners in primary care offices. The LME Medical Director will work closely with community psychiatry and primary care physicians to educate them on issues related to mental health, substance abuse and developmental disabilities.

Responsible: UR/STR, Provider Relations, Medical Director, and CEO

Stakeholders: Consumers, CFAC, hospitals, Physicians and Providers

Target Date: 7-2010

Housing

- The LME will manage housing from a systems perspective and plan future initiatives and solutions to assist individuals to move to the least restrictive, most independent setting. The LME will develop and implement policies and procedures from an LME perspective in the area of housing development and oversight.

Responsible Party: Housing Specialist

Stakeholders: Housing Organizations and Committees, and CFAC

Target Date: 7-2009

- The LME Housing Specialist will be assigned and dedicated solely to the housing activities of the catchment area as outlined in Communication Bulletin #69. This position shall represent the LME as the lead agency on local Housing Support Committees.

Responsible Party: Housing Specialist, Provider Relations and UR/STR

Stakeholders: CFAC, consumers, families and shelters

Target Date: 7-2007

- The LME will develop a Strategic Housing Plan that includes an inventory of existing housing options for consumers and the housing needs in the community. The LME will collaborate with local community housing initiatives to develop new and innovative housing options.

Responsible Party: *Housing Specialist, Provider Relations*

Stakeholders: *CFAC, consumers, families and shelters*

Target Date: *7-2008*

System of Care

In March 2006 recurring funding was allocated to LMEs for the “implementation and on-going support of local community collaborative activities including community based system of care child and family teams for children, adolescents and their families with mental health and substance abuse concerns”. Two FTEs are devoted to System of Care (SOC) efforts. Per Division guidelines, the System of Care Coordinator’s efforts focus on the following functions:

- The LME will work to include youth and families at all levels of the system, including representation at local collaborative(s), and providing support and leadership opportunities. This will be accomplished through recruitment of family members to participate in collaboratives, subcommittees and SOC activities, trainings, and by implementing a Parent Partner and/or Parent Navigator program, as funds allow.

Responsible Party: *SOC Coordinator*

Stakeholders: *Community, schools, juvenile justice, social services, providers, consumers, families and other child-serving and community groups*

Target Date: *1-2008*

- The LME will serve as staff to the local community collaborative(s), work with the collaborative(s) to identify and engage community partners in the process, facilitate the decision-making process regarding flexible funds, and measure the effectiveness of System of Care efforts. Collaboratives will implement SOC strategic planning including need and resource identification, and resource development. SOC Coordinator will provide education and technical assistance regarding CTSP funding, develop and distribute RFAs for Non-UCR services, complete and submit to Division Non-UCR funding requests, and monitor and report on use of funds.

Responsible Party: *SOC Coordinator*

Stakeholders: *Community, schools, juvenile justice, social services, providers, consumers, families and other child-serving and community groups and Community Collaborative*

Target Date: *Current & On-going*

- The LME will ensure that provider agencies utilize the Child and Family Team process as the vehicle for person centered planning for children, adolescents and their families with MH/SA concerns. The LME will provide training, education, and

technical assistance regarding CFTs and the LME's expectations to the LME's provider agencies.

Responsible Party: SOC Coordinator

Stakeholders: Community, schools, juvenile justice, social services, providers, consumers, families and other child-serving and community groups

Target Date: 1-2008 and on-going

- The LME will ensure that collaboratives, provider agencies, and LME staff receive needed SOC training and technical assistance by developing, providing, and/or facilitating provision of initial and ongoing SOC trainings to providers, LME staff, and stakeholders.

Responsible Party: SOC Coordinator

Stakeholders: Community, schools, juvenile justice, social services, providers, consumers, families and other child-serving and community groups

Target Date: 1-2008 and on-going

- The LME will engage agencies in local collaborative(s), work toward maximizing funding opportunities, ensure a continuum of care, and identify community capacity needs, and plan to meet those needs. The LME will participate with community agencies in child-focused interagency efforts including work with School Systems, Departments of Social Services, Departments of Juvenile Justice and Delinquency Prevention, Partnerships for children, JCPCs, local child serving agencies, faith-based groups, and other child serving groups.

Responsible Party: SOC Coordinator

Stakeholders: Community, schools, juvenile justice, social services, providers, consumers, families and other child-serving and community groups

Target Date: 7-2008 and on-going

5. Resource Allocation:

There are 19.5 FTE's allocated to UR/STR, including UM Specialist (2 FTEs), Manager (1 FTE), Medical Director (.5 FTE), support staff (2 FTEs), Receptionist (1 FTE), UM Coordinators (5 FTE's), Crisis Clinicians (4 FTEs), FTE Hospital Liaison (1 FTE), CAPP Coordinator (1.5 FTE), and Hospital Liaison (1.5 FTE).

The LME is in the process of reorganizing a separate Care Coordination Department that will include: SOC Coordinator (1 FTE), SOC staff (1 FTE), Care Coordinator (1 FTE), Grant Specialist (1 FTE), Crisis Team (staff to be determined), CAP Coordinator (1 FTE), CAP Data Specialist (.5) and a Hospital Liaison (1 FTE). It is yet to be determined if this department will function separate from UR/STR or within the oversight of the UR/STR Manager. In the formation of the Care Coordination Unit, it will transition staff from both the Provider Relations Department (1.5 FTE) in addition to an additional position added for the oversight of grants. The UR/STR Department will separate functions and move 7

FTEs. The SOC Coordinator will be brought into this unit. The Care Coordination Department would be staffed at the 7 transferred FTEs initially. This reorganization should occur by July 2007.

The LME expense associated with Service Management will be \$1,164,208. The Cost Model allows for \$1,433,188 for STR, UR and Care Coordination. The LME is within the allowable 30% variance from the Cost Model.

6. Business Rules:

Rules that Enhance:

1. Providers are expected to have services pre-authorized with the exception of crisis and physician services.

Payment for state funded services is made on a fee-for-service basis: providers must obtain authorization prior to delivery of services in order to bill and receive payment for services provided. Crisis services are an exception to this. The LME provides training and technical assistance to providers to ensure the availability of and access to services by consumers, as well as the ability of providers to maintain financial viability.

2. Children who are referred to an out of home placement are required to go through the Care Review Team for review.

In an effort to keep children in the least restrictive but appropriate placement the LME requires that all children who are being considered for a residential placement (except in a crisis) be presented to the Care Review Team (CRT) which is a subcommittee of the Alamance Community Collaborative. By going through this committee, the CRT is assured that a Child and Family Team meeting has occurred. This process gives the client and provider a chance to meet with a multidisciplinary team that can offer other alternatives when appropriate.

3. Service Plans are developed with the treatment team, clinicians and stakeholders using the State Template, in addition to the guidance provided via Division Communication Bulletin and required DDTI training.

This rule has helped the LME in providing consist information to providing across disabilities. In giving guidance, the LME refers the provider to the PCP tool and Division website. Additional training is required by the LME to ensure accurate interpretation and application as follow-up to the required PCP training.

Rules that Inhibit:

1. The LME experience has been reflective of the vast shift from that of authorizing services based on medical necessity to that of a balance between clinical appropriateness and financial availability and restraints.

At different times throughout the past 18 months, the LME has turned off elements of the managed care system in order to help accommodate provider issues, staffing shortages in the UR/STR department, the Rockingham County merger and changes made at the Division level (Value Options carve-out/ nNo wrong door/registration). The LME brought to a halt financial control elements of the system when providers or staff had concerns about the ability to continue to authorize services regardless of funding available or if the system impacted smooth authorization, provider claims submission and payment to the provider network. The LME focused on flexibility in provider financial support as opposed to focusing on controlling capped funds and the impact that would have on financial operations.

2. The LME has held off in deciding whether to implement a separate Care Coordination Unit as it is identified in the FY 08 Cost Model. Although, care coordination has occurred, consistently have suffered for not having a centralized focus.

The LME had staff in QI, Provider Relations and UR/STR providing care coordination functions in the past. The organization chart has been redeveloped to create a separate Care Coordination Unit

3. Enhanced service providers are held responsible as the Clinical Home and are expected to help coordinate appropriate services for the consumers.

The Clinical Home concept is a positive move by the State to help identify the responsible provider agency. There are concerns due to the competition among providers for clients and the interpretation of Clinical Home responsibilities. Community support providers have been hesitant to refer clients to other providers, who have a wider array of services for fear that the client will be recruited as a community support client as well. If the Division could release "standard/good practice rules", the providers may be more accountable across the state and LME's would have standards to refer to for training and also for support to intervene. In many cases, Consumers are not receiving the most appropriate response in a crisis by the Clinical Home until the standards are released and supported by the Division.

CUSTOMER SERVICE/CONSUMER AFFAIRS LME FUNCTIONS

1. Mission

To provide oversight and ensure that the rights of individuals receiving services are protected and to ensure fair and reasonable treatment for those accessing the public behavioral healthcare system.

2. Purchaser Standards:

Per the 2004-07 Performance Contract, the LME adheres to and complies with all rules and regulations related to Customer Service.

3. Current Operations

Customer Services and Consumer Affairs currently operates within the Quality Improvement (QI) Department. In the future, Customer Service will be a more formalized department which will have staff relocated from QI and Provider Relations departments.

At this time, staff from QI and Provider Relations share the following responsibilities:

- Consumer and provider complaints, concerns, grievances and information requests. These are triaged and handled via phone, e-mail, fax, or in-person within 24 hours of receipt;
- Assistance with navigating the system by consumers, family members, stakeholders and providers is provided as needed basis by staff verbally and in writing;
- Development and distribution of information about LME services and system access;
- Oversight and enforcement of consumer rights and forwarded to QI for investigation;
- Oversight of LME and Provider Human Rights Committees and functions related to review of rights violations and concerns;
- Oversight of rights investigations, follow-up and reporting to appropriate committees and State agencies;
- Training, education and enforcement of rights protections to both the community and providers on an annual and as needed basis;
- Technical assistance, direction and guidance to assure the person-centered approach by those involved in the system;
- Ensuring client choice through development of policies and procedures; and

- Coordination, oversight and management of the Consumer and Family Advisory Committees, meetings, documentation, and follow-up for all CFAC related activities.

4. Strategic Objectives:

- The LME will work to increase the internal communication across departments from front line staff to the executive leadership to ensure a responsive approach to problem resolution and a proactive focus on the LME services in the future. Staff will be trained throughout the year on all aspects of the LME beginning with the need for good customer service skills and the purpose of the LME.
Responsible: Customer Services, Human Resources, IT and Provider Relations, COO and CEO
Stakeholders: Providers, Consumers, Stakeholders and Families
Target Date: 7-2007 and on-going
- The LME will organize open forums in each community on no less than an annual basis to get public feedback on the LME, status of mental health, developmental disabilities and substance abuse service provision and the Local Business Plan.
Responsible: Customer Services and Provider Relations
Stakeholders: Providers, Consumers, Stakeholders and Families
Target Date: 1-2008
* (Began this process in November 2006.)
- The LME will develop a mechanism for increasing consumer awareness on how to access and navigate the system. The LME will develop and distribute welcome packets to new consumers within 30 days of entering the system, which will include welcome letter, rights information, access, crisis and HIPAA information.
Responsible: Customer Service Staff
Stakeholders: Consumers
Target Date: 7-2007
* (Began the process in 3-2007.)
- The LME will train law enforcement officers, schools, hospitals, and other community stakeholders on the role the LME, funding availability and information about the provider community. Trainings to be held in each community on no less than an annual basis.
Responsible: UR/STR, Customer Services, Provider Relations
Stakeholders: The Community
Target Date: 7- 2008
- The LME will provide annual consumer rights protections training for providers, stakeholders, consumers and family members. Trainings to be held in the communities on an annual basis and will be based on the targeted audience.
Responsible: Customer Service Staff
Stakeholders: Consumers and Providers
Target Date: 1-2008

- The LME will translate the LME Consumer Handbook, Welcome Packet and other relevant access information into Spanish.
Responsible: *Customer Service Staff and Spanish Translator*
Stakeholders: *Spanish speaking population*
Target Date: *7-2008*
- The LME will work with local interest groups to educate the community about community resources. This will be coordinated by the LME representative who will interface with local interest groups.
Responsible: *Provider Relations, Customer Services, and QI*
Stakeholders: *Providers, Consumes, Advocacy/Interest Groups*
Target Date: *7- 2008*
- The LME CFAC Committee will serve in an advisory capacity to the LME. Submitting data and information to the CFAC on a quarterly basis as part of a Local Business Plan review. Feedback and recommendations will be taken to the LME Management Team and QI Committee for consideration and review. This will include a CFAC member being an active participant on the QI Committee on at least a quarterly basis.
Responsible: *QI and Customer Service Staff*
Stakeholders: *CFAC*
Target Date: *1-2008*
- The LME will ensure that choice is offered to individuals in the MH/DD/SA system. A system will be developed for ensuring and tracking consumer choice of service providers. The LME will develop and distribute standard procedures for ensuring choice by providers and training concerning those procedures with the provider community.
Responsible: *UR/STR, Customer Services*
Stakeholders: *Providers, Consumers*
Target Date: *1- 2008*
- The LME is committed to involving the community in the activities of the LME. The LME will request input and responses from the community and stakeholders concerning changes in goals, progress toward goals and overall satisfaction with the LME. This will be done through surveys, mailings, and website requests for information of performance by the LME. This will be on no less than an annual basis. The LME will collaborate with stakeholders to develop projects in the community that better the lives of those in the community with disabilities.
Responsible: *QI, SOC and Customer Service Staff*
Stakeholders: *Provider, Consumers and the community*
Target Date: *1-2008*
- The LME will include the Board, CFAC, Human Rights and QI Committees in the review of all collected data on activity and movement toward these objectives and provide updates and reports quarterly and on an as-needed basis for their review

and evaluation of the LMEs progress toward the objectives in the Local Business Plan.

Responsible: Customer Service

Stakeholders: Provider and Consumers

Target Date: 7- 2008

5. Resource Allocation:

At this time, the LME has 3.5 FTE's dedicated to the Customer Service functions with additional support provided by the QI/Provider Relations Manager. The positions include a complaint staff (1 FTE), Human Rights/CFAC (1 FTE), Caswell staff (1 FTE), a contract employee (.25 FTE) and the Manager position (.25 FTE).

This Department will be restructured as part of the broader reorganization of the LME. A Provider Relations staff person will be changed to CFAC/Stakeholder Liaison and placed in the Customer Service Department; total assigned FTEs will not be altered. The position is now shared between 2 members staff and will be combined into 1 FTE. The position should be filled by 7-2007.

The actual staff salaries and benefit cost for the Customer Service Department is \$164,208. The Cost Model allows for \$210,108 for staffing expense. This department is within the 30% allowable expense.

6. Business Rules:

Rules that Enhance:

1. Anyone can file a complaint via writing, fax, e-mail, voice message or in-person.

The LME staff is committed to ensuring that complaints are heard and responded to in a timely manner. This process includes standardized letters that are sent to all parties involved in the complaint to ensure documentation, status, and resolution expected.

2. Consumers, family members and advocates are to be responded to in a respectful and timely manner by LME staff. The first option of contact is face to face or over the phone.

The LME staff will continue to respond to consumers, family members and advocates in a respectful and timely manner. At any time, a consumer's need or crisis will take priority over the documentation or paperwork of the LME.

3. The community will be provided with the most up -to-date and accurate information available to the LME concerning the provider community.

The LME shares information gathered from providers in order for the community to be aware of the status of providers and to assist in making choices concerning the provider they would like to receive services from. The LME is in the process of developing a Provider Status Report to provide information concerning complaints, monitorings, incidents, and DFS visits.

Rules that Inhibit:

1. The LME has enabled consumers to make choices concerning their provider agency without limitations and consideration of the contract process.

The LME is planning to right-size the provider network in the rural areas to ensure the providers are stable and funded at a level to ensure the continued provision of those needed services in the more rural communities. The LME will unendorse providers that have not provided the service since endorsement or for those that cannot provide the service after 30 days. The LME needs the backing of the State to support the decisions that are made at the local level concerning dis-endorsement and contract discontinuation.

2. The LME adheres to the compliance standard of 10-day resolution for complaints.

Due to working with other public agencies, providers and stakeholders, a response is often delayed or resolution of a complaint does not occur within 10 days. It is a challenge to ensure that providers make the needed changes systematically and not just on an individual complaint basis. The complaints can often be resolved within 10 days but systematic issues tend to continue after the 10 days and are time consuming for the LME to track, monitor and provide the needed technical assistance.

3. The LME has focused on the internal role of the LME and the community continues to see the LME in the same role as the previous Area Program – which is to be all things to all people.

Consumers, family members and stakeholders have unrealistic expectations that exceed the intent or definition of the service definition. In the past, the Area Program developed a reputation of being “all things to all people”. The LME has had to discontinue this approach to the disbelief of the community. The LME is no longer the safety net that ensures a place for all individuals. The focus is now on the provision of service to those most in need and that IPRS funding is not an entitlement and based on a balance between allocated budget for the particular target population and medical necessity.

QUALITY MANAGEMENT

1. Mission:

To provide oversight to the public behavioral healthcare system while educating the community on an approach to quality behavioral healthcare that is understandable, applicable, practical and in compliance with standards.

2. Purchaser Standards:

Per the 2004-07 Performance Contract, the LME adheres to and complies with all rules and regulations related to Quality Improvement and Management.

3. Current Operations:

The operations of the Quality Improvement Department are guided by the QI Plan developed on an annual basis. The plan is based on community needs determined in the previous year and in conjunction with State guidelines and requirements. The QI Committee reports the QI Plan to the Board on an annual basis and complies with requirements set by the State. QI oversees the implementation of the LBP and tracks progress on strategic objectives on a quarterly basis.

The QI Department focuses over 50% of staff time on quality assessment. This involves assessing data that has been submitted by providers, on-site visits and State reported data. The remaining 50% of staff time is spent on quality improvement activities. These activities include technical assistance, plans of correction, training and guidance to providers in order to improve the quality of the services offered. QI and QA ensure compliance with State and Federal regulations and also in moving towards evidence based practices and outcomes.

Both clinical and administrative projects are selected each year and data is tracked. The QI Department coordinates five QI projects per year and submits an annual report to the Division of MH/DD/SAS.

A QI Plan is developed each year, submitted and approved by the Board, then implemented. The following areas are currently being implemented, tracked and reported:

- Incident Management: Review, tracking and reporting completed as soon as the incidents are submitted to the LME and follow-up provided;
- NC TOPPS: Oversight, tracking , corrections and follow-up provided on a monthly basis;
- DD COI and NC SNAPS: Reporting, tracking and submitting on a monthly basis;

- Complaint: tracking, reporting, follow-up, resolution and plan of correction monitoring;
- Mystery Shopper Calls: Conducted, tracked and reported on a quarterly basis across all services, providers, including the LME;
- UR Service Utilization Data Collection on Urgent, Emergent and Routine appointments on a monthly basis for all new record numbers assigned;
- Medical record distribution and oversight of historic records in all three counties by qualified staff with a degree in medical records;
- Provider Monitoring: On-site, documentation, and plan of correction conducted at least 2 a week with a team approach;
- Credentialing of Providers: Review, oversight of licensure, disciplinary action and reporting on a bi-weekly basis;
- Policy oversight and implementation of rule for the LME and provider community by the staff via monitoring and review;
- Training and technical assistance for providers twice annually and on an as-needed basis;
- Satisfaction Surveys: Development, distribution, data collection and trend analysis for providers, stakeholders and consumers on both the local and State level conducted on a quarterly basis;
- Service Record Review: PCP sampling, review, plan of correction conducted when on-site monitoring and completed;
- Technical Assistance: Training to providers on plans of correction or areas not within expected standards as needed;
- QI Training: Training on the development of QI Plans, committees and reporting conducted twice annually;
- Oversight, compliance and tracking of the LME Performance Contract on a quarterly basis;
- Assistance with Care Coordination as it relates to complaints and incidents as needed;
- Development of policy and procedures related to compliance with URAC accreditation standards;
- Facilitation and mediation of LME and Provider problem resolution on an as needed basis;
- Client Data Warehouse input, tracking, corrections, and submissions completed daily and submitted to the State;
- Risk management functions and assessing Level III incidents and individuals with Division's involvement;
- Gap analysis and trends analysis conducted annually by staff; and
- QI Plan development by the QI Manager and QI Committee on an annual basis.

Consumers, family members, stakeholders and providers are involved at multiple levels in the oversight of providers and review of data to ensure quality. A mechanism for the involvement of interested parties in the QI process shall be accomplished through the establishment of a strategic plan that includes monitoring the implementation of the QI Program and State requirements throughout the organization. A QI Plan is currently in place but will be redeveloped once the LBP has been approved by the Division.

4. Strategic Objectives:

- The LME will provide oversight and accountability of the provider network through a QI team that conducts monitoring of providers on a regular scheduled basis, upon the receipt of a complaint, if an incident is not appropriately handled, when concerns arise, or prior to providing services for 90% of all IPRS contracts.
Responsible: *QI staff and Provider Liaison*
Stakeholders: *Providers, consumers, and CFAC*
Target Date: *1-2008*
- The LME Qualified Provider Development Plan will be implemented to ensure consistency with disciplinary actions and sanctions to providers. Documentation and evidence of efforts taken by the LME to ensure compliance will be maintained and reviewed through the Credentialing Committee.
Responsible: *Credentialing Committee*
Stakeholders: *Providers and consumers*
Target Date: *7-2007*
- The LME QI Department will collect data from contract providers via monitoring related to: outcomes associated with satisfaction, admissions, discharges, incidents, committee minutes, intake times, complaints, and other relevant data. The information will be compiled and provided to the community via the website.
Responsible: *QI staff, UR/STR, and Provider Relations*
Stakeholders: *Providers, CFAC and consumers*
Target Date: *7-2009*
- The LME will add additional data elements to its computer system to track provider issues and contacts, monitoring, incident management and endorsement. These elements will be added to current payment, authorization and contracts management elements. The database will be accessible by all departments within the LME.
Responsible: *All LME Departments*
Stakeholders: *Providers, community, stakeholders and consumers*
Target Date: *1-2009*
- The LME will summarize data related to Performance Agreement and submit or present to QI, CFAC, Human Rights and at LME Board on a quarterly or as requested basis in order for all those involved with the LME to have a better understanding of LME operations and provider status.
Responsible: *QI staff and CEO*
Stakeholders: *Board, CFAC, consumers and providers*
Target Date: *1-2008*

- The LME will make the minutes for Human Rights, QI, and CFAC Committee meetings available to the community via the website on a quarterly basis.
Responsible: *QI, Provider Relations and Human Rights staff*
Stakeholders: *Consumers, CFAC, Providers and stakeholders*
Target Date: *10-2007*
- The LME will assist providers in focusing on improving the quality of their service provision in the community through their identification, approval and submission of three QI projects during the fiscal year. The QI Department will provide education, suggestions and require projects based on plans of corrections for providers.
Responsible: *QI staff and Provider Liaison*
Stakeholders: *Providers and consumers*
Target Date: *7-2008*
- The LME will provide and/or coordinate training and technical assistance on no less than an annual basis on the topics of quality, best practice and evidenced based practices to the community and to providers. CFAC and Board members will be encouraged to attend.
Responsible: *QI staff*
Stakeholders: *Providers, consumers and Board*
Target Date: *1-2009*

5. Resource Allocation:

At this time, the LME has designated 3.25 FTEs to the QI Department. Two (2) FTEs being clinical and two (1) FTE is data analysts for the QI and CDW functions. The QI Manager provides assistance and direction to staff person concerning all QI functions on a .25 basis.

At this time, the LME has 2 FTEs dedicated to the Customer Service functions with additional support provided by the QI/Provider Relations Manager. Provider Relations and QI staff are cross-trained and assist when needed. An additional staff will be added in the 2007-2008 fiscal year.

The actual staff salaries and benefit cost for Quality Management is \$172,641. The Cost Model expense allowable is \$136, 606. The Quality Management Department is within the 30% Cost Model allocation.

6. Business Rules:

Rules that Enhance:

1. Provider performance is driven and measured by the collection of accurate data.

The LME QI Department will distribute data that is valid and reliable. At this time, the data collected can not be ensured to be accurate. The QI Department will continue to work to meet this Business Rule. The QI staff will sample provider data submitted as well as on-site review of data to ensure reliability and validity.

2. The QI staff provides technical assistance to any provider when time allows and the assistance is within the role of the LME.

The LME is committed to providing information as needed and on a regular scheduled basis concerning quality. The staff makes a special effort to provide direction, support and guidance on rules, regulations, interpretation and best judgment when requested and if the LME determines it is necessary.

3. The QI Department adheres to the Qualified Provider Development Plan.

The LME will use the Qualified Provider Development Plan as a guide to ensure consistency and fairness across the provider community for both contracts and MOA's.

Rules that Inhibit:

1. The LME will conduct an annual quantitative/qualitative review for all contract providers.

Reviews are not always possible when complaints take precedence over the regular scheduled monitorings and endorsement reviews. The amount of time needed to bring a provider into compliance and the associated six month review that follows adds to an already overbooked schedule for the year. The number of non-contract monitorings often out-number those with contracts. There are also more out-of-compliance issues with the non-contract providers than those with contracts. Staff expend more time and attention assisting the non-contract provider with technical assistance in order to comply with rule.

2. Competent providers shall meet minimum education and clinical competency requirement as outlined in service definitions to receive endorsement for service provision.

There is a lack of clarification on what "competent" means and how to identify competency. On the day of the monitoring, the provider may appear to be in compliance but what occurs once the LME is off-site may change once endorsed. Also the role of the LME in assisting the provider with technical assistance and their level of competency is not clear. The LME expends a vast amount of energy assisting providers in understanding licensure rule even though they were licensed by DFS and passed the DFS review.

3. The LME will enforce all out of compliance issues with providers in a timely and efficient manner.

The unendorsement authority of the LME to ensure compliance is not a viable option at this time. Revoking endorsement is not the solution for issues related to data reporting (i.e. NC TOPPS) timeliness of data submission. The Provider Network has many large providers that have limited but significant issues not yet warranting pulling all service provision from them via the "Unendorsement" process. The Provider Community is not equipped to take on the closure of a large provider agency at this time and the LME needs other levels of enforcement that may be more appropriate to the type of issue that does not warrant shutting service provision down.

LME Commitment

Change is occurring at every level within the LME and can be seen in many forms. Regardless of size, change can be a difficult process to manage, and just like most LMEs, ACR must undergo continuous change. The LME leadership approaches change as a constant, ongoing activity, rather than just an ad-hoc event or single project.

The LME is committed to working with the community to ensure buy-in, ownership and commitment from the community to the continuation of behavioral healthcare management on a local level. The building blocks to making this plan work are:

- Collaboration
- Communication
- Quality Management
- Cultural Competency
- Workforce Development
- Leadership

This document is to be considered a “living and breathing” document. Changes and updates will be made on an as-needed basis and as new input is provided, and objectives and goals are revised.

The LME is devoted to the success of this plan and will work to ensure progress toward the objectives and report the progress back to the community.

The Local Business Plan represents the scope of work of the contract between the Department of Health and Human Services and Alamance- Caswell-Rockingham LME.

Local Business Plan Development and Stakeholder Input

The formulation of the Local Business Plan was a collaborative effort between staff from the LME, CFAC and Area Board representatives, community stakeholders and providers. A total of nine (9) meetings occurred in the preparation, writing and editing of the plan. Additional input was received from the community through email when people could not attend.

Forums

Three community stakeholder forums in each of the three counties occurred in the fall of 2006 to introduce the requirements of developing a 2007-2010 Local Business Plan.

1. These initial forums began in November 2006 with the first one occurring in Alamance County on November 7, 2006 at the Grand Oaks Building at Alamance Regional Medical Center. Twenty people attending.
2. The second initial forum occurred at Rockingham County Community College on November 20, 2006 with 33 people attending.
3. The third forum occurred on November 27, 2006 at the Caswell County Civic Center with seven people attending.

Stakeholders from all three counties attended. Those present represented local community colleges, law enforcement, school systems, faith-based organizations, Department of Social Services, public health, United Way organizations, local municipalities, Departments of Juvenile Justice and local advocacy groups. Community stakeholders were notified of these forums and invited to participate through a variety of ways, including mail and email invitations, posters, announcements in local newspapers and through community list serves.

Input Meetings

A follow-up stakeholder forum occurred on January 31, 2007 at the Alamance County Human Services Center to continue Local Business Plan strategic planning with specific information presented about the current operations of the LME and information gathering regarding LME strengths, weaknesses, and challenges for the next three years. Participants came from Alamance and Rockingham Counties although Caswell County stakeholders were invited. Seventeen were in attendance representing Alamance and Rockingham counties, not including the LME staff. Due to lack of Caswell representation at this meeting, an additional stakeholder meeting was scheduled at the Caswell County Mental Health Clinic and five people attended.

A similar forum was conducted prior to this meeting on January 24, 2007 targeting representatives from the CFAC and Area Board. Again, this agenda was similar to the January stakeholder meeting with seven people in attendance.

A third forum followed on February 14, 2007 for providers where additional input was sought and information presented on the future of the LME. Ten providers were in attendance.

Input

Information from these three groups was documented via minutes and incorporated into the first draft of the local business plan. The minutes were then emailed, mailed and handed out to those individuals who had been involved in the planning process for additional input. Those interested in continuing this input process came back to a follow-up meeting on February 23, 2007 for a complete review of the goals that had been developed based on the input meetings. There were seventeen people at the meeting and the group reviewed the strategic objectives and provided feedback.

The Local Business Plan draft continued to receive input and fine-tuning with another draft distributed for a final review by a group that consisted of a DSS Director, State Liaison, LME Director, LME QI/Provider Relations Director, Community Resource Director, and CFAC Representative. This group met on 3-16-07 and the entire Plan was reviewed in detail. A total of six were in attendance.

A draft version of this Local Business Plan was then developed internally and distributed to the Board for review one week prior to the Board meeting. At the Board meeting on 3-20-08, the LME Board discussed and approved the ACR LME Local Business Plan. CFAC was also presented with the draft of the LBP on 3-27-07 for review and discussion.

Crosswalk of Key Functions to LME's Organizational Structure

LME Function	Per Cost Model Organizational Structure	Per LME Organizational Structure	Page # of Local Business Plan
CEO	General Governance	General Governance	5-11
Board support and expense	General Governance	General Governance	5-11
Policy analysis	General Governance	General Governance	5-11
Human Resources	Business Management	General Governance	5-11
Accounting/Budgeting/Payroll	Business Management	Business Management	12-21
Financial reporting	Business Management	Business Management	12-21
Claims processing, billing, payment	Claims Processing	Claims Processing	12-21
CDW and IPRS reporting	IT	IT / QI	12-21; 42-47
Provider endorsement and monitoring	Provider Relations	Provider Relations/ QI	22-27; 42-47
Provider recruiting and contracting	Provider Relations	Provider Relations / Business Management	12-21; 22-27
Provider technical assistance	Provider Relations	QI / Provider Relations	22-27; 42-47
Handling provider complaints	Provider Relations	Provider Relations	22-27
24/7/365 Access, screening, triage and referral	STR	STR	28-36
Consumer registration	STR	STR	28-36
Person Centered Plan reviews	Service Management	Service Management / QI	28-36; 42-47
State funded service authorization	Service Management	Service Management	28-36
Maintenance of waiting list for CAP-MR/DD Waiver	Service Management	Service Management	28-36
Care Coordination	Service Management	Service Management	28-36
Community Collaboration	Service Management	Service Management and Customer Service	28-36; 37-41
System of Care and other interagency coordination/collaboration	Service Management	Service Management	28-36
Education to general public and activities to address stigma	Service Management	Service Management/ Customer Service	28-36; 37-41
Consumer appeals and grievances	Customer Service	Customer Service	37-41
CFAC staff and expenses	Customer Service	Customer Service	37-41
Consumer education and outreach	Customer Service	Customer Service	37-41
Internal data analysis and reporting	Quality Management	Quality Management	42-47
Critical incident reporting	Quality Management	Quality Management	42-47
Quality Improvement studies	Quality Management	Quality Management	42-47
Develop and stabilize a highly qualified provider system**	Provider Relations	Provider Relations	22-27
Implement comprehensive crisis services**	Service Management	Service Management	28-36
Assure a unified system and standardization**	Service Management/ Provider Relations	Service Management/ Provider Relations / QI	22-27;28-36; 42-47
Develop opportunities for consumer employment**	Service Management	Service Management	28-36
Develop opportunities for consumer housing**	Service Management	Service Management	28-36

**State Strategic Goals

Alamance-Caswell-Rockingham LME

