

East Carolina

Behavioral Health

Local Business Plan

July 2007 – June 2010

Table of Contents

	Page
Local Business Plan Narrative.....	3
Governance and Administration.....	5
Business Management and Information Management.....	9
Provider Relations and Development.....	15
Customer Service/Consumer Affairs.....	20
Service Management.....	26
Screening, Access and Triage.....	32
Quality Management.....	36
ECBH Organizational Chart.....	Appendix A

East Carolina Behavioral Health Care Narrative

The enclosed three year Local Business Plan was developed by staff from Neuse Center, Pitt County Mental Health, and Roanoke-Chowan Human Services. The three existing agencies plus Beaufort County will merge on July 1, 2007 and become East Carolina Behavioral Health (ECBH). The plan was developed after receiving much input over the last few months from our CFACs and many other stakeholders throughout the nine county region.

Fifteen stakeholder meetings occurred between January 3rd and February 7th. There were four in each of the existing LME areas, two in Beaufort County and one joint CFAC meeting. Invitations were sent to all stakeholders in the communities ECBH will serve July 1. An advertisement also ran in each of the local papers advertising the event. Invitees included all of those mentioned in our preplan document. Beaufort County made a preliminary decision to join our merger in January. Because we did not have any mailing list for that county, advertisements were put in their local papers and CFAC members in that area were contacted. All Beaufort county providers were also notified about the meetings.

A LBP management team was developed in late October, which included representatives from Neuse, Pitt, and Roanoke-Chowan LMEs. The seven-member team developed a powerpoint presentation, which was shown at each of the fifteen stakeholder meetings. The presentation (available upon request) included a review of mental health reform, discussion of merger activities, a brief description of each LME functional areas and a review of the continuum of services by age and disability. There was also a review of crisis services, which should be available to all citizens. The focus of the presentation was to educate our community stakeholders about what they should expect from ECBH as a LME and to educate them about the minimum level of services that should be available in every community so they could better advocate for their needs. There was also an educational component and emphasis on recovery and self-determination.

At the conclusion of the LME presentation, each stakeholder was given the opportunity to provide input. A LME representative recorded all input received and at the conclusion of each meeting, stakeholders were asked to use three dots to mark their highest priorities. Once input was gathered from each of the 15 meetings, all input was prioritized in a spreadsheet according to the number of votes received. Surveys were also distributed to all stakeholders present to provide input about the process and to make any additional comments. Staff members at each agency were also given the opportunity to provide input. There was some input received from stakeholders that could not attend the meetings that was included.

All meetings were extremely positive and across all nine counties, there were several common themes. One major theme was a request for additional training across all LME functional areas. The training ranged from training for consumers on what services they should expect to training for other private and public stakeholders on community resources. There were also other common requests such as the need for recovery and/or

crisis centers in areas where it does not exist, the need for CIT training and requests for updates to our local business plan. Input received was very positive and was utilized to improve on future presentations.

After all stakeholder meetings were completed and input was organized, the three ECBH assistant directors each wrote the plans for their functional areas. Ideas on objectives and strategies were shared and received from other staff and from stakeholders. After completion of the plan, copies were submitted to all county commissioners. From March 5th through March 19th, executive members of ECBH attended County Commissioner meetings throughout the nine counties to present a summary of the plan, answer any questions, and request approval. During the months of February and March, the plan was also shared with Neuse and Roanoke-Chowan's local Boards for input and approval.

While this plan was written as part of a State requirement, the plan allowed us to gain meaningful input to guide us all in the creation of our new agency. The executive staff of ECBH is very dedicated to ensuring that this plan is reviewed and refined by us and our valuable stakeholders as we move through the next three years together.

#1

GOVERNANCE AND ADMINISTRATION LME FUNCTIONS

1. MISSION: The mission of Governance and Administration is to provide strategic and operational leadership to ensure that the mission, vision, values, and policy set forth for ECBH are consumer focused and promote evidence based practices and that strategic planning continuously involves our community stakeholders and our Consumer and Family Advisory committee.

2. CURRENT OPERATIONS: Listed below are the current operations for each of the three existing LMEs.

East Carolina Behavioral Health (ECBH) will be comprised of Neuse LME, which currently manages mental health, developmental disability, and substance abuse services for Craven, Jones and Pamlico Counties, Pitt County LME, Roanoke-Chowan LME, which currently serves Bertie, Gates, Hertford and Northampton Counties, and Beaufort County, currently served by the Tideland LME. With the exception of Pitt County, the other eight counties are governed by local Boards comprised of one county commissioner from each county and additional community members. Neuse has eleven Board members, Roanoke-Chowan has fifteen and Pitt's Board is their nine member Board of County Commissioners. Pitt County also currently has a twenty-one member advisory Board made up of local stakeholders using the General Statute requirements for Mental Health governing boards as the basis for filling its positions. Neuse and Roanoke-Chowan each currently have one CEO that reports directly to the Board. The CEO position in Pitt County is vacant and those functions are being carried out by the Pitt County Deputy County Manager – Financial Services. Roy Wilson, the Neuse CEO, will be the CEO of ECBH effective July 1. ECBH's management structure will include three assistant directors to carry out the LME functions across the nine county region. (See ECBH organizational chart in appendix A) These three positions have been filled and all other remaining positions will be filled by April 2007 for July 1 implementation. The three LMEs jointly entered into a contract this year for a LME Medical Director.

None of the individual LMEs is accredited at the time, although all were previously accredited as a service provider by the Council on Accreditation. Neuse, Pitt and Roanoke-Chowan are totally divested of services and have providers within the communities delivering services to our consumers.

While each existing LME is organized somewhat differently, a new organizational structure will be in place July 1 with central administration to provide oversight of each of the LME functional areas across the nine county region.

3. STRATEGIC OBJECTIVE: The strategic objectives of the Governance and Administrative department are listed below along with the strategy and projected implementation date to obtain each objective.

Objective 1: ECBH employees will operate under a single set of policies and procedures effective July 1.

Implementation Date: July 2007

Strategy to Obtain objective: Policies and procedures of Neuse Center will be utilized as ECBH's policies and procedures. All ECBH employees will be given access to the policies and procedures prior to July 1 so that they are aware and are educated about any changes.

Objective 2: ECBH will comply with all areas of DHHS/LME contract.

Implementation Date: July 2007

Strategy to Obtain objective: Assistant directors will ensure all components of contract are understood by all relevant staff. All parts of the contract, which require reporting, will be assigned to staff members to ensure all deadlines are met. Any problems with compliance will be addressed immediately by the assistant director and/or executive management team, which include the CEO and the three assistant directors. ECBH will strive to meet and exceed all benchmarks as set in the contract.

Objective 3: ECBH Board members will operate in full compliance with S.L. 2006-142 regarding structure of area boards and under a single set of bylaws and will begin to receive education and training to ensure they are unified and operating as one.

Implementation Date: October 2007 – June 30, 2008

Strategy to Obtain objective: Roy Wilson, CEO for ECBH, will arrange or provide for an annual Board retreat to provide governance training for all ECBH Board members. This training will include Carver model training and general education regarding their role as ECBH Board members. In addition, Board members will receive training on ECBH's benefit plan for state funded consumers. Training will also be focused on unification of the Board to operate as one Board serving all nine counties. He will also provide the Board with Neuse's current Board bylaws to operate under and to review for any changes needed to function effectively as ECBH Board. Once the Board is legally formed in July 07, other training needs will be assessed and provided as needed.

Objective 4: All ECBH Board members, staff, and CFAC will receive ongoing training and education on recovery, self-determination and evidence-based practices.

Implementation Date: October 2008

Strategy to Obtain objective: Training and general education to the above group regarding the specified areas will be provided or arranged for by the CEO and the three assistant directors. This will ensure all policies are focused on these ideas and that all

strategic planning going forward supports these fundamental concepts. Board training will be provided at the annual Board retreat and staff and CFAC training will follow.

Objective 5: ECBH will provide an educational training session for all Boards of Commissioners and legislative representatives in our nine county area on MH/DD/SA issues.

Implementation Date: July 2009

Strategy to Obtain objective: ECBH CEO and executive leadership will provide or arrange for training to the above-mentioned stakeholders so that they understand as the ultimate decision makers the impact of the decisions they make. Training will address their statutory authority, use of county funds, use of State/Federal funds and statistics related to service provision in their community. They will also be trained on LME responsibilities and duties. This general training should lead to other annual training events to increase public awareness about MH/DD/SAS services and needs in the community.

Objective 6: ECBH will increase awareness about our agency throughout the nine county region.

Implementation Date: January 2010

Strategy to Obtain objective: ECBH will begin a public awareness campaign across our area by publishing an annual report. The annual report will highlight LME accomplishments and goals for the next year. We will also provide data on our budget and on other relevant statistics. ECBH will also hold an annual recognition banquet to recognize our community partners and private providers for their services to people with MH/DD/SA needs. This will create interest and give recognition to local leaders and supporters.

4. RESOURCE ALLOCATION: The resource allocation to support the Governance and Administrative function for July 1 is listed and described below.

Per the LME cost model there are 6.56 FTEs allocated for this function. The organizational chart found in Appendix A has 6.0 FTEs. The FTEs and estimated cost does not vary more than 30% from the cost model. As per the organizational chart, there will be three assistant directors who will each be responsible for specific functional areas across all nine counties. The three assistant directors will work collaboratively with the CEO as an executive management team to ensure ECBH is a fully functional and efficient LME. Our budget for ECBH will be prepared in April and specific figures will be available at that time if needed. There are no operational variations from the assumptions in the cost model.

5. BUSINESS RULES: Listed below are two of the most significant business rules, which enhance or inhibit the efficiency and effectiveness of the operations of the

Governance and Administrative department and how operations would be different if there were effective changes to the business rules.

1. There will be two representatives from each county serving on ECBH's Board of Directors. One of these is the required county commissioner position and that commissioner appoints the other representative. This enhances our ability to operate and gives each county equal opportunity for input without regards for size. It also enhances ECBH to attract future partners.
2. Counties served by ECBH can participate financially at any level they choose within the statutes and each county can stipulate how their local dollars are spent in their community. This enhances our relationships with our county partners and allows each county to participate at a level they are comfortable. It does not set barriers for future counties who may wish to join ECBH.

#2

BUSINESS MANAGEMENT AND INFORMATION MANAGEMENT

1. MISSION: The mission of the Business Management and Information Management department is to efficiently and effectively manage LME administrative funds and State and Federal service funds in a manner that is compliant with State and Federal fiscal requirements and for ECBH's information management system to support all applicable State and Federal requirements for system monitoring, analysis, and reporting so that consumers receive needed evidence-based practice services.

2. CURRENT OPERATIONS: Listed below are the current operations for each of the three existing LMEs.

Finance:

All three existing LMEs prepare and submit annual balanced budgets to their Boards as per statute for approval, which include LME administrative and State funded services. The finance committee of the Area Board reviews and discusses the budget prior to submission to the Board. Budgets are prepared primarily based on projected revenues from the DHHS and other expected receipts. The finance officer receives input for budget preparation from LME staff, Area Board finance committee and CFAC. LME administrative revenues determine the LME staffing and anticipated State funded revenues are the basis for the budget for contracting with providers. Each LME has a State funded benefit plan for their consumers, which determines the type, and amount of State funded services providers can bill the LME. Any budget revisions needed throughout the year are also presented and approved by the Board and Board's finance committee.

The finance department is responsible for all LME contracts and any contract addendums. This task includes assurance that there is funding budgeted to financially support each contract by signing the pre-audit statement. The State's standardized contract is used for all provider contracts for IPRS and Medicaid and a standardized contract is used for all other professional services. All other daily accounting functions are carried out by each LME's finance department.

HR:

Neuse, Pitt, and Roanoke-Chowan each have a HR department to carry out all personnel and other human resources responsibilities. These duties include recruitment of staff, any disciplinary actions necessary, FMLA, licensure verification, and pay plan administration. Since Neuse is substantially equivalent in all areas of personnel, ECBH will operate under their plan for July 1, 2007.

Claims Processing:

Neuse is currently providing claims processing functions for Pitt. Both Roanoke-Chowan's and Neuse's systems allow providers to process claims electronically. Providers bill for IPRS funded services; the services are verified against an authorization

(if relevant) and then filed with the appropriate third party. Once payment is received, claims are sorted by provider and are in turn paid to the provider. Any denied claims are reported to the provider with an explanation for correction. The approved services are batched and used to create a voucher to pay providers within the DMH guidelines for prompt pay.

IT:

All three LMEs are using Netsmart products for their IT needs. Neuse is currently providing CMHC software for Pitt's which is the system used for consumer authorizations, provider billing, STR functions, provider contracts, complaint tracking, and asset management. Roanoke-Chowan utilizes CSM for these same functions. Both systems provide the LMEs with reports that are used for managing the benefit plan for State dollars. The systems also provide all other reporting needed for State and local uses. Both systems have been informally evaluated and because CMHC has efficiencies in utilization management, that software will be used by ECBH for July 1. ECBH will continue to evaluate future Netsmart products for upgrades.

All three entities use different accounting software. Roanoke-Chowan's accounting software will be used for ECBH July 1 and will be integrated with the CMHC software.

Neuse and Pitt both have websites, which contain information for the community, providers, and consumers. ECBH will have one website on Neuse's web server for July 1. Providers will use the website to access CMHC. Neuse also maintains their email servers, which will be used July 1.

Neuse and Roanoke-Chowan are on one Voice Over IP phone system and Pitt will be added July 1. This system enables all staff, including STR, to make a warm transfer for consumers or other staff members from one LME location to another.

3. STRATEGIC OBJECTIVE: The strategic objectives of the Business Management and Information Management departments are listed below along with the strategy and projected implementation date to obtain each objective.

Objective 1: All ECBH employees and providers will operate on one IT platform.

Implementation Date: July 2007

Strategy to Obtain objective: All ECBH IT staff will be trained on CMHC system. Staff will be trained in specific areas of their job functions and all staff will be cross-trained for relevant positions and duties.

Objective 2: ECBH website will be established and maintained.

Implementation Date: July 2007 – June 2010

Strategy to Obtain objective: IT department will finalize and publish on the internet ECBH's website. Website will include at a minimum the information listed below. Many of these items were requested by our stakeholders.

- Relevant LME functional areas and how and who to call for assistance.
- ECBH LBP and any updates including quarterly reporting.
- How consumers and their family members can access services.
- Provider information and services they offer.
- Links to other websites such as Value Options, DMH, DMA and NCTOPPS.
- Gateway for providers to access CMHC system to request authorization or to bill for services.
- General Information for consumers and family members regarding complaints and how to file an appeal or grievance.

We will also request input from our CFAC for other information they might want included in a separate link that they access.

Objective 3: Finance department will set up system, which allows ECBH to pay providers via electronic deposits.

Implementation Date: September 2007

Strategy to Obtain objective: ECBH Assistant Director of Finance will gather information from bank and from providers so that electronic payments can be made to providers by the above date.

Objective 4: All staff in ECBH business and IT departments will operate with uniform systems and policies.

Implementation Date: October 2007 – June 2008

Strategy to Obtain objective: All IT and business staff will meet (prior to July 1) to discuss and review all ECBH policies and procedures related to these areas. Staff will receive training provided by or arranged for by Assistant Director. Staff will discuss as a team any changes needed to operate more efficiently and implement changes as needed. The following are specific areas, which must be addressed and investigated:

- Understanding the flow of work from one department to another and roles of each department.
- Fixed Assets – All ECHB fixed assets must be recorded in software program with the ability to calculate depreciation as required by GASB 34

Objective 5: ECBH Business department will investigate setting up and offering consultation to providers around efficient business practices.

Implementation Date: July 2008

Strategy to Obtain objective: A workgroup will be set up that will include finance and MIS personnel who will work in conjunction with provider relations on business

practices. The group will develop a standard tool, which will include consultation in the following areas:

- Records management
- Filing and refiling of claims
- Assistance with accessing private insurance panels
- Assistance with claim denials at the first (MCO) and second level of adjudication (Medicaid and IPRS)
- Assistance in understanding Medicaid and IPRS reporting requirements
- Assistance in setting up systems to maximize revenue

Objective 6: ECBH will have the ability to accept electronic 837s from providers.

Implementation Date: July 2008

Strategy to Obtain objective: ECBH's IT department will work with software and with our providers to obtain this objective. CMHC software is capable of this function and development will occur in ECBH's IT department. The IT department will train providers on use of this capability.

Objective 7: ECBH will enhance HR activities.

Implementation Date: July 2008

Strategy to Obtain objective: A workgroup, which will include HR coordinators, will be formed to review, revise and update the following:

- Employee handbook
- Policies, procedures and protocols
- Personnel forms
- Human resources section of ECBH website
- Employee Assistance program
- Orientation program and the ability to offer this electronically
- Employee recognition program
- Customer service training for all staff
- Computerizing all employee data

Objective 8: ECBH will investigate the use of video conference equipment in all office locations.

Implementation Date: September 2008

Strategy to Obtain objective: ECBH IT and finance department will gather information from vendors who sell this equipment. The cost and integration with our phone and MIS system will be important weighed against the cost and time of travel across our geographical region. It will allow us the opportunity and flexibility of having staff, Board, and CFAC meetings when needed and still receive the benefit of feeling more connected than typical teleconferences.

Objective 9: ECBH will have written plan to request from Division the ability for the flexible use of State IPRS dollars.

Implementation Date: July 2009

Strategy to Obtain objective: ECBH, in partnership with UNC BHRP, or other identified consultant, will complete a service needs assessment of our nine county area. This needs assessment will be compared to our IPRS allocation to determine where funding and needs do not match. A benefit plan will be designed around these needs and based on our total IPRS budget. This benefit plan will also incorporate input received from our stakeholders and CFAC.

4. RESOURCE ALLOCATION: The resource allocation to support the Business Management and Information Management functions for July 1 is listed and described below.

Per the LME cost model, there are 8.0 FTEs allocated for business management, accounting and human resources and the organizational chart found in Appendix A has 9.0 FTEs. Claims processing per the cost model has 6.12 FTEs and our organizational chart has 5.0. FTEs in the cost model for information management analysis and reporting are 6.67 and our organizational chart has 6.0. As per the chart, both finance and IT have lead positions that report directly to the Assistance Director. The FTEs and estimated cost does not vary more than 30% from the cost model. Our budget for ECBH will be prepared in April and specific figures can be made available at that time if needed. There are no operational variations in these functional areas from the assumptions in the cost model.

5. BUSINESS RULES: Listed below are six of the most significant business rules, which enhance or inhibit the efficiency and effectiveness of the operations of the Business Management and Information Management departments and how operations would be different if there were effective changes to the business rules.

1. All ECBH providers will be expected to request authorizations, do all billing and enter their IPRS, CDW, and other relevant client information electronically via their CMHC connection to receive IPRS dollars. This requirement enhances business practices for both the provider and the LME.

2. ECBH will offer IPRS dollars to a select number of providers. Those providers must offer comprehensive services and/or high cost (psychiatric) services. ECBH will ensure all counties are covered. This practice enhances providers as it promotes economies of scales and enhances LME operations. This business rule allows our IPRS funded consumers to choose from providers offering comprehensive services.

3. Providers must submit IPRS billing within 60 days from date of service to be processed and paid. This enhances ECBH's ability in monitoring State dollars and frees

up encumbered dollars in the system for reallocation for consumer services. It also forces the provider to bill more timely so that they can receive their funding within a reasonable time.

4. Pitt MH currently pays providers via electronic billing while Neuse and Roanoke-Chowan pay by paper check. This delay in payment does not financially assist our providers, and the time to process paper checks inhibits our ability to function efficiently as a LME. Paying electronically will provide a faster turnaround in payment to our providers.

5. The ECBH budget will be prepared each year with input received from ECBH executive staff, CFAC, and Area Board members.

6. The inflexible use of State IPRS dollars and the complexities associated with earning IPRS dollars inhibits the business practices of ECBH LME and of providers. If ECBH were given the option of flexible use of those dollars (as Smokey has), the needs of the consumers in our nine counties could be better met.

#3

PROVIDER RELATIONS AND DEVELOPMENT LME FUNCTIONS

1. MISSION: ECBH Provider Relations and Development Department work in partnership with network providers and the community at large to ensure services are available for people who face significant challenges related to substance abuse, mental illness and/or developmental disabilities. Our commitment is to collaborate with providers to offer consistently excellent, person/family-centered, recovery-oriented, evidenced based services within a system that is flexible, accessible, and respects a consumer's freedom of choice.

2. CURRENT OPERATIONS: Neuse, Roanoke-Chowan, Pitt County and Beaufort County, who are merging to become East Carolina Behavioral Health, all participate in activities related to Provider Relations and Development as per our current operations described below:

- **PROVIDER CHOICE LIST**-All LMEs maintain a list of endorsed and enrolled Medicaid and State funded provider agencies under MOA with LME. They also each maintain accurate contracted State funded service provider agency list, residential treatment room & board, CAP-MR/DD agency list and directly enrolled independent practitioners list.
- **GAPS & NEEDS ANALYSIS**-The LMEs assist with ensuring adequate provider service capacity exists in catchment area and evaluate the provider community on a regular basis to determine gaps in services and to pursue competent and willing providers who are interested in developing those services which are needed. This also includes supports to administration with review and dissemination of RFP's, RFI's, etc.
- **PROVIDER FORUM**- Provider relations directors facilitate provider forums as a mechanism to share and receive information pertinent to the LME and Provider Agencies.
- **MCO ALERT AND RESOURCES & COMMUNITY HAPPENINGS BULLETIN**-Weekly, or as necessary, information and/or newsletters are emailed to all provider agencies
- **TECHNICAL ASSISTANCE, TRAINING, COLLABORATION AND REPORT REQUESTS**- Provider relations departments function as first point of contact for all provider agencies. The LME takes an active role in providing training opportunities for providers and other agencies in the community. They also ensure provider agency establishes connectivity with computer system for authorization and claims submission and ensure questions from provider agencies are addressed by appropriate LME personnel in a timely manner.
- **PROVIDER ORIENTATION**- All provider agencies are required to complete a brief orientation regarding the policies and procedures of the LME.
- **COMMUNITY PROVIDER DEVELOPMENT**- This department provides daily assistance via telephone, emails, informal scheduled meetings and written correspondence to individuals and/or agencies that contact the LME for assistance with interpretation of rules, standards and statutes. There is also assistance with

- providing education on implementation of a new provider agency in the catchment area and direction on navigation of the Division processes.
- CONTRACTS- Provider relations currently oversees/completes State contracts, Memorandums of Agreement (MOA), and Purchase of Services Agreement. Prior to the initiation of a Purchase of Services Agreement, compliance verification occurs using appropriate methods. Department approves or disapproves provider agency sub-contracts.
 - PROVIDER OPERATIONS MANUAL- Manuals are developed, maintained and distributed using electronic methods to provider agencies under contract, endorsed, or under MOA with the LME.
 - PROVIDER COMPLIANCE MONITORING- All provider agencies will, at a minimum, have an annual site visit review performed by a team of staff that are knowledgeable in the areas to be reviewed. Provider agency compliance monitoring will be conducted at the discretion of the LME and in accordance with State regulations. Triggered monitoring of a provider agency may also occur and any corrections needed will be communicated to provider.
 - ARBITRATION / PROBLEM RESOLUTION OF PROVIDER COMPLAINTS – Providers are encouraged to voice any complaints or grievances. Provider Relations handles all complaints and assists the provider in resolving all issues.
 - ENDORSEMENT- The LME utilizes policies and procedures established by the Division for endorsement, which includes review of applications, conducting on-site reviews, completion of Notification of Endorsement Action letters, MOAs, and endorsement withdrawals as necessary.
 - CAP-MR/DD UNLICENSED AFL ON-SITE REVIEW- Any provider agencies providing CAP-MR/DD Residential Supports in an unlicensed home are required to have the LME complete an on-site review of the home.
 - NATIONAL ACCREDITATION- The LME monitors provider agencies progress towards obtaining national accreditation.
 - LETTER OF SUPPORT FOR RESIDENTIAL FACILITY- The LME will verify that additional residential beds are needed in their catchment area before new residential treatment facilities are recommended.

3. STRATEGIC OBJECTIVE: The strategic objectives of the Provider Relations and Development department are listed below along with the strategy and projected implementation date to obtain each objective.

Objective 1: ECBH will streamline and standardize operations and procedures.

Implementation Date: July 1, 2007 - January 2, 2009

Strategy to Obtain Objective:

All current policies and procedures of the three LMEs will be reviewed. From this review existing Neuse policies will be revised and implemented as needed in accordance with National accrediting body standards and to assure a unified system and standardization of ECBH practices. Appropriate LME unit staff, CFAC, and Area Board will approve final product.

Objective 2: ECBH will implement a provider evaluation system.

Implementation Date: January 2009

Strategy to Obtain objective:

ECBH will coordinate the development of recommendations for a local provider quality report card working in conjunction with the Quality Management and Customer Service departments. This quality report will be designed to provide comparative information on standardized measures of access, quality and effectiveness of services and supports. ECBH will implement the use of a standardized provider rating system. The purpose of this rating system will be to facilitate the right sizing and stabilization of a highly qualified provider community. Input into the system will be obtained from CFAC, provider agencies, consumers, and other relevant stakeholders to assist with criteria.

Objective 3: ECBH will improve Continuity of Care for all Consumers

Implementation Date: July 2009

Strategy to Obtain Objective:

ECBH will ensure adequate capacity of its provider network and ensure adequate access to supports and services through the use of incentives to address services gaps including prevention, intervention, treatment, maintenance, recovery and coordination with primary care. Specific areas to be targeted for development and expansion include: substance abuse continuum, employment, housing, comprehensive crisis services, and psychiatric/physician services. Activities to achieve this objective will include:

- ECBH will utilize medical director as a trainer of primary care physicians in the community regarding psychiatric diagnoses and for integration with behavioral health care.
- ECBH will establish and maintain a user-friendly website that allows for consumer informed choice that includes a mechanism for identifying community resources, both natural and paid.
- ECBH will encourage the provider community and partners to actively participate in the System of Care initiative for children and their families.
- ECBH will encourage and support the development of consumer-owned and operated services to maximize the success of such endeavors.
- ECBH will create and maintain a Community Partners Handbook for our community partners. This handbook will include information about ECBH and the LMEs new role in the nine counties that comprise ECBH.
- ECBH will research potential community partners and evaluate options for the creation of a resource manual/guide to assist with provider choice and information.

Provider Relations will collaborate with appropriate LME unit staff, CFAC, providers and Area Board for input.

Objective 4: ECBH will facilitate workforce development.

Implementation Date: July 2010

Strategy to Obtain objective:

As a mechanism to increase the quality of care, achieve improved individual consumer outcomes, and ensure integration with behavioral health care, ECBH will provide on-going technical assistance to the provider community using various techniques such as sponsoring AHEC events, hosting trainings, and sharing available resource information. The goal is to create a provider community that is multi-cultural, competency-based, utilizes evidenced based models of fidelity, is available to geographically remote areas, and is responsive to emergent needs. Cultural diversity goes far beyond language differences. It includes how people view their world and all that goes on in it. ECBH will provide technical assistance and education to provider agencies regarding the PCP process to include crisis planning, development of measurable goals and objectives and the use of “person first” recovery oriented language.

Objective 5: ECBH will complete monitoring responsibilities.

Implementation Date: July 2010

Strategy to Obtain objective:

The LME will assure compliance with statutes, rules and administrative codes through on-site scheduled and triggered monitoring reviews. ECBH will ensure that client rights are protected and that the health and safety of all consumers is the first and foremost priority by ensuring that all provider agencies have an established human rights committee that functions in accordance with standards.

Objective 6: ECBH will enhance and support relationships within the provider community.

Implementation Date: July 2010

Strategy to Obtain objective:

The LME will assist with collaboration among providers, as it is crucial to their survival. The LME will foster a collaborative community and educate providers on the advantages of collaborating with each other on some level. ECBH will expand the involvement of consumers within the LME framework to include provider meetings, decision-making meetings, and review of provider data. We will also facilitate the establishment of local consumer support and advocacy systems by connecting providers and consumers with similar interest and needs. ECBH will provide regular ongoing community education to ensure knowledge is shared about resources.

4. RESOURCE ALLOCATION: The resource allocation to support the Provider Relations and Development department for July 1 is listed and described below.

Per the LME cost model there are 8.4 FTEs allocated for Provider Relations. The organizational chart in Appendix A has 13.5 FTEs. Even though the cost model did not allocate additional FTEs after Beaufort County joined, ECBH felt the need to add positions to our organizational chart due to the infancy of the provider community. ECBH will be a rural nine county program with a large number of small newly created (approximately 200) providers who will need extensive monitoring, education and nurturing by the LME, to create a right sized, highly qualified provider community focused on recovery and evidence based practices. Provider Relations and Monitoring staff will be geographically distributed throughout the nine counties. Additional dollars will be needed from the Division for a start up period of at least one year. This is due to geography and other reasons described above. After that time, ECBH will reevaluate with plans for the provider relations department to function within the cost model. The FTEs and costs vary more than 30% from the model for these reasons. Our budget for ECBH will be prepared in April and specific figures will be available at that time.

5. BUSINESS RULES: Listed below are six of the most significant business rules, which enhance or inhibit the efficiency and effectiveness of the operations of the Provider Relations and Development Department and how operations would be different if there were effective changes to the business rules.

1. Persons should be served close to home: Out of Catchment Residential Treatment should be used as a last resort and only after attempts have been made to utilize resources within one hour from the consumer's natural home.
2. Operations Manual: Changes to the operations manual made during the term of the contract agreement do not require signatures of both parties agreeing to the specific changes; only notice that changes have been made in accordance with State and other rule changes. Providers will be notified via email noting the revision, which will be posted on ECBH's website.
3. Follow-up monitoring reviews: The LME currently conducts follow-up monitoring approximately 90 days after a review in order to hold providers accountable for being in compliance with rules and standards; however, there are times that the same deficiency is identified in the following years. Quarterly follow-up monitoring of habitual offenders by the LME has been effective in ensuring that compliance is maintained throughout the following year.
4. Any willing and qualified provider: ECBH agrees to include all qualified providers currently participating in the networks of Neuse LME, Pitt LME, Roanoke-Chowan LME and Beaufort County.
5. Right sized and qualified provider network: ECBH will limit the size and scope of its State funded network based on the need to promote evidence based practices and availability of funding.

6. Electronic interface with providers: All providers must use the identified electronic method for submission of claims and service authorization requests using a web based process.

#4

CUSTOMER SERVICE/CONSUMER AFFAIRS LME FUNCTIONS

1. MISSION: “Service, above all else” is the mission of ECBH’s Customer Service department. This mantra describes how ECBH values our customers. At ECBH, everything we do revolves around the people we are here to serve in our communities, listening to their needs, advocating for optimal service, and going the extra mile to support people to reach their potential.

2. CURRENT OPERATIONS: Listed below are the current operations for the three existing LMEs.

Neuse Center, Roanoke-Chowan and Pitt County are three existing LMEs that are merging to become East Carolina Behavioral Health. Each participates in activities related to Community Collaboration and Consumer Affairs as described below:

- Share information about services, natural supports, and consumer rights throughout the community with a focus on empowering consumers.
- Maintain and update on a regular basis a resource list of self-advocacy/support groups and community resources. This list is shared internally and externally.
- Participate in all meetings within the county, including but not limited to: Department of Social Services, Health Department, Courts, Law Enforcement, Advocacy groups, Peer-Support groups, interagency councils. This specifically includes county disaster planning and coordination for assigned counties
- Manage and investigate all service-related complaints that are not resolved at the provider level and facilitate win/win resolutions that satisfy the complainant and strengthen the system.
- Monitor, review and investigate all critical incident reports that involve the use of restrictive intervention, which may include but are not limited to allegations of abuse, neglect, or exploitation and deaths to ensure the rights of consumers.
- Identify areas requiring plans of correction and forward recommendations to Quality Improvement staff.
- Provide and/or arrange for technical assistance in the areas of client rights and customer service.
- Responsible for second-level reviews for a consumer rights violation and when necessary, this committee will call a special meeting and require attendance of at least five committee members to perform that second-level review function. In addition, this committee will continue to review relevant aggregate data.
- Submit Annual Human Rights Report to the Division of MH/DD/SAS.
- Adhere to a complaint procedure that reflects a collaborative effort and models NC Administrative Rule T10A 27G 606 and 0607.
- Ensure timely follow-up on complaints and expedient, appropriate resolution.

- Track all non-Medicaid appeals and all clinical reviews of non-Medicaid appeals to ensure timely follow-up and compliance with Communication Bulletin 38 and 10A NCAC 271.0601-.0609.
- Work in collaboration with utilization management staff to coordinate clinical reviews for all non-Medicaid appeals and maintain a centralized filing system of all non-Medicaid appeals.
- Participate in panel hearing reviews at the Division as required by NCAC 271.0601.0609
- CFAC operations include the duties as identified in HB 2077, Section 5.

3. STRATEGIC OBJECTIVE: The strategic objectives of the Customer Services department are listed below along with the strategy and projected implementation date to obtain each objective.

Objective 1: All staff working for ECBH in Customer Services will operate with uniform policies and procedures

Implementation Date: October 2007

Strategy to Obtain objective:

- Arrange workgroups with staff, consumers and other stakeholders to develop uniform processes, policies and procedures related to the department that meet accreditation standards.
- Train staff on utilization of customer service database.
- Provide staff with opportunities for team building and education in quality customer service delivery.

Objective 2: Develop one uniform Customer Service Handbook and Community Stakeholder Handbook and training program for distribution to all Consumers and Stakeholders in the ECBH area.

Implementation Date: October 2007

Strategy to Obtain objective:

- Organize a workgroup to address the format, design and content for a Consumer Handbook that is useful for consumers and families to understand how to access and what to expect from engagement in services.
- Organize a workgroup to address the format, design and content for a Community Stakeholder Handbook that is useful for all community partners, providers, and public partners to understand how to access services and what to expect from services when making a referral.
- Using input from public forums develop and provide a community and consumer education program in each community. The program will at minimum target specific groups to assist them in understanding system changes, service requirements and expectations, how to access services and what to do when services are not improving their situation.

Objective 3: Develop uniform methods of communication with consumers, families and other community stakeholders across all areas regarding addressing service needs and gaps in local communities.

Implementation Date: December 2007

Strategy to Obtain objective:

- Organize a workgroup from all LME departments and representative stakeholders to address the medium, format, design and content needed for people in each community to access information about how to get help and what to do when services are not available and/or are not working.
- Develop a training program for all stakeholders about this process and provider public awareness campaign.
- Quarterly Action Alert disseminated to all stakeholders identifying community resources and needs in an effort to engage the community to help develop needed resources to fill gaps such as housing options, services for homeless, day care for children with disabilities, after-school or schools out programming in community based integrated settings, support groups, culturally competent partnerships, transportation, legal assistance, financial assistance and any other identified community need.
- Plan and execute a Service Organization Recognition Day and Annual Community Awards program along with area advocacy groups in each community to celebrate the contributions of essential partners who support enhancement of the quality of life through service for people who experience mental health, developmental disabilities and substance use, abuse and addiction issues.

Objective 4: Develop a Community Education and Resource Program.

Implementation Date: June 2008

Strategy to Obtain objective:

Provide Educational Seminars and self directed Webinars and resource links for the following targeted areas:

- Consumer rights and responsibilities
- Parent orientation and education about disability management
- Crisis management for families and consumers
- Crisis management for first responders
- Crisis management for other stakeholders
- Continuum of Care, what is it, what we should expect from it
- How funding works
- Eligibility who can and who cannot be served and what to do about it
- How to choose a service provider and what questions should be asked
- Respite Care

- Evidence Based Practices (school to work/life transitions, Substance Abuse, Supported Employment)
- Education for parents and caregivers about substance use, abuse and addiction
- Appeal Rights
- Early Intervention and Prevention Campaign
- Community Education about Person Centered planning
- Others topics as identified

Objective 5: Develop a Consumer Reports System for rating providers so consumers and families can have information from other consumers and families about service providers.

Implementation Date: June 09 (start July 07)

Strategy to Obtain objective:

- Work with CFAC to develop a meaningful survey tool and rating system for providers related to what is important for Consumers and Families to know about providers. (Use existing baseline rating systems like the star rating system utilized by Division of Social Services for day care providers)
- Assist CFAC in training providers about tool to offer providers opportunities to address areas identified prior to implementation of rating system.
- Support CFAC to survey provider agencies using tool.
- Work with CFAC to correlate survey results and create a CFAC website and other published media to convey the results of the survey tool.
- Assist with website design, format, hosting and support to include consumer compliments and complaints about providers along with rating using formal tool. (Use existing web based industry examples such as Angie's List and Consumer Reports)
- Work with Provider Relations and IT departments to offer providers the opportunity to include information about the agency and logo on ECBH webpage, which might include capacity available, hours of operation, services, offered. All information will be updated by provider as needed via web login.

Assist with Objective 6: Human Right Committee will work with providers to understand and adhere to Client Rights and Confidentiality.

Implementation Date: June 2007

Strategy to Obtain objective:

- Organize workgroup with Human Rights Committee (HRC) members from existing LMEs and reconfigure active HRC for ECBH.
- Assist HRC in developing operational procedures that empower the HRC to improve consumer services through HRC actions that meet accreditation standards.

- Assist HRC in developing quarterly training program for consumers, families, stakeholders and provider's agency staff and provider agency HRCs implemented by ECBH HRC.
- Support HRC to address with provider agencies any issues related to consumer rights issues and/or right violations. When possible this will occur HRC chair to HRC chair. When providers do not have a HRC, ECBH HRS will provide technical assistance for the development of HRC for provider.
- Support HRC to work with CFAC and ECBH LME executive staff liaison to report rights or issues that are not resolved by administration for action up to and including sanctions and/or termination of provider from community of providers.

4. RESOURCE ALLOCATION: The resource allocation to support the Customer Services department for July 1 is listed and described below.

Per the LME cost model there are 3.75 FTEs allocated for this function. The organizational chart as shown in Appendix A has 4.0 FTEs. The FTEs and estimated cost does not vary more than 30% from the cost model. Our budget for ECBH will be prepared in April and specific figures will be available at that time if needed. There are no operational variations from the assumptions in the cost model.

5. BUSINESS RULES: Listed below are five of the most significant business rules, which enhance or inhibit the efficiency and effectiveness of the operations of the Customer Services department and how operations would be different if there were effective changes to the business rules.

1. Policies and procedures that promote the involvement of consumers and families in operations of the LME at various levels within various workgroups and committees are needed in a broader scope.
2. Policies and procedures that guide the development of a robust social marketing plan for consumers and families to learn about available services.
3. A well-developed community outreach and education plan to include all stakeholders not just providers, but natural and community supports, other public agency staff and consumers and families.
4. A HRC that is mission driven and operates at a level of advocacy for consumer rights throughout all communities to hold providers accountable for Rights Protection and least restrictive interventions
5. Empowerment of CFAC members to take the initiative to develop components missing in the system. For example, support CFAC to develop a provider profile that is from consumer to consumer in the absence of State policy or guidance to ensure consumers are able to make an informed choice when they are choosing a provider.

#5

SERVICE MANAGEMENT

1. MISSION: The mission of the Service Management department is “People will live better as a result of our efforts to empower individuals, families, communities, and other agencies and organizations to improve services and supports.”

2. CURRENT OPERATIONS: Listed below are the current operations for each of the three existing LMEs.

The Service Management process ensures compliance with State and Federal laws as well as regulatory, best practice, and accreditation standards. The process assures people receive appropriate services and supports that are sufficient in scope, frequency and duration to achieve effective outcomes, to reduce unnecessary care, to reduce variability in practice, to assure quality-individualized service, and to promote the availability of scarce resources for the greatest number of people. The scope of the Service Management process is wide-ranging; it authorizes services, monitors and evaluates consumers, providers, care settings, and types of service. The efficacy of this process in relation to a consumer’s condition is the degree to which the care/service of the consumer has been shown to produce the desired outcome. Currently, Neuse, Pitt, and Roanoke-Chowan LMEs are providing all functions of Service Management. There may be some differences in delivery due to software applications and staffing ratios but the mission is standardized across the three LMEs.

Requests for service authorizations are processed electronically and include requests for new services, reauthorizations, and increases or decreases in services. All data is maintained and used for detailed reporting. Authorizations are reviewed by master’s level and/or licensed clinicians specific to their disability expertise to determine appropriateness of requested service. The clinician verifies eligibility based upon Target Population groups, funding sources, individual treatment needs, outcomes and consumer choice. Tools used in this process include medical necessity definitions, person centered planning criteria, CMS service definitions, the LME’s benefit plan, and clinical pathways/EBPs. Services are approved, pended or denied within 48 hours of request with justification of the action documented.

Care and service coordination is provided in a variety of ways for all consumers of services and for those who do not have clinical homes. All consumers who are admitted and discharged from the State hospitals and alcohol/drug treatment centers have clinicians to provide assistance with discharge planning to assure continuity of care and integration back into the community. When consumers are transferring from one agency to another, need assistance with finding the appropriate provider, or need a higher or lower level of care, care coordinators assist consumers and providers in this process to ensure comprehensive planning and inclusion of available community and natural supports. Each LME has a System of Care Coordinator who assists families and children at risk of out-of-home placement to remain in the community through collaboration with community agencies to develop necessary services and supports. Two counties, Bertie

and Pamlico, have Child and Family Team Specialists that are primary contacts for children who have been identified as high risk. These specialists receive, coordinate and follow-up on all school referrals to assure the children/families are screened, assessed and connected with needed services/supports as well as monitor for successful outcomes.

Utilization review is an ongoing process used in conjunction with service authorization and care coordination. Clinical record reviews look at the effectiveness of Person Centered Plans, treatment protocols, progress notes, history of services, and natural supports. When these reviews are on site, they may also include consumer/family and staff interviews. Outcomes are monitored and reviewed for cost effectiveness and over and/or underutilization of services.

Non-Medicaid Appeals are processed according to statute with Clinical Review of UM decisions for appropriateness, service definition criteria, and available funding.

3. STRATEGIC OBJECTIVE: The strategic objectives of the Service Management department are listed below along with the strategy and projected implementation date to obtain each objective.

Objective 1: ECBH Service Management department will establish uniform processes for care coordination and authorization of State funded services using one software system and electronic interface with all providers in the nine county area.

Implementation Date: July 07 – December 07

Strategy to Obtain objective:

- ECBH will develop a benefit plan for all consumers receiving State funded services.
- All providers in Roanoke-Chowan and Beaufort County will be trained on authorization process using electronic interface.
- All providers in the Roanoke-Chowan and Beaufort County areas will enter client information for all clients into CMHC system for conversion from CSM to CMHC.
- All State funded consumer services will be authorized and all Medicaid services billing through the LME will be no prior authorization required and will pass through after provider data entry is completed as all documentation for all pass through services is the responsibility of the provider.

Objective 2: ECBH Service Management department will establish multidisciplinary clinical staffing for Community collaboration with all providers and community partners to develop a System of Care in each community.

Implementation Date: July 07

Strategy to Obtain objective:

- ECBH Clinicians in each discipline will work collaboratively to offer the consultations telephonically to private providers, public partners, and primary care physicians for hard to serve clients.
- ECBH Clinicians will work with consumers and families to offer weekly rounds with local partners to come to the table to discuss hard to serve clients thereby establishing a system of care for all populations and all disability groups in each community. ECBH Clinicians will be responsible for establishing these committees or joining existing groups already established for this purpose when it makes sense and for the inclusion when possible of primary care physicians.
- ECBH Clinicians will work with other community partners collaboratively to provide education about services, supports and resources for targeted populations who receive support for mental health, developmental disabilities and substance abuse issues for all stakeholders in attendance in an effort to build community collaboration to support people to be successful in the community setting.
- ECBH Clinicians will work collaboratively to support the community and providers to identify gaps and needs through the multidisciplinary staffing process and forward those gaps to the Provider Relations department for development.
- ECBH Clinicians will work with consumers and families to educate and support other stakeholders to understand how to navigate the system and help consumers access needed services within and outside the community.
- ECBH Clinicians will work to support providers to fully implement Person Centered planning by ensuring that all plans that are reviewed include a crisis plan, has measurable goals and objectives supported by clinical interventions and are written in person centered language that is meaningful to the consumer versus just another document that is required by the system.

Objective 3: ECBH Service Management department will work with providers to offer community outreach clinics and education for targeted groups and locations such as schools, DSS and Health departments or other identified locations.

Implementation Date: July 2008

Strategy to Obtain objective:

- ECBH Clinicians and consumers and families will work with school system exceptional children's programs to provide in-service training for teachers, teachers aides, and other school personnel on symptoms and interventions that address child related disabilities in the areas of mental health, developmental disabilities and substance use and abuse issues.
- Service Management department will work in partnership with schools and designated providers to support children who need additional support in the school setting to understand the role of support, type and degree as well as timeframes and appropriateness of services as it relates to the overall unique situation of the child in the school setting.

- ECBH will implement a public awareness campaign to reduce stigma.
- ECBH Service Management department will maintain an updated and integrated waiting list for eligible CAP MR/DD Waiver recipients while supporting consumers and families who are waiting through care coordination efforts and linkage to community and natural supports and services when needed.

Objective 4: ECBH Service Management Clinicians will work with hospitals and state institutions to ensure adequate and appropriate services are established for people who are discharged and to decrease admissions through the use of other trauma reducing alternatives.

Implementation Date: June 2008

Strategy to Obtain objective:

- ECBH Clinicians will aggregate all hospital admission data for all three existing LMEs.
- ECBH Clinicians will work with private providers to target crisis plans for known consumers to address the appropriateness of crisis plans.
- ECBH Clinicians will assist providers and consumers to identify additional responses and/or resources to access during crisis to support individuals.

ECBH clinicians will work with hospitals and first responders to manage crisis situations using trauma reducing alternatives including CIT training for First Responders (law enforcement, dispatchers, Sheriff's department, EMS, Fire Departments, Rescue, etc) and jail diversion programs along with Peer Run Drop in Centers, Facility Based Crisis, Detox and other alternatives to support community based treatment when possible instead of inpatient admissions

Objective 5: ECBH Service Management department will promote, design, and establish when needed Prevention, Recovery and Self Determination initiatives to empower consumers and families to have hope, education, personal responsibility, self advocacy and peer support to improve person centered outcomes.

Implementation Date: June 2010

Strategy to Obtain objective:

- Work with consumers and families to develop a recovery oriented and self-directed survey tool for providers and community partners.
- Based on gaps identified from the survey tool, ECBH Clinicians will work with consumers and families and UNC-BHRP to develop a training program for providers and community partners that promotes the implementation of policies, procedures and practices that promote recovery and self direction for people who experience symptoms associated with mental health, developmental disabilities and substance use, abuse or addictions.
- Jointly provide community outreach, education and training along with proven methods for understanding, engaging and supporting people using a recovery orientation and self-directed approach.

- ECBH Service Management staff will develop a community prevention plan that will use existing community strengths to enhance prevention activities and promote the use of prevention services such as Wellness Recovery Action Planning and other evidence based, science based or best practices to promote early detection and prevention for all disability groups including non-target populations.

4. RESOURCE ALLOCATION: The resource allocation to support the Service Management department for July 1 is listed and described below.

Per the LME cost model there are 14.29 FTEs allocated for this function. The organizational chart in Appendix A has 16.0 FTEs. The FTEs and estimated cost does not vary more than 30% from the cost model. Our budget for ECBH will be prepared in April and specific figures will be available at that time if needed. There are no operational variations from the assumptions in the cost model.

5. BUSINESS RULES: Listed below are six of the most significant business rules, which enhance or inhibit the efficiency and effectiveness of the operations of the Service Management department and how operations would be different if there were effective changes to the business rules.

1. A uniform set of processes and practices for service authorization with providers for nine counties that make up ECBH will enhance the efficiency and effectiveness of operations. For example, requiring for all services that support a residential setting for the consumer to have a lease arrangement in the consumers name to ensure that as service needs decrease the consumer does not end up losing his or her home; state dollars are not used to support people who also receive CAP funding, authorization schedules for residential services for Adults with DD or MRMI are semi annually versus every 90 days just to mention a few.
2. Development and implementation of Clinicians as resources for all service providers to staff complex cases through a system of care approach for all age and disability groups will enhance services for people.
3. Clinicians with age and disability specific training working with providers, hospitals and institutions to improve crisis planning and debriefing opportunities will enhance the effectiveness of this department and the quality of life for people who experience crisis.
4. No prior authorization required for outpatient therapy for up to eight visits for Adult MH and SA and sixteen for child MH and SA low cost low-end services. Prior authorization required on ninth and seventeenth visit only.
5. No prior authorization required for TCM and other not yet available Medicaid services, which require the provider to bill through the LME for claims on CMHC systems with out second level authorization from LME since VO has already authorized the services.

6. Clinicians working with consumers and families to transition agencies and organizations into a real self directed and recovery oriented person centered process and practice will improve the engagement with services and support the successful outcome of system transformation.

#6

Access, Screening, Triage

1. MISSION: The mission of the Access, Screening and Triage department is “Care when you need it or are ready for it with no wrong door”.

2. CURRENT OPERATIONS: Listed below are the current operations for each of the three existing LMEs.

In accordance with the “No Wrong Door Policy”, consumers of Neuse, Pitt, and the Roanoke Chowan catchment areas may access MH/DD/SAS services by presenting for screening at Access, providers’ offices, or by calling a toll free number, which connects to the Access team. The Access team is staffed 24/7/365 with live, trained and qualified personnel. Between 8am and 5 pm, Pitt is staffed with Access clinicians who answer the phone for Pitt consumers and Roanoke-Chowan is staffed with Access clinicians who answer the phone for Neuse and Roanoke-Chowan consumers. Currently contractual agreements exist for after hours and weekends for Neuse, Roanoke-Chowan and Pitt. All calls are answered within five rings or thirty seconds. Phone lines have TTY and foreign language interpretation. All consumers are screened utilizing the Division of MH/DD/SAS standardized screening tool, intensity of need is determined, and the consumer is referred to the provider of choice within established timelines. Information collected with the standardized screening tool is entered into two computer systems, CMHC for Neuse and Pitt consumers and MSO for Roanoke-Chowan consumers. This allows CDW information to be collected, generates a unique identification number for the consumer, allows for the entering of initial authorizations and for STR clinicians to access consumers’ current providers. Clinicians maintain a log of all telephonic requests, which includes 1) time of request, 2) the time determination of need is made, 3) time care is available, and 4) the referring provider.

Current consumers whose needs are deemed emergent are linked via warm transfer to their provider. If the provider cannot be located or if the consumer is new, the Access team arranges for the consumer to be seen by a provider within a two-hour timeframe. After hours and weekends when emergent care is needed, and the consumer does not have a first responder, the consumer is referred to the Emergency Room or Mobile Crisis where available for services.

Current consumers whose needs are deemed urgent are linked via warm transfer to their provider. If the provider cannot be located or if the consumer is new, the Access team arranges for the consumer to be seen within the forty-eight hour timeframe. After hours and weekends when urgent care is needed, and the consumer is new to the system, the consumer is notified that the Access team will follow up the next business day to schedule an appointment.

Current consumers whose needs are deemed routine are linked via warm transfer to their provider. If the provider cannot be located or if the consumer is new, the Access team arranges for the consumer to be seen within the seven-day timeframe. After hours and

weekends when routine care is needed for new consumers, the consumer is notified that the Access team will follow up the next business day to schedule an appointment. Consumers who are discharged from any inpatient setting are scheduled within a five-day timeframe. All appointments that are scheduled by Access are followed up on to ensure the consumer met the appointment.

3. STRATEGIC OBJECTIVE: The strategic objectives of the Access, Screening and Triage department are listed below along with the strategy and projected implementation date to obtain each objective.

Objective 1: ECBH will offer Access to Care 24/7/365 for all consumers.

Implementation Date: December 2007

Strategy to Obtain objective:

- ECBH will implement a public awareness campaign to inform all communities of the Access phone number to call via media resources.
- ECBH will integrate Roanoke-Chowan, Pitt County and Beaufort County client registration, access and information into the existing Neuse Access to Care software system using the CMHC software product.
- ECBH will design and fully staff 24/7/365 STR department.
- ECBH will train providers in all areas in the application of appointment scheduler/slot management software to maximize appointment scheduling for all callers 24/7/365 regardless of appointment acuity.
- ECBH will offer providers with available appointments as a choice to consumers who call in for access.
- ECBH will continue to support direct access for all Medicaid enrolled consumers via electronic data registration/submission of STR data requirements by providers.
- ECBH will provide training for all providers to complete adequate screening, triage and referral functions for all consumers and business practices to support such processes to fulfill a no wrong door mission for consumers.

Objective 2: ECBH will follow up with callers to ensure they were able to access available resources and if not to attempt to facilitate access through alternative approaches.

Implementation Date: June 2008

Strategy to Obtain objective:

- Identify no show data and trends
- Follow up with reasons for no shows- i.e. lack of transportation, symptom reduction, stigma, engagement issue, provider not culturally competent
- Offer alternatives for engagement- Community support agency willing to come to client for first appointment, evaluator willing to come to client home/community for assessment, motivational interviewing, willingness to meet in alternative non-stigmatizing location other than agency office like over coffee,

- provider used language that made person feel bad resulting in disengagement, provider lacks language proficiency for population,
- Other strategies as identified to improve penetration rates

Objective 3: ECBH will provide an aggressive community education program to support consumers, families, providers and other public partners and referral sources to know how to access care for children and adults with mental health, developmental disabilities including traumatic brain injury and substance use, abuse and addiction issues.

Implementation Date: June 2010

Strategy to Obtain objective:

- Develop uniform training program including a formal presentation and written materials for every community in English and Spanish that explains how to access care.
- Develop a web based video tutorial that walks people through what to expect when they access care from the phone call, first appointment and upon treatment engagement that embodies a message of hope.
- ECBH staff will provide a minimum of twenty culturally competent outreach education programs related to Access to care per month. (a minimum of two per county) This will require the engagement of various cultures in the development and implementation process to include many diverse communities and cultures in the geographical area some of which are non-English speaking residents.

4. RESOURCE ALLOCATION: The resource allocation to support the Access, Screening and Triage department for July 1 is listed and described below.

Per the LME cost model there are 16.80 FTEs allocated for this function. The organizational chart as shown in Appendix A has 14.0 FTEs. The FTEs and estimated cost does not vary more than 30% from the cost model. Our budget for ECBH will be prepared in April and specific figures will be available at that time if needed. There are no operational variations from the assumptions in the cost model.

5. BUSINESS RULES: Listed below are six of the most significant business rules, which enhance or inhibit the efficiency and effectiveness of the operations of the Access, Screening and Triage department and how operations would be different if there were effective changes to the business rules.

1. Electronic interface between LME and Provider agencies using CMHC MCO product create efficiency as data is only keyed once into the system for reporting purposes by the originating source.
2. CMHC systems offers slot management system for 24/7/365 appointment scheduling capacity for consumers. Providers are able to give LME real time appointment capacity through this electronic interface that allows STR to look at all available appointment

times to ensure access to care is when people need it, consumers never get put on hold to find out if a provider has an appointment available.

3. Uniformity improves access and capacity for all citizens across county lines that previously limited capacity under the old Area Program model, increased mergers would improve such capacity even more in other functional areas.

4. ECBH is willing to incorporate programs that do not experience functional capacity to purchase it from ECBH in the future to gain additional economies and efficiencies, which enhance and standardize access for people living in Eastern NC.

5. Follow up with consumers who no show for appointments to determine what the barriers to access were and if we can work with a provider to come out to the consumer when identified as a barrier.

6. Encourage provider agencies with improved capacity to see consumers evenings and weekends.

QUALITY MANAGEMENT

1. MISSION: The Quality Management System of East Carolina Behavioral Health is a balance of Quality Assurance and Quality Improvement activities designed to ensure that Local Management Entity core functions and Qualified Provider Network services are delivered in a manner that meets or exceeds the standards and statutory requirements under which the agency operates.

2. CURRENT OPERATIONS: Neuse Center, Roanoke-Chowan, Pitt County and Beaufort County are merging to become East Carolina Behavioral Health participate in activities related to Quality Management as per the current operations below:

- Quality Improvement Committee – The Quality Improvement Committee (QIC) is responsible for discussing pertinent quality improvement issues, overseeing QI projects, and analyzing aggregate data that forms the foundation of such projects. The QIC consists of representation from all departments in the LME, including CFAC.
- Quality Improvement Studies/Projects – QM is responsible for designing and implementing three to five annual QI studies/projects. Opportunities for system improvement projects are identified through the QIC's regular review of information from a variety of sources. This review of information helps guide decisions about how to focus QI efforts, and to evaluate the impact of QI projects.
- Quality Improvement Report – QM prepares a Quality Improvement Report on the QI studies/projects on an annual basis. The purpose of this report is to ensure that the LME is using an ongoing, systematic QI process as an integral part of its planning and policy-making activities. This report is presented to the QIC, Executive Team, Area Board, and Division of MH/DD/SAS. Any recommendations made as a result can be incorporated into future projects.
- Plan of Corrections – QM determines the need for plans of correction from providers when issues are identified that do not meet minimum standards or when patterns/trends are identified as deficiencies over a period of time.
- Level 1 incidents – QM receives quarterly reports regarding Level 1 incidents from providers. QM analyzes data of Level 1 incidents to identify patterns/trends.
- Level 2 and 3 incidents (critical) – QM receives Level 2 and Level 3 incidents from providers. QM maintains a database of incidents and reviews incidents for problems. QM ensures the timely reporting of such incidents and analyzes incidents for patterns/trends. QM makes recommendations for triggered monitoring based on trends/patterns identified in incident reports.
- QM provides training and technical assistance to providers regarding the reporting of incidents.
- Quarterly Incident Report – QM completes a quarterly report regarding Level 1, 2, and 3 incidents, which includes strategies developed to address any problems, actions taken, evaluation of results, and recommendations for next steps. Quarterly report is presented to the Client Rights Committee and the Quality

Improvement Committee. Report is submitted to the Division of MH/DD/SAS on a quarterly basis.

- NC-TOPPS (initials and updates) – QM is responsible for monitoring the NC-TOPPS system by ensuring that providers submit the appropriate assessments for consumers in a timely manner. LME must maintain a compliance rating of at least 90%. QM follows up with providers who have failed to submit the assessments.
- COI – QM is responsible for monitoring the DD-COI assessments by ensuring that providers submit the assessments for consumers in a timely manner. QM follows up with providers who have failed to submit the assessments.
- Consumer Satisfaction Surveys – QM is responsible for coordinating the annual administration of the consumer satisfaction surveys. QM ensures that providers survey their MH and SA consumers and ensures that surveys are submitted to the Division of MH/DD/SAS by the deadline.
- DD Core Indicator Surveys – QM is responsible for coordinating the annual administration of the DD Core Indicator Surveys. QM ensures that providers survey their DD consumers and ensures that surveys are submitted to the Division of MH/DD/SAS by the deadline.
- Quality Improvement Plan – QM is responsible for writing and implementing the QI Plan. The plan articulates the overall purpose, processes, and expectations of the QM system. The plan places an emphasis on QI activities, support by QA activities that ensure the safety of consumers and compliance with minimum standards of serve quality and best practice.
- National Accreditation – QM has been responsible for researching, evaluating, and assisting in the selection of a national accrediting body, as well as evaluating current policies/procedures for compliance with the chosen accrediting body. QM leads the LME accreditation activities in coordination with all LME departments.
- Performance Contract Compliance – QM monitors the LME's compliance with the State Performance Contract, ensuring that all reports are completed accurately and submitted to the Division of MH/DD/SAS by the specified due dates. QM reviews the quarterly Performance Contract Report issued by the Division of MH/DD/SAS to identify any deficiencies in the performance areas and makes recommendations to improve compliance ratings.
- Provider Monitoring/Endorsement – QM develops policies/procedures related to the monitoring of private providers and conducts on-site provider monitoring reviews in concordance with mandated procedures. Providers are monitored, at minimum, on an annual basis. Triggered monitoring may be conducted, as needed, based on incidents and/or complaints regarding client rights and the health and safety of individuals served. Providers are monitored for compliance with State and Federal rules and regulations. A monitoring report is submitted to the Division of MH/DD/SAS on a monthly basis.
- Client Rights - Complaints that involve client rights violations or health and safety issues may be investigated by the QM Department in conjunction with the Provider Relations or Customer Services Departments. Investigations may include interviewing all parties involved, reviewing facts of the complaint, determining whether the complaint is substantiated, and making recommendations as a result of the complaint outcome. QM is responsible for reviewing aggregate data of

consumer grievances to identify any patterns or trends, and presenting data to the QIC, Client Rights Committee, Executive Management, and CFAC.

3. STRATEGIC OBJECTIVE: The strategic objectives of the Quality Management department are listed below along with the strategy and projected implementation date to obtain each objective.

Objective 1: Implement an ECBH QM program.

Implementation Date: October 2007

Strategy to obtain objective: The Systems Performance Coordinators, under the guidance of the External Assistant Director, will design and implement a quality management program for ECBH that would be effective in serving one million people. Within three months staff will be identified who will be responsible for ensuring the achievement of QM and other LME strategic objectives. Once implemented, the QM program will have ongoing responsibility for ensuring internal quality control regarding LME compliance and general overview of organization.

Objective 2: Ensure standardization of ECBH functions and practices.

Implementation Date: July 2008

Strategy to obtain objective: To ensure standardization of practices throughout ECBH's catchment area, all policies and procedures will be reviewed and updated. QM, in coordination with all ECBH departments, will be responsible for ensuring the policies and procedures address current business practices and conform to standards of the (to be chosen) national accrediting body. QM will also oversee the standardization of all LME forms as they relate to the procedures. It is anticipated that the initial policy and procedure review and revisions will take at least twelve months. Bringing the policies and procedures into conformance with accrediting standards will take between twenty-four and thirty-six months. QM will also ensure policies and procedures are updated/revised as LME practices are changed. This will be an ongoing objective.

Objective 3: Implement a provider evaluation system.

Implementation Date: January 2009

Strategy to obtain objective: To allow consumers to make informed choices, a provider evaluation system will be developed and implemented. The system will be based on established objective criteria. QM in coordination with Customer Service and Provider Relations will be responsible for the development of the system. As major stakeholders, providers and CFAC will be involved in the development of this system. It is estimated to take up to eighteen months to develop and implement the system. After the system has been in use for at least six months, an evaluation will be conducted. Improvements will be made based on the results of the evaluation.

Objective 4: Attain national accreditation for ECBH.

Implementation Date: Phase I - January 2008, Phase II- January 2010, and Phase III- July 2010

Strategy to obtain objective: QM will coordinate and oversee the LME's effort to attain accreditation from a nationally recognized and DMH/DD/SA approved accrediting body. Within six months, an accreditation committee will be formed to begin developing a timeline for achieving accreditation (Phase I). ECBH will need to function under accrediting body standards for at least six months prior to making application for accreditation (Phase II). It is expected to take at least 36 months to attain accreditation. All ECBH departments will be involved in this endeavor (Phase III). Once accredited, QM will oversee the organization's compliance with accrediting body standards to ensure that re-accreditation will be obtained. QM will coordinate the development and submission of all Quality Improvement Plans and annual Conformance to Quality Reports required by accrediting body (ongoing).

Objective 5: Initiate an ECBH Quality Improvement Committee (QIC).

Implementation Date: January 2008

Strategy to obtain objective: QM will organize and maintain a QIC for ECBH comprised of QM staff, representatives from all LME departments, and other identified stakeholders (CFAC, Providers, etc.). The QIC will meet monthly to review progress on attaining the LME's strategic objectives and performance requirements, as well as identify methods to assist the providers' compliance with all statutes and rules. The QIC will take six months to form and will be ongoing thereafter.

Objective 6: Ensure ECBH's quality performance.

Implementation Date: Phase I - January 2008, Phase II - January 2009 and Phase III - Annually

Strategy to obtain objective: QM will establish and oversee a system to ensure ECBH's full compliance with the State Performance Contract. It will take six months to develop and implement the system and it will be ongoing thereafter (Phase I). QM will also assist all LME departments in the identification of their key indicators for quality performance. Within 18 months, QM will develop data collection and analysis systems that will aid in the evaluation of each department's progress in achieving and maintaining their key indicators (Phase II). To further facilitate quality performance, QM will review ECBH's Quality Improvement Plan on an ongoing annual basis (Phase III). The Plan will be revised or updated as necessary to reflect the changing roles and goals of the QM Program to maintain quality performance at ECBH.

Objective 7: Utilize data for quality management

Implementation Date: January 2009

Strategy to obtain objective: QM will develop systems to collect, analyze, and utilize data concerning consumer outcomes (i.e., NC-TOPPS, COI's, etc.) to ensure consumers are receiving quality care that aids in their efforts towards recovery. QM, in coordination

with other LME departments, will develop systems to collect and utilize data to assist in making risk management decisions. These systems should be operational in eighteen months.

Objective 8: Enhance Providers' and CFAC's quality performance involvement

Implementation Date: Phase I - July 2008 and Phase II - July 2009

Strategy to obtain objective: QM will participate with the Monitoring and Provider Relations departments in ongoing training, education, and technical assistance to providers on quality assurance and quality improvement activities. Within the next twelve months, QM will assist providers with QI project development and monitor compliance of providers' QI systems (Phase I). QM will identify and implement ways to involve CFAC in LME quality improvement. Within the next twenty-four months, QM will educate and train CFAC to be able to participate in ECBH's QI related activities (Phase II).

4. RESOURCE ALLOCATION: The resource allocation to support the Quality Management department for July 1 is listed and described below.

Per the LME cost model there are 3.5 FTEs allocated for Quality Management. The organizational chart as shown in Appendix A has 3.5 FTEs. The FTEs and cost do not vary more than 30% from the model. Our budget for ECBH will be prepared in April and specific figures will be available at that time if needed. There are no operational variations from the assumptions in the cost model.

5. BUSINESS RULES: Listed below are six of the most significant business rules, which enhance or inhibit the efficiency and effectiveness of the operations of the Quality Management department and how operations would be different if there were effective changes to the business rules.

1. Lack of a standardized monitoring process: Each LME is allowed to develop and implement individual monitoring process and forms. This variability among LMEs inhibits the monitoring process statewide as the LMEs communicate inconsistency to the providers. The development of one monitoring procedure, tool, and manual would decrease provider confusion and frustration.

2. Endorsement process: There appears to be variability in the implementation of the endorsement process statewide. LMEs would benefit from establishing an Endorsement Manual, which contained all of the endorsement information in one resource manual. This would contribute to increased consistency across the State, thereby decreasing provider confusion and frustration.

3. 3-strike-monitoring process: The LME has established a "3-strike" policy regarding monitoring providers. A provider has three attempts to submit an acceptable plan of correction and/or correct the deficiency before it is forwarded to the Division of MH/DD/SAS. However, the "3-strikes" have to be related to the same deficiency. If the

LME could refer a provider to the Division after any three major deficiencies, it would get issues resolved in a timelier manner, thereby ensuring that consumers receive the highest quality services from the highest quality providers.

4. Follow-up monitoring reviews: The LME currently conducts follow-up monitoring approximately ninety days after a review to hold providers accountable for being in compliance with rules and standards. There are times when the same deficiency is identified in the following years. Quarterly follow-up monitoring by the LME has been efficient in ensuring that compliance is maintained throughout the following year.

5. Provider appeals to Division: A formal process does not exist at the Division level for appeals that providers make regarding monitoring findings from the LME. While the Division may request documentation from each party, there is no formal process to allow the LME or the provider to present their case. The development of a formal process would allow the LME and the providers to understand the decisions made by the Division.

6. LME and Division of Facility Services interaction: Currently, a gap exists in the relationship between the LME and the Division of Facility Services (DFS). The LME is often not included in the reviews of providers conducted by DFS, even though the LME may have pertinent information regarding the provider and the complaint that is being investigated. LME's are often notified of the DFS results months after the reviews are conducted. This lack of communication inhibits the LME's ability to be aware of the actions taken against a provider. Increased communication would enable the LME to stay on top of provider's who have had deficiencies to ensure compliance with rules.

East Carolina Behavioral Health
Organizational Chart













