The Beacon Center

Serving Edgecombe, Greene,
Nash and Wilson Counties

Local Business Plan 2008—2011

INTRODUCTION

This document serves as the Local Business Plan for The Beacon Center, a Local Management Entity that will manage Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS) in Edgecombe, Greene, Nash and Wilson Counties. The strategic objectives detailed in the following Chapters cover the period of March 1, 2008 through December 31, 2011.

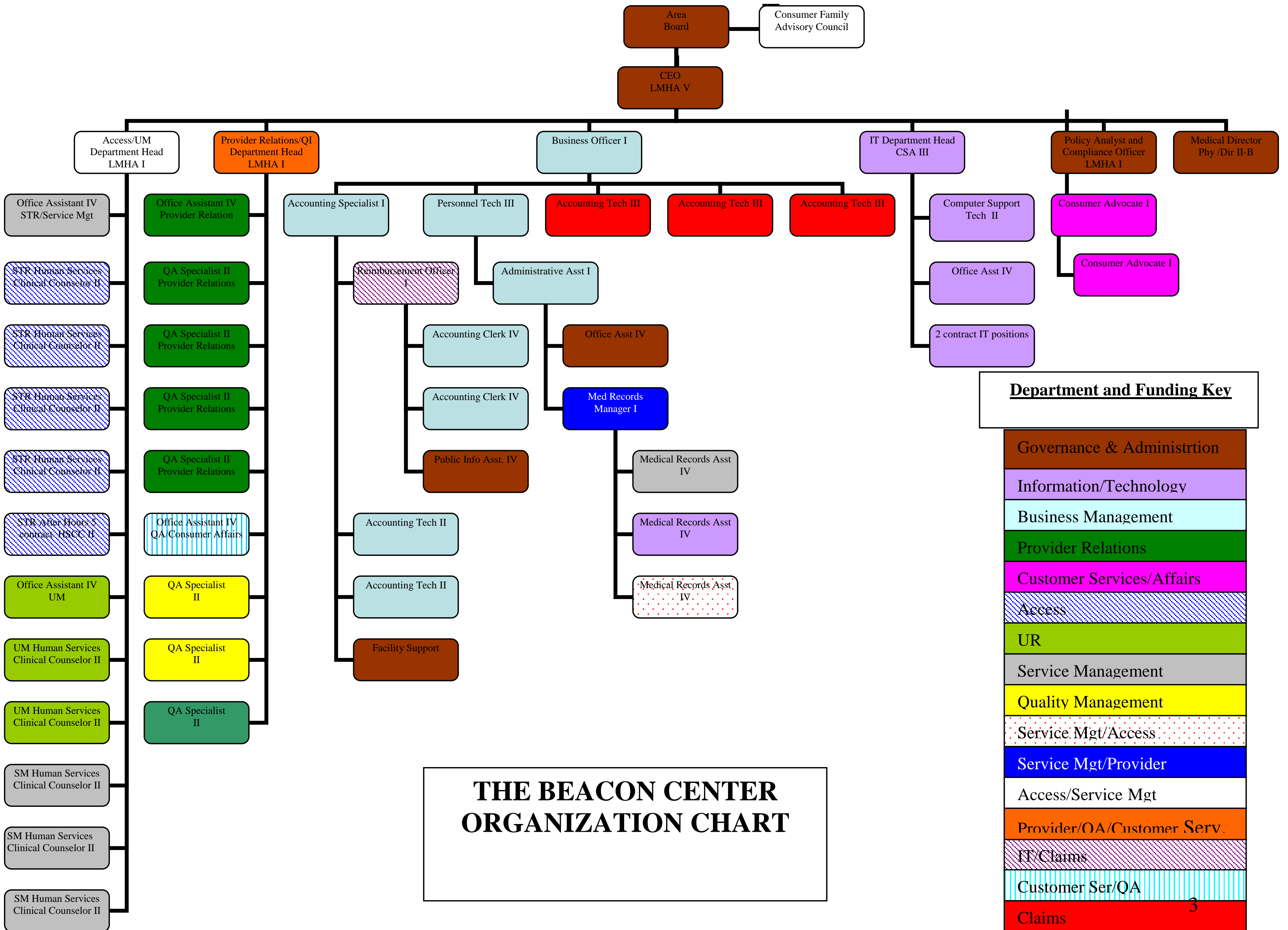
The Beacon Center came into existence on July 1, 2007 when the merger of two former Area Authorities, Wilson-Greene and Edgecombe- Nash MH/DD/SAS occurred. Edgecombe, Greene, Nash and Wilson Counties have a combined population of approximately 247,000 and meet the statutory size requirements. In addition to the contiguous geographical boundaries, the four counties share similar and compatible economic and cultural histories as well as values and goals. The merger occurred after a period of time that allowed for a thorough planning processing involving input from the citizens we serve, governmental partners, Area Board members, staff, community stakeholders, providers, etc. The success of this detailed planning process has resulted in the creation of a Local Management Entity that has a firm foundation of trust among its partners; respect for the mission, limitations and challenges that the partners face; and a true commitment to promote a system where all individuals have a voice that is heard and sense of success.

The Beacon Center is in the initial stages of exploring ways to maximize efficiencies and increase standardization in procedure and policy among Local Management Entities with representatives from Onslow-Carteret, Southeastern Regional Center, Southeastern Center and Eastpointe Local Management Entities. Some of the strategic planning objectives included in this document will detail the Eastern Alliance's efforts.

This Business Plan will be reviewed annually to assess progress toward the stated objectives. Data used to revise this plan will be obtained through the use of public forums, regularly scheduled interagency meetings, smaller focused meetings with primary targets, i.e., hospitals, law enforcement, consumers and families, etc. Changes to Strategic Objectives will be driven by the needs of the consumers served, the capacity of the network of providers, resources available in compliance with mandates from County, State and/or Federal Governments.

The Plan includes components of the following major strategic objectives:

- Identify and develop strategies to address gaps in the local continuum of care.
- Reducing the current level of reliance on State Institutional services.
- Successfully implement a community education program that heightens awareness on how to access services and lessening the stigma associated with seeking services for mental health/developmental disabilities/substance abuse needs.
- Maintain financial viability of the organization.
- Provide rapid telephonic and face-to-face response to citizens in crisis.
- Stabilization of a fragile provider network.


Area
Board
Consumer Family
Advisory Council
CEO
LMHA V
Access/UM
Department Head
LMHA I
Provider Relations/QI
Department Head
LMHA I
Business Officer I
IT Department Head
CSA III
Policy Analyst and
Compliance Officer
LMHA I
Medical Director
Phy /Dir II-B
Office Assistant IV
STR/Service Mgt
STR Human Services
Clinical Counselor II
STR Human Services
Clinical Counselor II
STR Human Services
Clinical Counselor II
STR Human Services
Clinical Counselor II
STR After Hours 5
contract HSCC II
Office Assistant IV
UM
UM Human Services
Clinical Counselor II
UM Human Services
Clinical Counselor II
SM Human Services
Clinical Counselor II
SM Human Services
Clinical Counselor II
SM Human Services
Clinical Counselor II
Office Assistant IV
Provider Relation
QA Specialist II
Provider Relations
QA Specialist II
Provider Relations
QA Specialist II
Provider Relations
QA Specialist II
Provider Relations
Office Assistant IV
QA/Consumer Affairs
QA Specialist
II
QA Specialist
II
QA Specialist
II
Accounting Specialist I
Personnel Tech III
Accounting Tech III
Accounting Tech III
Accounting Tech III
Reimbursement Officer
I
Administrative Asst I
Accounting Clerk IV
Accounting Clerk IV
Public Info Asst. IV
Office Asst IV
Med Records
Manager I
Medical Records Asst
IV
Medical Records Asst
IV
Medical Records Asst
IV
Accounting Tech II
Accounting Tech II
Facility Support
Computer Support
Tech II
Office Asst IV
2 contract IT positions
Consumer Advocate I
Consumer Advocate I
Department and Funding Key
Governance & Administrtion
Information/Technology
Business Management
Provider Relations
Customer Services/Affairs
Access
UR
Service Management
Quality Management
Service Mgt/Access
Service Mgt/Provider
Access/Service Mgt
Provider/QA/Customer Serv.
IT/Claims
Customer Ser/QA
Claims
THE BEACON CENTER
ORGANIZATION CHART

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CHAPTER 1

GOVERNANCE & ADMINISTRATION

Mission

The Beacon Center will be governed and administered to assure that the organization complies with all applicable Federal, State, and Local Statutes, Rules, and contractual agreements, while never losing focus on those that we serve.

Purchaser Standard

The Beacon Center is guided by and complies with all applicable Local, State, and Federal Rules, mandates, and laws including but not limited to those outlined in the Local Business Plan template/Communication Number 68.

Current Operations

The Area Board and staff of the Beacon Center, in partnership with our Consumer and Family Advisory Council, community stakeholders, and providers, work in collaboration to provide quality services to consumers in Edgecombe, Greene, Nash, and Wilson counties. The Beacon Center came into existence in July 2007, when the merger of Edgecombe-Nash and Wilson-Greene Mental Health, Developmental Disabilities, and Substance Abuse Services occurred.

Area Director

The Area Director who is appointed by the Area Board oversees the Beacon Center's day-to-day operation. The Area Board hires the Area Director to serve as the Chief Executive Officer of the agency and to be responsible for the implementation of Area Board policy. The Area Director does not maintain a written contract with the Board and serves at the pleasure of the Board. The Director serves as the liaison to each of the four county governments, with the point of contact identified in each county as the County Manager.

Management Team

The Area Director meets at a minimum twice per month in a formal Management Team meeting with the Directors of Finance, Provider Relations, Quality Assurance, Medical Records, Human Resources, Information Technology, Policy and Compliance, Utilization Management, Screening Triage and Referral and the Medical Director. The Management Team assesses the current performance of the organization, develops strategies to address identified gaps, analyze trend data and develops policy recommendations for consideration by the Area Board. The Area Director has an annual evaluation that is overseen by the Personnel Committee of the Board and is then presented to the entire Board for their consideration and action. The evaluation includes the seven key function areas as outlined in Communication Bulletin #20, Evaluation of the Area Director (June 1, 2004).

Area Board

The Beacon Center Board consists of 20 members – 5 members from each of the four counties. One of these five members from each County is a County Commissioner, and the other four Board Members meet one or more of the various statutory requirements for Area Board composition as indicated in HB2077 and the resulting Rules. The Board meets in the months of February, April, May, June, August, October, and December. These meetings rotate between sites in Rocky Mount and Wilson, North Carolina. The Board currently operates Finance and Personnel Committees and Consumer and Family Advisory Council, and Consumer Rights advisory groups. The Beacon Center complies with the legislative requirements that were enacted because of House Bill 2077. The Human Resources Director serves as our clerk/staff liaison to the Board. The Clerk is responsible for compiling and distributing the meeting Board packets to members, taking minutes at meetings of the full Board meeting as well as the Finance and Personnel Committees, and assisting with compiling the data used in the Boards annual evaluation of the Area Director. The Board is given a packet at least one week prior to each meeting that contains information pertaining to the agenda items to be discussed at the upcoming meeting. We had a number of Board Members participate in the recent Area Board training opportunities available through the Institute of Government. Area Board payment consists of a meeting stipend and mileage from their home to the meeting site. There is a budget line item identified for not only these expenses but also Area Board training, supplies and operational expenses.

County Government Communication

The County Managers are copied on the Area Director's report to the Board, quarterly fiscal statements, and meet face-to-face with the Area Director on an as-needed routine basis. As a multi-county LME, The Beacon Center maintains close working relationships with the governments in each of the four counties, and the Governmental sub-groups that are pertinent to the operation of the agency and services to our consumers. The County Manager and/or County Finance Officer share fiscal and communication reports with the Boards of County Commissioners at the next meeting after their receipt. The Local Management Entity is actively engaged with the County Managers and the Boards of Commissioners in a collaborative relationship to meet the needs of the citizens within their communities. The County Commissioner Representative serves as a liaison between the Area Board and the Board, the County Commissioners. Legal representation for the Area Board and the organization is contracted on an as-needed basis. The particular Counsel utilized varies depending on the particulars of the situation.

CFAC

The Beacon Center Consumer and Family Advisory Council (CFAC) was formed in June 2002, and currently has fewer members than their bylaws indicate as their maximum threshold. CFAC membership includes representation of consumers and/or families from each of the three disability populations. CFAC regularly participates in the organization's strategic planning process, identification of gaps, strategies to address these gaps, Quality Improvement and Provider Relations activities, and monthly provider meeting presentations. CFAC reviews on a monthly basis improvement measures and performance indicators including consumer complaints and the result of investigations regarding these complaints. The Area Director attends all CFAC meetings along with the LME staff assigned as the CFAC liaison. The CFAC provides input into

the development of LME policies and procedures. These policies not only guide the LME's operations, but also assure that practices principles, services, and the service culture developed within our community for behavioral health, supports the value of being consumer and family friendly and evidence-based practice. The Consumer Advocacy section of the LME provides assistance with the coordination of travel and stipend reimbursement for consumers. Training given to CFAC has involved evidence-based practice and clinical practice standards for various services, information on understanding how to read and interpret data and quality reports issued by the LME, Division, and other community partners, information on client rights for not only the LME, but other institutions and agencies within our community. The CFAC has a Relational Agreement with the LME, has an adopted set of bylaws, and maintains oversight of its budget for stipends, travel, training, etc

Having a CFAC with a strong voice has been beneficial to the organization. A strategic objective of the organization and the CFAC is to magnify the presence of consumers not only within the organization but also in community as a vital partner in system design. Some of the major focus areas of this plan will involve increasing consumer educational opportunities; receiving input from them early in frequently in program development and in promoting the creation of consumer run organizations.

Strategic Planning

Our previously submitted strategic plan was developed prior to the completion of the merger between Wilson-Greene and Edgecombe-Nash MH/DD/SAS. For this reason, the plan focused primarily on merger and consolidation activities. In the development of this plan our stakeholders, families and consumers, agency staff, and the Area Board provided input after analysis of the data into the highlighted objectives and their timelines. In the early first quarter of each calendar year after submission of this plan, input will be received from all previously indicated partners and an analysis of the data will occur to determine the continued appropriateness of the stated objectives, reassessment of the timelines, indicated progress and the revision of objectives and timelines as indicated. The Beacon Center will conduct an annual Community Needs Assessment and Ongoing Service Gap Analysis as a mechanism to survey and analyze the status of behavioral health resources in our community and gaps that exist. The Community Development Plan will combine internal expertise, but more importantly involve community stakeholders, families and consumers external to the organization. The Community Development Plan will be the guiding roadmap for future adjustments to this strategic plan.

Strategic planning focuses on areas that are impacted by the organization and the consumers we serve. This would include strategies that impact and/or involve external partners resulting in benefit for those we serve, but also strategies that influence the critical quality indicators that consumers and families use to assess the Beacon Center's performance as an LME.

Medical Director

The Medical Director serves as lead clinician on various clinical, service delivery integrity and quality issues, working with Administration, Quality Management, Provider Relations, Customer Affair, Access, Utilization Management and Finance departments. The Medical Director attends Provider Meetings and is a member of the agency's Management Team.

Divestiture of Services

The Beacon Center had divested of all clinical services, including psychiatric, at the time of its creation in July of 2007. After multiple unsuccessful efforts to secure a provider for Mobile Crisis Services, the LME requested and was granted a waiver to provide this service. It is our intent, after creation, and full implementation of this service to begin the process of identifying a provider to assume its operation. This provider will be identified through an RFP selection process.

System of Care Community Collaboration

In addition to the numerous informal efforts in our community to promote System of Care philosophy, there are a number of formalized initiatives. These include the Child/Adolescent Community Collaborative that represents all four counties. This collaborative resulted when the two Community Collaborative groups previously representing Wilson-Greene and Edgecombe-Nash merged. There is also an Interagency Council that has membership from all four counties and focuses on the needs of citizens in our community with developmental delays. This Council uses a rating and evaluation scale for identifying consumers who are potentially eligible for CAP waiver slots. The Interagency Council uses the evaluation scale to determine these consumers acuity and eventual ranking on the waiting list.

System of Care for children has been a philosophical pillar for a significant period in our communities. As an original System of Care site in North Carolina through the PENPAL project, we have demonstrated a long history of active child collaborative efforts. This collaboration and its philosophical underpinning are strengthened by the existence of two funded Child and Family Teams in our catchment area: one in the Nash Rocky Mount School System and the other in the Greene County School System. We have staff identified and dedicated to these Child and Family Team initiatives. We also have dedicated staff that oversee our System of Care initiatives in the community and serve as our liaison to the Community Collaborative. A strategic objective of the organization is to expand the System of Care philosophy outside the realm of children’s services to involve our adult consumers who are impacted by substance abuse and mental health issues.

Compliance

The Area Director is ultimately responsible for overseeing the implementation of the Local Business Plan as it has been developed and presented in this document. The requirements of the DHHS contract will be overseen by various members of the LME staff, but will be the ultimate responsibility to assure compliance with its contractual terms is the Area Director. The Area Director and the Policy and Compliance Director are responsible for overseeing the development of policy and the implementation of Board approved policy. These policies not only guide the LME’s operations, but assure that practices and principles, the service culture developed within our community for behavioral health supports the concepts of being consumer and family friendly, based in evidence-based practice, and fiscally responsible.

National Accreditation

The Beacon Center has identified CARF as the organization from which we will be pursuing accreditation. The Area Director and Policy/Compliance Director have attended a Network Accreditation Training offered by CARF in December 2007 and will be purchasing the Standards

Manager conformance software packet once it is available to assist us in our accreditation efforts. We do not anticipate any issues that would prevent us from complying with the timeline established by the Division for obtaining accreditation. The lead staff for our accreditation efforts will be the Policy and Compliance Director.

Public Marketing/Awareness Campaigns

The Beacon Center is similar to other communities across the State and the Nation in that the stigma associated with mental health, developmental disabilities and substance abuse services negatively affects those we serve and the community as a whole. The stigma associated with receiving treatment impacts prevalence rates and results in individuals often times reaching a crisis before services are sought. We are currently working with our advocacy partners NAMI and MHA to enhance the efforts presently being made to counter these stigmas. NAMI is expanding their Family-to-Family program in our efforts and is working with the LME to start the CIT program in our community. MHA is taking the lead or increasing the number of WRAP trainings offered and will be working on a plan to target an anti-stigma campaign to middle school students.

With education comes a wonderful opportunity to dispel misconceptions about those we serve. Over the next three years we will continue to provide educational trainings for providers, law enforcement, hospital partners, judicial staff, and other community stakeholders to improve crisis prevention and intervention strategies, how to access services and the "fact vs. fiction" of mental health, developmental disabilities and substance abuse.

Strategic Objectives

Objective **Indicates an Objective tied to a Community Systems Progress Indicator	**Responsible Party (Bold) and other Participating Groups**	**Targeted Completion Date**
Develop and implement an annual Community Development Plan in collaboration with providers, community stakeholders, consumers and their families to identify capacity issues, service gaps and potential areas of expansion.	**Policy Compliance Director,** Provider Relations, Consumer Affairs, Consumer/Family Advisory Council, Area Director, Area Board, Community Partners	12/1/08 ** 1.4,1.5,1.6
Identify three quality measures that providers and consumers/families believe are critical indicators of organizational performance and/or consumer outcomes and implement a regular measurement and reporting system.	**Quality Management Director,** Consumer/Family Advisory Council, Provider Relations, Providers, Consumer Affairs	7/1/08
Demonstrate support for consumer involvement by promoting both philosophically and fiscally the development of consumer run services.	**Area Director**, Consumer Affairs, Consumer/Family Advisory Council	7/1/09

Objective **Indicates an Objective tied to a Community Systems Progress Indicator	Responsible Party (Bold) and other Participating Groups	Targeted Completion Date
Develop and implement strategies to assure the continued short term and long term financial viability of the organization.	**Business Director,** Area Director, Area Board	7/1/08 and annually thereafter
Development and implementation of marketing/public relations strategies with consumers to increase awareness of MH/DD/SAS issues and decreasing the stigma associated.	**Area Director,** Screening/Triage/Referral, Medical Director, Consumer/Family Advisory Council	12/1/09 ** 3.0
Development and implementation of educational trainings for providers, law enforcement, hospital partners, judicial staff, and other community stakeholders to improve crisis prevention and intervention strategies, in particular CIT training.	**Area Director,** Screening/Triage/Referral, Medical Director, Provider Relations, Hospital Partners, Law/Judicial Partners, Community Stakeholders	12/9/08
After assessment, develop and implement strategies by which resources can be shared with other Eastern Alliance members to increase efficiencies and decrease redundancy among our organizations.	**Area Director,** Business Director, Information/Technology Director, Screening/Triage/Referral Director, Provider Relations Director, Quality Management Director, Policy Compliance Director, Consumer/Family Advisory Council, Medical Director, Eastern Alliance Membership	9/08 and ongoing
Development and implementation of a plan to assure compliance with the timelines established in Rules, Policy and/or Statutes for obtaining accreditation through CARF.	**Policy Compliance Director,** Area Director	12/1/08
Increase the number of network providers who provide Evidence Based Practice as a foundation for service delivery.	**Provider Relations Director,** Quality Management Director, Medical Director	12/9/08

Resource Allocation

The Cost Model allocates 5.56 FTEs in the area of Governance and Administration. FTEs allocated to this area are the CEO, Medical Director, Policy and Compliance Director, and Public Information Assistant IV, Office Assistant IV and .5 FTE support person. Although the total number of FTEs is not in excess of the Cost Model, we do anticipate a variance in excess of 30%

from the allocation in the Cost Model due to the inclusion of the Medical Director in Governance rather than Service Management and Provider Relations. This category as well as all that follow will reflect a fringe benefit package that will exceed that allowed in the Cost Model. It is very difficult to recruit and retain staff in a rural setting unless a very competitive benefit package is offered. Our benefit package is in line with that offered by county government in our area. We will adjust our LME expenditures for non-salary items to cover this anticipated difference in fringe benefit costs. The current LME budget allocation for this function is $1,414,098.

Business Rules

Business rules that will enhance or inhibit the efficiency and effectiveness of this function are as follows:

Limit on Area Board Member terms could potentially result in a Board that is so "new" to their roles, responsibilities and functions that the Board is in a constant flux of education and training and has a compromised ability to develop a strategic plan with a forward focus.

The mandate that an LME obtain National Accreditation from two different bodies if they provide services could result in an extreme fiscal and staff resource burden on the LME when they are the default provider of services and must pursue two separate accreditations.

Some of the current rules are no longer consistent with statutory requirements for an LME. This results in expenditure of fiscal and staff resources and lack of consistency between LME's in some cases.

Policy requirements that are jointly and consistently communicated from DMA and DMH are more frequently occurring than in the past. This results in an implementation on the local level by the LME and the provider community that is more likely to be standardized statewide.

Release of a "schedule" communication rather than sporadically during the month has resulted in better implementation in the field of Division and Department procedure and policy.

Internal policy regarding staff reimbursement under a Merit System has helped with recruitment efforts.

More timely access to data regarding consumers, i.e., Medicaid, IPRS, and HEARTS, paid claims data is occurring so that trends can be analyzed and timely strategies developed to address identified issues.

Clarity of the roles and responsibilities of the LME Board and CFAC provided in HB 2077 has been helpful.

CHAPTER 2

BUSINESS MANAGEMENT AND INFORMATION MANAGEMENT

Mission

The mission of the Business/Information Management section of the organization is to ensure the effective business management and financial integrity of The Beacon Center, by developing, implementing, and monitoring department-wide policies and systems in the areas of budget administration, program analysis and evaluation, finance and accounting, internal controls and human resources.

Business Standards

The Beacon Center is guided by and complies with all applicable Local, State, and Federal Rules, mandates, and laws including but not limited to those outlined in the Local Business Plan template/Communication Number 68.

Current Operation

The Beacon Center is the result of the merger of Edgecombe-Nash and Wilson-Greene Area Authorities on July 1, 2007. These agencies had a long history of being financially sound when they operated as Edgecombe-Nash and Wilson-Greene MH/DD/SAS and it is the Beacon Center's intent to continue this trend of fiscal responsibility within a framework that provides clinically sound, evidence-based services. The Business Management department of the Beacon Center is divided into five distinct areas: Accounting, Reimbursement, Contracts, Human Resources, and Medical Records.

The Accounting segment is responsible for all Payroll, Accounts Payable, Purchasing and General Ledger functions.

The Reimbursement segment is responsible for submitting the providers' billing to IPRS and Medicaid, overseeing, and processing the claims submitted. Payments and denials are reviewed and processed as indicated.

Human Resources is responsible for the recruitment, retention, and development of LME staff, payroll, and benefit administration. They also serve as liaison and consultants to the Provider Relations staff to assist with provider human resource training and credentialing issues.

The Contracts section of the organization is responsible for the development of contracts with vendors and compliance with the terms and conditions of those contracts. They also assure compliance with the prompt-pay criteria. Contract staff is responsible for reviewing paid claims and Value Options/LME authorization data to assure that payments only occur for authorized services, supply and equipment.

The Medical Records section of the organization processes release of information requests, transmits CDW data to the State and researches and corrects data errors for resubmission.

Conducts quality assurance reviews of provider and internal records regarding consumers, does analysis of error reports regarding data specific to consumers and providers, tracks consumer movement between providers and services to assure that payments and reimbursement are occur correctly.

The Finance Officer assures that funds managed by the LME including MH/DD/SAS funds for services for non-Medicaid-eligible consumers and non-Medicaid-covered cost of services, limited Medicaid fee for service reimbursement for ineligible, directly enrolled service providers and County allocations are managed in compliance with all Rules and Statutes. IPRS earnings are analyzed by Finance Department staff after each check write to ensure that reimbursements are at anticipated levels and to assess the availability of IPRS funding for future authorizations of service. Revenues and expenditures are reviewed and reconciled to general financial statements that are reviewed monthly by the Area Board and the counties. Once per year, an independent financial audit is prepared and the results are submitted to the Area Board and governmental entities as indicated by Rules and Statutes. Fixed assets are inventory tagged and tracked, and bank statements are reconciled monthly to ensure the integrity and financial responsibility of the organization.

Financial Reporting

The Beacon Center currently reports financial activity as required in Federal, State, and local rules, mandates, and laws. The Beacon Center's internal controls assist in administering and enforcement of Federal and State regulations so that the organization complies with all grant and reporting requirements. The Finance Officer reports directly to the Area Director and provides regular updates as to the fiscal status of the organization. The Finance Officer is a member of the agency's Management Team and works closely with Utilization Management supervisor and staff to assure that authorized and expended funds are based on established policies/procedures and support evidence-based practice. There are currently systems in place to track and report the use of County funds as well as non-UCR reimbursement funds. Quarterly Fiscal Monitoring Reports are reported to the Division of Mental Health, the Finance Chairperson of the Area Board, as well as to County Finance Officers for reporting at the next meeting of the Board of County Commissioners. Financial statements are provided to the Area Board monthly. In person during months when there is a scheduled meeting and in the mail during months when there is no meeting. Reports are submitted on a cash basis for the first and third quarter and on an accrual basis for the second and fourth quarters.

Claims Adjudication

Claims adjudication currently exceeds the prompt pay requirements and in most cases, reimbursement occurs sooner than those requirements established in the Performance Contract. There are currently two full-time positions responsible for the processing of claims and invoices, as well as other aspects of the contract and service authorization process. Our reimbursement system for provider submission of claims is fully automated through the web-based program, CareLink. Provider notification of denied, pended and paid claims is also fully automated and web based. Authorization and claim status information is electronically available on a 24/7 basis for providers.

Information Management, Analysis, and Reporting

The Information Technology department is responsible for the operation and analysis of internal data systems and the exchange of data with external sources. They prepare custom reports to assist with CDW and IPRS reporting and assure accuracy. They provide access to FTP reports and ensure the safe communication of data both internally and external to the organization. Data is critical to our fiscal and consumer operations, so positions funded by IT in the cost model are placed in a number of departments throughout the organization. The IT department has access to State standardized reports, i.e. Bed Days and IPRS reports, but also has the knowledge and skills to create reports for internal use. The data systems are HIPPA compliant and are backed up with a disaster recover plan that ensures the organizations ability to maintain operations in the event of a catastrophic occurrence. One of the strategic objectives of the IT department will be to assure that not only consumer and fiscal data systems have an adequate disaster recovery plan but that other critical data systems also have a disaster recovery plan in place, i.e., phone tracking data system, monitoring report data, etc. We currently have consumer data from Edgecombe Nash and Wilson Greene consumers on the same server but separated by a partition. We will be developing a transition plan to move the Wilson Greene data to the Edgecombe Nash side prior to our upgrade to a new software platform operated by Netsmart. We are working with the IT departments within the Eastern Alliance membership to assure that the internal and external practices and protocols in this new platform are consistent among our organizations. A helpdesk position is readily accessible to assist not only internal users, but also external users with system use issues. Due to fluxes in IT service needs that exist during the fiscal year (i.e., software upgrades and conversions), we utilize the services of a contract IT vendor to maximize allocated LME funds for this section. Partners in the Eastern Alliance are currently in discussions regarding standardization and possible areas of consolidation of LME Information/Technology functions.

The IT department maintains oversight of the organization's website. They are responsible for data submission as well as implementing changes to the format. They are currently gathering data that will be used in updating our site to make it more consumer, provider, staff and stakeholder friendly.

Risk Management

The agency currently has established Risk Management policies and procedures in place to assure compliance with all requirements and conditions set upon it by local, State and Federal funding requirements. Risk Management procedures are also in place to assure that there is a check and balance system in place to assure that we comply with all standards. The agency is in receipt of Federal substance abuse funds and therefore most conduct sub-recipient monitoring activities for the services that are provided through a private provider network contract. A condition of the contract with the provider is that the SAPTBG (Substance Abuse Prevention and Treatment Block Grant) Report must be provided to the LME for review and reporting to the Division. We currently contract with PORT Human Services for this service. They have extensive knowledge and history of the requirements for the reporting required with these funds. Additionally, Substance Abuse services under the Work First initiative are provided by PORT Human Services. A condition of this contract with the provider is that the Work First initiative quarterly report information is provided to the LME for review and submission to the Division. A recent audit revealed issues with compliance with NCTOPPS reporting guidelines and the frequency of Urine Drug Screen testing. The provider has implemented a plan of correction that

will be reviewed at their next sub-recipient monitoring review that is conducted by the agencies Quality Management Department.

Purchasing

Purchasing of goods and services falls under the responsibility of the Business/Finance section of the organization. They are charged with negotiating administrative contracts, for example leases on equipment, IT services, auditor and non-provider contracts. These contracts are negotiated and managed by the Finance Officer and staff, with oversight by the Area Director. All contracts and purchases are executed only after there is certification of funds availability in accordance with GS 159-28. Contract management is centralized by vendor, with a specifically assigned staff, so that non-service provider organizations as well as provider organizations have one-stop help desk access.

Service Funds Management

We do not anticipate at this time that The Beacon Center will be required to do Cost Finding Reporting until enhanced services are directly provided as the Mobile Crisis Team. The LME will submit the required reports as indicated in communications from the State. If we are below the threshold, the LME will submit to the Division a request for a waiver. CareLink, under the CSM/Avatar platform and through the use of custom reports, assures that authorizations for state-funded services are done in conjunction with evidence-based practice, Utilization Review policies and procedures, and within available fiscal resources. Finance and Utilization Management will be working on expanding the detail in our basic benefit package, and the development of a system that allows the quick return of unused encumbered dollars back into the system to meet additional consumer needs. Data reports currently exist to allow for analysis of IPRS funds so that adjustments and budget allocation movement requests can be made in a data driven manner.

Accounting

The Payroll section of the agency is responsible for the proper payments to and maintaining necessary records for all Beacon Center employees. They process annual income reports to staff for tax filing. The Accounts Payable section is responsible for processing payments for merchandise and services where a valid purchase order was placed with the invoicing vendor. This section is responsible for paying bills for all merchandise and services received by The Beacon Center, which were not ordered by purchase order. The Accounting Department is responsible for preparing reconciliation and reports for use in analyzing various financial functions of The Beacon Center. They oversee and perform the input of vouchers, reconciliation of accounts, bank statements, object codes etc. They are also responsible for maintaining vendor tax identification numbers and address. They are also responsible for maintaining facility and equipment in good working condition either through use of internal housekeeping staff or external contractors.

Human Resources

The Human Resources department is responsible for recruitment and retention of staff, and payroll/benefit administration. All positions within the Local Management Entity have job

descriptions that include educational, clinical and quality expectations. The HR department was instrumental in our recent movement of our agency to a merit-based payment system for salary. It is anticipated that this change will have a positive impact on our recruitment efforts. We are also exploring possible ways within existing fiscal resources to recruit for hard-to-fill positions, i.e., offering educational loan repayment assistance. The recruitment and retention of staff with qualified and professional status is a priority with this Department. We are currently in compliance with all Federal regulations, including but not limited to FLSA, ADA, and FMLA. This Department oversees annual staff training requirements, i.e., Bloodborne Pathogens, Consumer Rights, Confidentiality, etc. They have also completed training for internal staff and provider organizations in our network regarding the definitions of personnel, how to verify credentials, etc.

Strategic Objectives

Objective	Responsible Party (Bold) and other Participating Groups	Targeted Completion Date
Develop and implement a process for analysis of authorized units not claimed.	**Utilization Management Director,** Business	5/1/08
Update and support changes to the currently used disaster recovery plan for significant data systems including but not limited to consumer records, STR data, business operation accounts.	**Information/Technology Director**	7/1/08
Develop and implement strategies to assure the continued short term and long term financial viability of the organization.	**Business Director,** Area Director	7/1/08 and reviewed annually
Develop and implement a transition plan from the current CSM/Avatar system to the upgraded Netsmart platform.	**Information/Technology Director,** Business	7/1/09
Develop and implement improvements to The Beacon Center website making more user friendly as reported by our consumers, families, providers and community partners to navigate.	**Information/Technology Director,** Provider Relations, Consumer Affairs, Screening/Triage/Referral, Consumer/Family Advisory Council	7/1/08
Development and implementation of a standardized web based protocol for provider submission of data, claims, consumer warehouse data and authorization requests with the Eastern Alliance membership.	**Information/Technology Director,** Business, Eastern Alliance Membership	7/1/09

Resource Allocation

The Cost Model allows for 8.0 FTEs for the Business Management and Accounting function (including Human Resources). The Beacon Center will have the following positions comprise these 8 positions: Finance Officer, Personnel Tech III and Administrative Assistant I in the Human Resources Department, two Accounting Clerk IVs in Reimbursement, an Accounting Specialist I in Accounting, and two Accounting Tech II positions in Accounting.

The Cost Model for Information Management Analysis and Reporting allows for 6.67 FTEs. The Beacon Center will have the following positions comprise these positions: one Computer System Administrator III, one Computer Support Tech II, two FTEs will be utilized through a contract agency, one Office Assistant IV to assist with the Help Desk functions for internal and external users, .5 FTE will be used in the Business Management Section to fund a Reimbursement Officer I who is partially responsible for IPRS transmission and error analysis activities. This position will also be funded with a .5 FTE from Cost Model function Claims Processing. The current LME budget for this section is Business Management $721,514, claims process $217,072 and Information Technology $510,926.

Business Rules

Some of the current Rules and General Statutes do not fit well with our current business model and the new roles and responsibilities of the LME. An example would be GS 159 and the cross cutting criteria.

The fifteen percent fund balance limit is not realistic in our new role. We need operational reserve not only for LME costs but to also resume service operation in the case of a major provider failure.

Providers have 13 months to submit claims for services that result in encumbered service dollars due to service authorizations that are not always used. The results in unused IPRS dollars at the end of the year.

Medicaid services billed on behalf of providers who are not eligible to direct enroll has taxed the LME business operation at a rate that is not currently reimbursed adequately by the per claim rate.

Division flexibility with regard to creative initiatives and single stream funding to keep the provider community stabilized has been very helpful.

The current fiscal staff at the Division has been helpful with interpreting information and the development of strategies to assist in implementation at a local level.

CareLink has resulted in data, plans and authorization requests being sent in a standard, traceable manner.

CHAPTER 3

PROVIDER RELATIONS AND DEVELOPMENT

Mission:

The mission of the Provider Relations department is to provide all identified consumers a quality provider network with adequate capacity to meet community needs, staff with the required competencies, and sufficient choice.

Purchaser Standards

The Beacon Center is guided by and complies with all applicable Local, State, and Federal Rules, mandates, and laws including but not limited to those outlined in the Local Business Plan template/Communication Number 68.

Current Operation

Provider Endorsement and Monitoring

The Beacon Center is conducting provider endorsement activities in full compliance with Division of Medical Assistance, Division of Mental Health/Developmental Disabilities/Substance Abuse Services, and Department of Health and Human Services policies and procedures. In order to address peaks in the number of providers seeking endorsement for a service, we have created the concept of the "Provider Endorsement Mill". This is a one-stop process that allows the LME to quickly and effectively perform endorsement reviews. This process was instrumental in assuring that conditionally endorsed providers were reviewed for full endorsement status within the indicated timeframes. Provider Relations and Quality Assurance/Improvement staff work jointly with providers in this one-stop process resulting in increased standardization, readily available technical assistance for providers for whom areas of needed improvement have been identified that would negatively affect their endorsement status or compliance with SB163 monitoring criteria.

SB 163 monitoring is conducted by a team from the Provider Relations and Quality Assurance staff involving the review of a provider's compliance with standards and Rules, quality management efforts, documentation, personnel practices, assessment and service delivery per the service definition, first responder compliance, medication administration, consumer choice and rights compliance, etc. The provider's monitoring frequency depends on their Confidence Rating Score at this time and/or the occurrence of monitoring triggering events, i.e., increases in number of consumer complaints, licensure action, etc. Provider monitoring per SB163 has historically been scheduled on an annual basis; however, currently at this stage of reform, consumer complaints are driving the monitoring and follow-up schedule. Our LME has developed a draft monitoring tool as well as a Pre-Monitoring Worksheet to be completed by the provider prior to the scheduled monitoring visit to identify the services provided, number of consumers, out of catchment consumers served, etc. Each provider is assigned a QA/QI consultant that provides individualized technical assistance and support. If/when the Consumer Advocate identifies or

substantiates a consumer grievance/complaint involving a provider, the QA/QI team determines jointly if more intense monitoring is warranted and the assigned consultant provides any follow up required. Certified letters of Notification of Out-of-Compliance issues detail any and all areas needing Plans of Correction and follow-up may be provided within 30, 60, or 90 days depending upon the seriousness of the out-of-compliance. Notification to DFS is made of results involving 122-C licensed facilities to not duplicate regulatory monitoring and required oversight. Monitoring reports are submitted to the Division monthly. SB163 Monitoring results in the scoring of Confidence Grids that ultimately determine the frequency, intensity and technical assistance required. Our department uses the process of evaluating our Provider Network in relation to statewide criteria of High, Medium and/or Low Confidence ratings of each provider and determining guidelines for monitoring frequency based on a variety of indicators and data. As part of SB163, monitoring inquiries will be made as to efforts to obtain National Accreditation by the organization.

We are working with our Eastern Alliance Partners to regionalize the recently released Frequency of Evaluation and Monitoring Tool (FEM) within our respective LMEs. This would result in greater interagency reviewer reliability, result in the provider only having to be monitored once for all their regional sites and result in greater consistency in the quality of services from one service provider site to the next.

Provider Network Capacity

The Beacon Center Provider Network currently has over 265 endorsed providers who provide an array of Medicaid and state-funded services designed to meet the Mental Health, Developmental Disabilities and Substance Abuse Services needs of our consumers. The table in Appendix A details our endorsed service providers.

In addition, we have 121 licensed residential facilities with a total capacity of 513 beds available in our four-county catchment area to meet the needs of consumers who require residential placement. The majority of these are .5600 licensed facilities who serve those consumers with primarily mental health and developmental disabilities needs. The community does not appear to need additional .5600 beds for any population other than adults with substance abuse needs. Per the formula developed for child residential services we need approximately fifteen additional Level III residential beds in our catchment. We are currently seeking providers to develop more Alternative Family Living and Therapeutic Foster homes.

Partial Hospitalization and Mobile Crisis Team are the only Medicaid services not currently available in our network. After efforts to locate a Mobile Crisis vendor, the LME has requested and been granted a waiver to establish this service with the plan to transition it to the provider community. Although we would be interested in a provider willing to do Partial Hospitalization services in our area it is unlikely that we will be able to recruit one due to the low reimbursement rate, staffing requirements and low number of potential referrals.

Substance abuse providers, both residential and outpatient are very limited, with one large provider (PORT Human Services) being the primary service provider available within the majority of our catchment area. Several smaller substance abuse providers are endorsed, but do not have significant capacity to assist us in meeting the penetration and timeliness of service requirements indicated in the Performance Contract. We have implemented a loan repayment

program as a recruitment tool to assist in staff recruitment efforts for agencies that provide Substance Abuse treatment options.

Consumer choice is limited with State-funded services more than with Medicaid services. All State-funded services in our network have at least two providers with the exception of Psychosocial Rehabilitation. We currently have only one Psychosocial Rehabilitation provider who has facilities in both Wilson and Rocky Mount for both State and Medicaid funded consumers. Due to the number of consumers required to make this type of program a break-even fiscal operation it is unlikely that we would be able to recruit another provider.

Mental Health and Substance Abuse Outpatient Therapy, Community Support, and Diagnostic Assessment for State-funded consumers are available in all counties. Our smallest county, Greene, with a population of only 20,000 individuals, struggles with recruiting additional providers for outpatient therapy. To assist with this we maintain referral information, Memorandums of Agreement, etc with providers in Greenville and Kinston. Both of these cities are within the thirty minute, thirty-mile radius of much of Greene County.

The Beacon Center is not processing any applications for Community Support providers at this time. An analysis of our network indicates that the current capacity of providers can adequately meet consumer need.

The provider community delivering Medicaid and state-funded services and supports for Beacon Center consumers is very diverse, encompassing large, multi-corporate entities as well as numerous small "Mom & Pop" operations. Many of our providers have been very successful at recruiting minority and culturally competent staff with African-American population. There is a need to recruit more providers with expertise and cultural competency with our Hispanic population. This becomes more critical as we make a concerted effort to increase outreach efforts in the Hispanic community.

Provider resources are also being examined on not only an LME but also a regional basis. We have compiled a listing of those providers within the Eastern Alliance LME's, indicating who we have as common providers and also those that service only one or a few Eastern Alliance LME's. This data is important as we move to a regional monitoring model and in our efforts to recruit new providers.

The provider network continues to struggle with performance of first responder duties. The LME will continue to conduct education programs on crisis plan development and crisis services to positively impact the number of admissions to State facilities.

Technical Assistance

The Provider Relations Department has held monthly provider meetings on the fourth Monday of each month since July 2005. The attendance averages between 80-100 individuals representing the full range of community partners and services delivered to our consumers. Our provider community extends an open invitation to consumers and CFAC members who have an ongoing presentation slot at the provider meetings. Monthly provider meetings are crucial for the dissemination of information, handouts, policy and procedure clarification, getting technical assistance, providing Division updates, offering a forum for provider input, feedback, questions,

and concerns, as well as providing specific and ongoing training. The provider agenda and presentations are the result of the combined efforts and input from every LME department to ensure the full range of up-to-date information available to our consumers.

In addition to specific provider trainings, training has also been provided on the following topics: *Understanding State Requirements for Insurance* by consultants of the Citizens Insurance Group; *Working with People who are Deaf and Hard of Hearing* by Stephanie Johnson, Regional Deaf Specialist; *How to Access and Navigate the Division and LME Website* by LME staff; *How to Put Your Provider Information on our Website* by the LME staff; *NC Provider Council and What it Can Do for You* by English Albertson of the North Carolina Provider Council; *Incident Reporting* by LME staff; *Screening/Triage/Referral Train the Trainer* by LME staff; and *National Accreditation and How to Obtain This* by Sue Creighton. The LME Provider Relations staff in concert with the QA/QI staff and Consumer Affairs has also developed an ongoing training curriculum to address items that have been identified as technical assistance focus areas as a result of provider endorsement and monitoring activities. This curriculum will be reassessed on an annual basis to assure that it meets the needs of our providers, focuses on areas identified in the Community Development Plan, consumer advocacy data from incident reports, SB 163 monitoring results, etc. First Responder capability has been a focus of technical assistance in training for our provider network. We have also developed and implemented a model for potential statewide replication of a First Responder Capability mystery-shopping project. CFAC membership was utilized to review this to assist with our First Responder mystery-shopping project.

We will be working with our Eastern Alliance partners to broaden our focused technical assistance to a more regional platform. The first of these Regional trainings will be held in February 2008 and focus on assisting our Provider Network with obtaining National Accreditation.

The Beacon Center has a comprehensive Provider Manual that is available at the time of contract renewal or initiation. The Manual is also available for download on our agency website.

Technical assistance areas identified for emphasis are improvement in the quality of the PCP and in particular, the area of Crisis Planning, housing, employment and education; obtaining accreditation and the establishment of operational consumer rights committees.

The Provider Relations staff will be working with the IT department and others to update the organization's website so that it is provider, consumer, staff and stakeholder friendly.

Community Development Plan

The Provider Relations department take the lead in the process in which other LME departments, consumers, families, providers and community stakeholders, assesses data regarding current availability of providers/services and the needs that exist in the community. Input gathered from consumers, families, providers, community partners, fiscal data, penetration statistical data, etc is used to develop at plan to address identified gaps. The Community Development Plan is reviewed annually and adjusted accordingly. After review of the recently released draft version of the Plan format we are in negotiations with our local AHEC to conduct some of the activities associated with the Plan. This will minimize the possibility of a bias outcome in some of the

activities, i.e. focus groups, surveys. This plan will be the road map for provider recruitment efforts, increasing the number and types of evidence-based services and improving the crisis response network in our area.

Provider Contracting

Provider contracting for state-funded services is initiated through the Provider Relations department in conjunction with Finance Department. Insurance monitoring for contracts affiliates, as well as corporate providers located in the catchment area is monitored for continuation of coverage. Providers who wish to provide Medicaid Enhanced Benefit services must submit a letter of intent stating which services they wish to provide. The Beacon Center complies with the requirements specified in Communication Bulletins issued by the Division concerning endorsement flow, process, and timelines. The Provider Relations department as part of their monitoring responsibilities conducts sub recipient grantee monitoring.

Arbitration/Resolution of Provider Complaints and Grievances

The LME has established written protocols for dispute resolution and communicates these protocols in written form with providers at the time of their endorsement and/or contracting with the Local Management Entity. These policies and procedures are spelled out in the Provider Manual. Policies and procedures of the LME comply with those established by DMA and DMH for these activities. Statistical data regarding provider and consumer complaints and grievances is shared with the Area Board and CFAC at their meeting.

<u>Strategic Objectives</u>

Objective **Indicates an Objective tied to a Community Systems Progress Indicator	**Responsible Party (Bold) and other Participating Groups**	**Targeted Completion Date**
Assess the currently used Provider Training Curriculum and quarterly Provider Training content to assure that it promotes Evidence Based Best Practice principles and insures that First Responder and Crisis Plan development and implementation activities are represented.	**Provider Relations Director,** Quality Management, Screening/Triage/Referral, Care Coordinators	9/1/08
Develop and implement improvements to The Beacon Center website making more user friendly as reported by our consumers, families, providers and community partners to navigate.	**Information/Technology Director,** Provider Relations, Consumer Affairs, Screening/Triage/Referral, Consumer/Family Advisory Council	9/1/08
Development and implementation of a web based tracking system for vacancies in residential facilities in our catchment area	**Information/Technology Director,** Provider Relations, Eastern Alliance Membership	7/1/09

Objective **Indicates an Objective tied to a Community Systems Progress Indicator	Responsible Party (Bold) and other Participating Groups	Targeted Completion Date
initially and then in the Eastern Alliance geographical area.		
Develop and implement an annual Provider Survey to determine satisfaction, needs, etc.	**Quality Management Director,** Provider Relations	7/1/08
Develop and implement an annual Community Development Plan in collaboration with providers, community stakeholders, consumers and their families to identify capacity issues, service gaps and potential areas of expansion with particular focus on those areas that we need to increase our treated prevalence percentage.	**Policy Compliance Director,** Provider Relations, Consumer Affairs, Consumer/Family Advisory Council, Area Director, Area Board, Community Partners	12/1/08 ** 1.4,1.5,1.6
Develop and implement strategies to stabilize the Provider Network through the use of fiscal data, consumer input, provider feedback and stakeholder input.	**Provider Relations Director,** Consumer Affairs, Business, Information/Technology, Providers, Community Stakeholders, Consumer/Family Advisory Council	12/1/08
Develop educational and incentive strategies with the Provider Network to reduce State Hospital Admissions and lengths of stay.	**Care Coordinator Staff,** Provider Relations, Business, Providers, State Institutions	12/1/08 ** 3.0
Facilitate the Provider Council in becoming a Provider managed venue as evidenced by the provider's setting the agenda, running the meeting and establishing functioning committees.	**Provider Relations Director,** Providers	12/1/09
Develop and implement strategies to increase provider network capacity to assure that urgent and routine requests for services result in a "face to face" contact occurring in the timeframes indicated in the Performance Contract.	**Screening/Triage/Referral Director,** Provider Relations, Providers	2/1/09
Develop and implement strategies to improve the quality of Person Center Plans, stressing the importance of Crisis Plans, housing, employment and education.	**Utilization Management Director,** Consumer Affairs, Consumer/Family Advisory Council, Providers, Provider Relations, Care Coordinators	7/1/10

Objective **Indicates an Objective tied to a Community Systems Progress Indicator	Responsible Party (Bold) and other Participating Groups	Targeted Completion Date
Develop and implement a recruitment program with the Provider Community that resulted in an increase in the number of Substance Abuse provider staff so that treatment prevalence rates and timely initiation and engagement in services percentages met state performance standards.	**Provider Relations Director,** Area Director, Screening/Triage/Referral, Medical Director, Human Resources	7/1/11 ** 1.5,1.5, 2.3 a/b, 4.1
Develop and implement strategies to increase timely submission of STR's, PCP's and incident reports from providers.	**Screening/Triage/Referral Director,** Quality Management, Utilization Management, Provider Relations, Providers	7/1/09

Resource Allocations

The Cost Model allocates 8.4 FTEs for this function. Organizationally we have placed one Department Head over the staff of Provider Relations and Quality Improvement Section of the organization. We saw a conflict of interest in placing our Consumer Advocate function in the Utilization or Screening, Triage and Referral departments. For this reason, we have placed the Consumer Advocate under the direct supervision of the Policy and Compliance Director. The majority of Consumer concerns we receive center around provider and quality of care issues resulting in a good flow of information between the staff performing these three functions. Another significant organizational consideration is the function and role of the Provider Relations staff and the Quality Improvement Section in the team performance of the endorsement and monitoring activities. The primary function of the Provider Staff is enrolling the provider into the LME network. This includes endorsement activities, enrollment of non-endorsed providers into our network, communicating information to providers and the provision of technical assistance. In Provider Relations are 6.5 of the 8.4 allocated staff in the Cost Model. They are the following: One Department Head, one Office Assistant IV, four Quality Assurance II positions and .5 of an Office Assistant IV-Medical Records FTE who assists providers with documentation issues that inhibit or jeopardize network participation or endorsement compliance. The Provider Relations budget is $506,747, the cost model allows $551,368 for this function.

Business Rules

Current endorsement requirements do not place enough emphasis on quality measures on the front end, resulting in an agency being able to obtain endorsement but not have the quality standards our consumers seek.

Licensed 122-C residential providers should not be exempt from core rules study unless license has been obtained in the past 12 months.

No standardized statewide provider report card that communicates quality status to consumers, families etc.

Recent Endorsement policy to hold any processing of Community Support Endorsement applications is a step toward stabilization of the Provider Network statewide and in LME.

Standardized Frequency of Monitoring (FEM) document will result in increased standardization of monitoring across LME's.

We have good attendance at the monthly Provider Meetings and see a trend in providers being more willing to share good business practices with each other. Their willingness to develop less of a competitive and more of a collaborative relationship with each other will assist the movement to the comprehensive service provider model.

CHAPTER 4

CUSTOMER SERVICE / CONSUMER AFFAIRS

Mission

It is the mission of the Customer Service/Consumer Affairs department to ensure that consumers' voices are heard and responded to; that the consumer family and providers have an avenue for voicing complaints and concerns; and to promote within the public, information about services and related consumer rights.

Purchaser Standards

The Beacon Center is guided by and complies with all applicable Local, State, and Federal Rules, mandates, and laws including but not limited to those outlined in the Local Business Plan template/Communication Number 68.

Current Operation

Support to Committees and Consumers/Families

Consumer Services and Affairs staff members are available through an 800 number for ease of access to those we serve. In addition to providing assistance with consumer, provider and stakeholder concerns, they are assigned as the liaison to the CFAC. This support includes not only attendance at the CFAC meetings, but also assistance with compiling requested information, providing a detailed report of incidents and client rights impacting events, and acting as a conduit of communication for training opportunities. The Consumer Advocacy section of the LME also provides assistance with the coordination of travel and stipend reimbursement for consumers. Training given to CFAC has involved evidence-based practice and clinical practice standards for various services, information on understanding how to read/interpret data and quality reports issued by the LME, Division, and other community partners, information on client rights for not only the LME, but other institutions and agencies within our community. The CFAC has a Relational Agreement with the LME, an adopted set of bylaws, establishes and maintains oversight of its budget.

Consumer Affairs staff serve as liaison to the Client Rights committee. The committee meets at least once each quarter in accordance to with State requirements to review data from incident reports received and identifies trends and patterns that may require further investigation by the LME. This group looks at possible rights violations and appropriate action(s) with regard to identified trends. The group is composed of LME staff, providers, consumers, families, community agency representatives.

Both the CFAC and Client Rights Committees serve as advisory groups to the Area Board. Minutes from each of these groups is provided to the full Board.

Future efforts of the Consumer Advocacy department will be focused on assisting CFAC with increasing the number of regular attendees to their meetings and increasing the number of substance abusers and Hispanic consumers in participating in consumer activities. Another strategic objective for the organization is to have a stronger consumer voice in non- CFAC activities, i.e., WRAP activities, CIT, Family-to-Family activities, conducting satisfaction surveys. The Consumer Affairs staff will take the lead to promote WRAP activities in the community.

Appeals and Grievances

Our Consumer Affairs/Customer Service staff is available telephonically and face-to-face to discuss with consumers, family members, and providers regarding their complaints and concerns. These complaints and concerns not only involve non-Medicaid appeals, but also providing assistance with navigation of Medicaid appeals. The LME has a non-Medicaid appeals process that complies with Bulletin #38. The non-Medicaid Consumer must appeal within 11 days of the date of denial, reduction or suspension of non-Medicaid services. There is then a review by the Medical Director or designee in accordance with the policy and if the Consumer continues to be dissatisfied, it then goes to the Division for their opinion. The final decision rests with the LME. They are involved in arbitration with consumers and providers, and act in the role of support for consumers and families at the request of family members and consumers. The Consumer Affairs section of the LME registers complaints, follow-up efforts, and the outcome of the complaint. Trend data is compiled and shared with the Area Board, CFAC, Administration, QA/QI and Provider Relations staff so that appropriate follow-up monitoring can occur. Anyone may file a complaint with the department in writing by fax, email, telephone, or face-to-face. The Customer Service department also has procedures to manage complaints regarding the LME.

System Navigation

Consumer Affairs is available to assist consumers with navigating the system and providing information on how to access services. They are instrumental in working to transition consumers to a new provider in the case of withdrawal of endorsement or loss of licensure of a facility. They also work with their counterparts with other LME's across the State on transition of their consumers who may have services provided by providers who have lost their endorsement/license within the Beacon Center area.

The Consumer Advocacy staff along with Utilization Management staff and other partners will be conducting training to increase consumers and families understanding of the role that the PCP plays in service authorization, delivery and crisis planning. By educating these groups, we hope to see quality of plans improve and crisis plans be more consumer specific.

Customer Services and Rights

This section has developed a brochure that they utilize in education and outreach for families, consumers and stakeholders in the community regarding what are the rights of consumers and families, the process for complaints, opportunities for advocacy and empowerment, and assistance with navigating the service authorization procedures. Trainings have been held at advocacy group meetings, community groups, as well as CFAC. Consumer Affairs specialists have also presented at multiple support groups, mental health task force meetings, and consumer

run group events and interagency meetings. The Consumer Affairs contact information and brochure is also available on the website. Frontline staff of the LME have been orientated and trained to forward all calls for Consumer Affairs specialists for immediate attention when concerns are expressed regarding appeals, grievances, systems navigation, or consumer rights. A letter is sent to all complainants informing them of their rights and the process. Staff attempt to work with the complainant and other involved parties to resolve the complaint through an informal agreement, mediation. Sometimes, their investigation will result in a full SB163 monitoring, which is completed by the QA/Provider team. Letters are sent to complainants to notify them of the outcome and/or resolution of any complaint filed. When indicated, referrals are made to the Division of Health Services Regulation or DHHS. Our complaint policy can be found on our website, provider manual and in the previously mentioned brochure.

Incident Reporting

The Beacon Center reviews and monitors incident reports within the catchment area and for consumers residing outside the catchment area to assure that appropriate treatment and to assure the rights of all consumers are protected. This review of reports submitted by providers is to ensure completeness, accuracy, and the possible need for future action by The Beacon Center. Providers are required to submit incident reports for review. A compilation of incident reports and trends are provided to CFAC at their monthly meeting, and additionally to the Area Board at their meeting. Quarterly reports are submitted to the state for all incident report data collected over a three-month period. This trend pattern and action taking by the LME is also reported.

Consumer Satisfaction Survey

This section has administered surveys to assess consumers' knowledge and satisfaction with the process and the supports that they receive. They are also pivotal in our mystery shopping surveys involving consumers and families to assess the appropriateness of first responder and emergency crisis response of network providers. Consumer satisfaction surveys are conducted annually based on a State approved tool. The Beacon Center has a history prior to merger and has continued that pattern post merger of submitting more than the required number of surveys established by the Division. We also conduct surveys of consumers about their satisfaction with the LME, Provider Network, identified needs, gaps, etc. The CFAC is used to gauge the consumer friendliness of all surveys.

Strategic Objectives

Objective	Responsible Party (Bold) and other Participating Groups	Targeted Completion Date
Develop of an education and outreach curriculum for consumers and stakeholders about complaint procedures and how to access services.	**Consumer Affairs Staff,** Screening/Triage/Referral, Consumer/Family Advisory Council, Community Stakeholders	12/1/08

Objective	Responsible Party (Bold) and other Participating Groups	Targeted Completion Date
Assess the current system of reporting to CFAC and the Area Board complaints, incidents, provider-monitoring results to assure that indicated strategies are developed and implemented to assure that services are provided in a manner that promotes recovery, is consumer focused and assures safety and well-being.	**Area Director,** Area Board, Provider Relations, Quality Management, Consumer Affairs, Consumer/Family Advisory Council	4/1/08
Increase the number of Wellness Recovery Action Planning (WRAP) activities by 50%.	**Consumer Affairs Staff,** Area Director, Consumer/Family Advisory Council,	12/1/08
Develop and implement an education and awareness campaign involving consumer participation to emphasis the role that stable housing, employment and education plays in treatment, recovery and self determination.	**Care Coordinator Staff,** Consumer Affairs, Area Director, Consumer/Family Advisory Council, Housing Coalition Partners, Vocational Rehabilitation, Supportive Employment Providers, Providers	7/1/10

Resources Allocation

The Cost Model allocates 3.27 positions for the functions described in the Consumer Affairs and Customer Services section. The LME currently is within the 30 percent variance with 2.5 positions. The positions comprising this function in our organization are two Consumer Advocate positions and .5 of an Office Assistant IV position. The remaining part of this .5 FTE is funded with Quality Improvement funds resulting in a full time Office Assistant IV position. The budgeted amount for this section is $158,785.

Business Rules

The LME cannot share information with DHHS regarding a DFS investigation until the Plan of Correction has been filed and approved.

The System of Care positions are critical positions to promoting SOC philosophy in the community but with mergers larger geographical areas sometimes results in limited staff resources for the need.

Standardized surveys for statewide use – (Quantity vs. Quality) – would be welcome in our provider community and would result in the capability to do cross LME comparisons.

The Division is developing an electronic filing system for incident reporting. This will be an enhancement; however, there will be a great deal of training that will need to occur to ensure all Providers are submitting the required data.

The frequency at which change is occurring in the system has resulted in families, consumers, providers and stakeholders often being unclear as to which rules and regulations apply to their particular situation.

STR functions being done by the Provider community and not quickly communicated to the LME results in difficulty in assisting consumers with complaints.

CHAPTER 5

SERVICE MANAGEMENT

Mission

The Beacon Center will ensure appropriate and timely access to all services 24/7/365 by a uniform portal of entry. Through care coordination, we will modify plans for effectiveness and positive measurable outcomes that will better serve high cost/high risk consumers. The appropriate level of care and intensity of services will be monitored through a Utilization Management process that is consumer focused, evidence best practice grounded and fiscally responsible.

Purchaser Standards

The Beacon Center is guided by and complies with all applicable Local, State, and Federal Rules, mandates, and laws including but not limited to those outlined in the Local Business Plan template/Communication Number 68.

Current Operation

Care Coordination

The Care Coordinators not only work with consumers until they can be connected to a service provider but they also serve in a monitoring role with our high risk/high cost consumers. Care Coordinators are responsible for ensuring that all consumers admitted to Cherry Hospital are connected with a provider prior to discharge and that the consumer has sufficient supports and services to be successful in their transition to the community. Each workday morning, the care coordinators receive an electronic transfer from the State hospital indicating consumers admitted from our catchment area on the previous day. After screening our system, if the consumer does not have a provider, contact is made by the care coordinators with the hospital to determine if a provider has already been identified and, if not, to assist in securing a referral to a provider. Providers who have hospitalized consumers who are assigned to a provider already will be assuming the lead in discharge coordination. For consumers that have been long-term hospitalized at Cherry Hospital, care coordinators are involved with hospital staff to discuss transition. The Coordinators represent the LME at onsite treatment team meetings for those consumers who are in placements at Caswell Center. The Care Coordinators will track readmits to Cherry Hospital and assist providers with developing a plan of care for these consumers to increase the likelihood that they will be successful when they return to the community. Care Coordinators also contact consumers who have not followed up with a provider after assignment has been made. We have Care Coordinators with expertise in Mental Health and Substance Abuse consumers, both adult and child/adolescents. We are currently seeking a Care Coordinator with expertise in the area of Developmental Disabilities.

Care coordinators are also involved in activities involving individuals assigned as wards of the Area Director through the guardianship process who do not have assigned clinical home or case management providers.

Community Collaboration/System of Care/CAP-MR-DD Waiver

In addition to our care coordination efforts with high risk/high costs consumers and those in adult populations, we have numerous informal efforts in our community to promote System of Care philosophy; there are a number of formalized initiatives. These include the Child/Adolescent Community Collaborative that represents all four counties. This collaborative resulted when the two Community Collaborative groups representing Wilson-Greene and Edgecombe-Nash merged. In addition, an Interagency Council represents the four counties and focuses on the needs of citizens in our community with developmental delays. This Council uses a rating and evaluation scale that for identifying consumers who are potentially eligible for CAP waiver slots. The Interagency Council uses the evaluation scale to determine consumers acuity and ranking on the waiting list. System of Care for children has been a philosophical pillar for a significant period in our communities. As an original System of Care site in North Carolina through the PENPAL project, we have demonstrated a long history of active child collaborative efforts. This collaboration and philosophical underpinning for services to children in our area is strengthened by the existence of two funded Child and Family Teams in our catchment area: one in the Nash Rocky Mount School System and the other is in the Greene County School System. We have staff identified and dedicated to these Child and Family Team initiatives, the System of Care initiative for children, and function as the liaison to the Community Collaborative. We would like to expand System of Care philosophy outside the realm of children's services to involve our adult consumers.

Concurrent Review of Medicaid Covered PCP's

Utilization Management staff and Care Coordinators are responsible for reviewing PCP's and Plans of Care for Medicaid, as well as non-Medicaid recipients. Review of these plans includes quality of plan criteria, evidence of person-centeredness and the use of those principles, use of natural and community supports and their adequacy, and most importantly, adequacy of the consumer's crisis plan. This review can result in referral to Care Coordination in the case of our high risk/high cost consumers and/or referral to Value Options with concerns over plans that seem to be inconsistent with the level or type of service(s) indicated. These positions along with Care Coordinators in the Access/STR unit will review Provider submitted PCP's for quality, accuracy and evidence of adherence to best practice principles in plan development and implementation. Post Payment reviews are conducted by clinical staff in the UM staff.

Utilization Management and Review of State Dollars

Utilization Management Unit performs utilization management for non-Medicaid Consumers. In carrying out the function of authorization of services for non-Medicaid Consumers, the LME has a UM Unit that consists of 2 Clinical Staff that are reviewers, 1 support staff and a Director that oversees the operation of the Access/STR Unit. Providers use a standardized web based system, which includes the functionality of uploading the PCP, in making requests for the State Funded Services. The request for services is usually processed in 1-2 working days within receipt. If there is insufficient information, additional information is requested by the reviewers. If the request does not meet medical necessity or Level of Care, the request is denied. After the data is received and reviewed the provider receives an authorization electronically to continue or initiate services as indicated in the plan. Authorization periods depend on the type of service, needs of

the consumer, and availability of funds. Typically, the initial authorization is a period of 30 days, but authorizations may be granted for 60 or 90 days. A basic benefit package has been established for consumers. Since our merger we have tracked units of service authorized and claimed and in the future will be adjusting our benefit package in light of the data obtained. Care Coordination and Utilization Management work jointly for the authorization utilization of State psychiatric inpatient beds and ADATC, as well as private hospital beds that we pay for through contractual agreements.

Our Utilization Management representatives are the staff liaison to our DD Interagency Council and are responsible for the authorization process that involves community collaborative input to determine CAP waiver recipients. Demographic data that is required for CDW from PCP's is accessible to our Utilization Management staff, and is keyed into the data system by Medical Records data staff for transmittal to the State.

While use of IPRS dollars was lower last fiscal year than in previous years it is felt that this is a result of service divestiture and will increase now that the system has stabilized. Understanding and knowledge of Medicaid Services has been a provider priority, while knowledge and understanding of State services has taken a back seat. It is anticipated that LME technical assistance and training for State Services for providers will continue to grow.

At the time a service is denied, suspended, reduced or terminated, the LME notifies the Consumer of the same in writing and explains the appeal process, along with an appeal form that he/she may elect to use. The non-Medicaid appeals process complies with Bulletin #38. The non-Medicaid Consumer must appeal within 11 days of the date of denial, reduction or suspension of non-Medicaid services. There is then a review in accordance with the policy and if the Consumer continues to be dissatisfied it then goes to the Division for their opinion. The final decision rests with the LME.

The UM staff along with the Consumer Advocacy staff and other partners will be conducting training to increase consumers and families understanding of the role that the PCP plays in service authorization, delivery and crisis planning. By educating these groups, we hope to see quality of plans improve and crisis plans be more consumer specific.

Community Collaborative

Community Collaborative has been a long-embraced philosophy of our agency and our community. There is a community culture in which agencies work together to provide services to the citizens in our area. Both formal and informal agreements and communication protocols have been adopted among the community for partnerships involving various initiatives and projects. The Beacon Center participates in many committees and task forces, and has representatives serving on many boards in the local community and in the region. These boards include not only client disability specific initiatives, but also other agency initiatives that impacted the consumers that we work with. For example, Smart Start committees for Wilson and Edgecombe-Nash counties; Juvenile Crime Prevention committees for Edgecombe, Nash, Wilson, and Greene counties; Mental Health Association activities in Edgecombe, Nash, Wilson, and Greene counties; Healthy Community Task Force in Edgecombe and Nash counties; and Child Protection and Fatality review teams in our four-county catchment area, local disaster planning teams, transportation and housing partnerships, etc

The Service Management staff is involved with the Community Development Planning process outlined in Administration/Governance and Provider Relations section of this plan. They are also essential in our community awareness and anti-stigma campaign initiatives.

Screening Triage and Referral (STR)/Access to Care

Staff screen, triage, and refer consumers through a toll-free telephonic Access unit. When a Consumer calls or presents to the Access office, the STR staff utilize the screening tool developed by the Division to determine if the consumer's needs are emergent, urgent or routine. Information regarding the consumer, service need and provider of choice data is collected and entered into the HSIS information system. The time of request, time the determination of care that is needed, the referral and the time of the access to face-to-face emergent care is entered and can be retrieved for data collection. Access and referral to care are established by standards for the consumer to be seen in 2 hours for emergent situations, 48 hours for urgent situations, or 10 days in situations where a routine need is identified. The call center also refers callers who do not meet target population criteria to available community resources. Access offers consumers a choice of providers and is able to do a "warm transfer" of the call to the provider of choice so that an appointment can be scheduled. We are in the process of implementing in the winter of 2008 a Calcium scheduling product, which will allow more rapid access to available provider appointment times. We will be using Trust Fund dollars as an incentive for providers to use the Calcium system. Access also has staff available to see consumers face to face in the LME office if needed. We currently maintain contractual agreements with two providers who have physician access to see our emergency status consumers. During afterhours, we contract with Holly Hill Hospital to provide our STR function. They are able to electronically access crisis plans, make appointments for our consumers with providers and transmit call data to us the next working day via ProviderLink.

Once we have operationalized our Mobile Crisis team, they will be able to be dispatched to meet with the person face-to-face in the community rather than needing to be seen at the provider's office or the emergency room. The initial assessment package authorized by the STR unit is driven by consumer need, but may include community support services and clinical evaluation or a basic benefit package. Every effort is made to assure that the consumer receives services in a timely manner within a geographical and mileage distance that meets the 30-minute/30-mile parameter established by the state.

With the geography and rural nature of our catchment area, we want to establish more non-medical face-to-face access points in our rural areas by using our provider network. This will be an initial area of emphasis of the STR staff in the upcoming three years. We are also in discussion with our Emergency Rooms to possibly model a community embedded ER model to address behavioral health crisis needs and therefore reduce ER penetration rates.

Communication with consumers, referral agents, community partners is facilitated due to the LME's access to technology that assist with those who benefit from the use of TTY, video language relay, translation and interpreting services. All Access staff has immediate access to language translation services via Fluent Language services and the LME maintains contracts with local translators and interpreters for face-to-face needs. All LME staff recently underwent training on 711 services available for those with a hearing or speech need.

Registration of Consumers

Consumers who are screened by access staff are entered into the electronic data system at the time of the initial referral into services. Data entered involves not only demographic data, but also reason for referral, provider selected, units approved (if applicable), scheduled appointment time, etc. The provider can then access this data electronically via CareLink. Once they have met with the consumer the clinical record is transmitted via CareLink to the LME. Medical Records staff reviews the data, transmits the admission record data to the State and uploads the PCP for review by Utilization Management staff for access by STR day and after hours staff in the case of emergency.

Consumer Choice

Consumers are given a choice of providers throughout their treatment. If their provider of choice changes once they have initiated treatment, Care Coordination and/or Consumer Advocates are available to assist consumers with changing their provider of choice. Data on selected providers is reviewed regularly to assure that consumers are exercising informed and uninfluenced choice selection of providers. We currently have choice for all State funded services with the exception of Psychosocial Rehabilitation services. In smaller rural sites, the number of available providers is less than that available in the larger population areas, i.e. Rocky Mount, Wilson.

Strategic Objectives

Objective **Indicates an Objective tied to a Community Systems Progress Indicator	**Responsible Party (Bold) and other Participating Groups**	**Targeted Completion Date**
Development of non-medical face-to-face access points throughout the catchment area to increase access to services.	**Screening/Triage/Referral Director,** Medical Director, Area Director	7/1/09
Development and implementation of strategies to inform and empower consumers and families to be active and equal partners in the Person Centered Planning process.	**Utilization Management Director,** Consumer Affairs, Consumer/Family Advisory Council, Providers, Provider Relations, Care Coordinators	12/1/09
Develop and implement an education and awareness campaign to increase penetration rates of the Hispanic community.	**Care Coordinator Staff,** Screening/Triage/Referral, Area Director, Community Stakeholders, Providers, Medical Director	7/1/09
Development and implementation of System of Care for populations in addition to the currently targeted Child MH and SA populations.	**Care Coordinator Staff,** Provider Relations, Providers, Consumer Family Advisory Council, Community	7/1/10

Objective **Indicates an Objective tied to a Community Systems Progress Indicator	Responsible Party (Bold) and other Participating Groups	Targeted Completion Date
	Stakeholders	
Implement of the Crisis Plan as submitted in our Community Crisis Proposal in April 2007 resulting in a comprehensive continuum of crisis services.	**Care Coordinator Staff,** Screening/Triage/Referral, Provider Relations, Medical Director, Providers, Hospital Partners, Law Enforcement, Consumer/Family Advisory Council, Community Partners	12/1/10
Increase the number of housing units available for consumers by strengthening the positive working relationship with the Housing Coalitions in Nash, Edgecombe and Wilson Counties.	**Care Coordinator Staff,** Policy/Compliance Director, Provider Relations, Housing Coalition Partners	10/1/08
Expand and increase the effectiveness of care coordination for high risk/high cost consumers resulting in their needs being met in the least restrictive, clinically effective manner within available fiscal resources.	**Care Coordinator Staff,** Utilization Management	12/1/08 ** 2.2 a/b,2.3 a/b,3.0,4.1 ,4.2
Develop and implement an Integrated Payment Reimbursement System Benefit Package that reflects Evidence Based Best Practices, consumer needs within fiscal resources.	**Business,** Utilization Management, Consumer/Family Advisory Council, Providers	1/1/09

Resources Allocation

The Service Management, Access/STR and Utilization Management Sections of the organization are supervised by one Department head. The Cost Model allocates 3.09 FTEs for the Utilization Management functions in an LME the size of The Beacon Center. In our organization, we have allocated 3.0 FTEs for these functions. These positions are: one Office Assistant IV position, and two Human Services Clinical Counselor II positions. The Access/STR unit currently provides for 10.7 FTEs in the Cost Model. We have a total of 10.5 FTEs to provide this function. This includes one Department Head, five FTEs for after hours STR services through a contractual agreement, four Human Services Clinical Counselor II positions and a Medical Records Assistant IV.5 FTE to assist with the processing of STR data information. This position is also an Office Assistant with the Service Management functions for half of their time to make a full time position. The Service Management functions under the Cost Model allows for 6.34 FTEs. The Beacon Center has 6.0 FTEs allocated to these functions. These positions are: .5 of an FTE classified as an Medical Records Manager I-Medical Records (this position is funded as a full time FTE with .5 of their funding coming from Provider Relations funding), three Human

Services Clinical Counselor II positions, one Medical Records Assistant IV position and one Office Assistant IV position. Our LME costs are within the 30 percent ranged allowed for this function with a budget of $479,413 for Service Management, $463,708 for Access and $183,822 for Utilization Review.

Business Rules

The Federal Confidentiality laws stand in the way of quick Substance Abuse telephonic referrals.

The service definitions for Medicaid drives the State dollar authorization time frames and this does not allow for local discretion. The Division is to develop authorization time frames to use with State Dollars which will be positive if there is local input.

No funding for Community Support while a Consumer is in the hospital or jail continues to be a challenge in some situations.

Allowing the Provider Community to do STR, when this is clearly an LME function according to the SB2077, are creating problems for the consumer. They are often only referred to the services of the "screening" agency and are often not registered with the LME, hampering our ability to appropriately assist the consumer in a crisis.

The LME not being able to control State Hospital admissions from the ER and length of stay contributes to over usage of State Hospitals.

Restriction on the use of whom we can utilize for after-hours STR contractual agreements hinders the LME economically.

CHAPTER 6

QUALITY MANAGEMENT

Mission

The mission of the Quality Management department is to ensure consumer focus, quality, cost effective behavioral health services are designed and implemented by a choice of providers encompassing evidence-based practice protocols that deliver sustainable, functional outcomes for all consumers in our four-county area.

Purchaser Standards

The Beacon Center is guided by and complies with all applicable Local, State, and Federal Rules, mandates, and laws including but not limited to those outlined in the Local Business Plan template/Communication Number 68.

Current Operation

Quality Management (QM) Department is responsible for the oversight of Quality Assurance (QA) as well as Quality Improvement (QI) activities. Our QA/QI Department incorporates and interrelates with all facets of the LME's units/functions and departments. The LME coordinators meet weekly to ensure communication and collaboration in this rapidly changing reform/transformation environment. They also provide data analysis and reports to the full Management Team, CFAC, Administration and Area Board for use in their risk management determination, strategic planning process and to assure compliance with all applicable standards.

The QM section is responsible and must oversee, monitor, and utilize data and complaints about its own LME operations and services as well as those of its providers. Current LME data suggests the most pressing LME issues include a historically high use of State Hospital bed days, more ready access to crisis services and stabilization of the provider network.

Data Analysis / Reports

Providers are required to submit NC TOPPS reports upon admission, at the three-month, six-month and nine-month marks as well as when there is a change in services for all Mental Health and Substance Abuse consumers. Regular reviews of the submissions of these reports are done by the Consumer Affairs Specialist. Follow-up with providers where submissions are incomplete are routinely conducted. Annual reports of this data are required for submission to the Division.

NC Core Indicators Project is conducted annually through the submission of a pre-survey form for the Developmentally Disabled (DD) population. Names are selected at random by the Division and unique ID's are submitted electronically to the LME to distribute to appropriate service providers for completion and submission back to the LME. After review at the LME, the Core Indicators packet is submitted to the Division by a set deadline date.

All outcome instruments implemented by the provider network currently require consistent LME provider notifications/reminders, follow-up, and technical assistance to achieve the State's required timeframes.

The NC-SNAP is a needs assessment tool that is used by Targeted Case Managers as part of the person-centered planning/assessment of need for persons with DD. NC-SNAPs are submitted by providers to the LME and the results are then submitted monthly to the Division electronically. Currently, the provider network is more consistent in providing the NC-SNAP data. However, this may be due to the smaller number of providers for DD services compared to the substantially larger number of providers for the other disabilities. Current issues and trends center around utilization of the NC-SNAP instrument in conjunction with appropriate service planning commensurate with needs as identified, rather than timeframes and submission.

Service utilization patterns for IPRS uses are available through standard Statewide IPRS reports as well as custom reports that allow data from the CSM system to be analyzed. We can pull IPRS authorized units, encumbered amounts, billed to authorized units, etc on a daily basis. These use reports are accessible to the end user at the LME through a custom report link on their system. This "quick access" by the user feature allows data to be more quickly analyzed and any corrective actions put in place quickly.

Hospital utilization reports are downloaded from the FTP secure server by the IT department and reviewed by the Care Coordinator staff and Management Team. Significant for the first two quarters of this fiscal year we have 202 less admissions than in the previous fiscal year. Bed days for inpatient stays at private psychiatric facilities that we have contracts with is managed electronically through the Carelink system. Custom reports allow us to track the number of days authorized and those remaining on the contract.

Compliance reports that are generated by the Division and Department are distributed to Management Team members who then route the data to their respective staff for review and trend reporting. Areas of noncompliance are reported to the Area Board with a corrective action strategy plan. The data system is fully automated allowing for quick and accurate reporting of mandated data.

Critical Incidents: Individual Incident Reports (Level II and III) submitted by the provider agencies are reviewed by the Consumer Advocate and QM staff to determine timeliness of submission, appropriateness of response, follow-up actions needed, and on-going health/safety/wellbeing issues. Reports are made to the LME Client Rights Committee to assist in identifying trends and making recommendations. Quarterly submission of Level I reports are made to the Division and currently, QM has identified ongoing quarterly Incident Report training as the number one need in training and technical assistance for our provider network due to the inaccurate, problematic and relatively few incident reports currently received. Training and quarterly reminders to providers have helped to improve/increase timely reporting. However, accuracy remains poor overall and this element is crucial for the LME to complete and utilize data analysis for our LME to identify trends and complete strategic planning to meet the ongoing issues in our catchment area.

Planned restrictive interventions are reported to the LME when Quarterly Incident Reports are submitted by private providers. Effective 1/1/07, providers are required to notify the Consumer

Affairs Specialist of any consumers record numbers that include planned restrictive interventions for review and any needed follow-up by the Client Rights Committee and Medical Director if/when warranted.

The Consumer Affairs Specialist conducts consumer complaint reporting data and monitoring. Complaints are divided into two separate areas (those involving consumers and those involving provider vs. provider). Complaints are documented and reviewed during staff meetings, Quarterly Client Rights meetings, annually by the Area Board as well as monthly CFAC meeting to determine the possible need for technical assistance and/or arbitration. Current data demonstrates that there is a marked increase of over 300% of consumer complaints since Enhanced Service implementation and service divesture. This data is required to be reported to the Division quarterly and on a case-by-case basis if consultation is needed. General areas of the nature of complaints to date include: Client Rights violation/HIPAA violations, timeliness of services, courtesy, ethical issues, allegation of abuse/neglect/exploitation by staff.

Provider vs. Provider complaints are handled by the LME's Policy/Compliance Department where complaints have centered around unethical conduct reports and billing issues resulting from clinical home providers failing to meet UM guidelines thereby resulting in inability of service providers to bill and receive reimbursement for services rendered. The Policy Analyst serves as the provider grievance/appeals portal and arbitrator. In addition, the Policy and Compliance Department is responsible for interrelating with QM to ensure LME compliance with HIPAA, National Accreditation, Performance Agreement, as well as Policy review and maintenance. Conflicts of interest are reviewed in this LME department to ensure prohibition against conflicts of interest involving the LME Board, its employees as well as providers.

Service provider monitoring addresses the requirements as set forth by the Division as identified in and through a variety of State Statues, Bills, Bulletins, Implementation Guidelines, MOAs, etc. that establish the basic rules, regulations and guidelines that govern service provision. Provider monitoring per SB163 has historically been scheduled on an annual basis; however, currently at this stage of reform, consumer complaints are driving the monitoring and follow-up schedule. Our LME has developed a draft monitoring tool as well as a Pre-Monitoring Worksheet to be completed by the provider prior to the scheduled monitoring visit to identify the services provided, number of consumers, out of catchment consumers served, etc. Each provider is assigned a QA/QI consultant that provides individualized technical assistance and support. If/when the Consumer Advocate identifies or substantiates a consumer grievance/complaint involving a provider, the QA/QI team determines jointly if more intense monitoring is warranted and the assigned consultant provides any follow up required. Certified letters of Notification of Out-of-Compliance issues detail any and all areas needing Plans of Correction and follow-up may be provided within 30, 60, or 90 days depending upon the seriousness of the out-of-compliance. Notification to DFS is made of results involving 122-C licensed facilities to not duplicate regulatory monitoring and required oversight. Monitoring reports are submitted to the Division monthly. SB163 Monitoring results in the scoring of Confidence Grids that ultimately determine the frequency, intensity and technical assistance required. Our department uses the process of evaluating our Provider Network in relation to statewide criteria of High, Medium and/or Low Confidence ratings of each provider and determining guidelines for monitoring frequency based on a variety of indicators and data.

Consumer satisfaction surveys are conducted annually based on a State approved tool. The Beacon Center has a history prior to merger and has continued that pattern post merger of submitting more than the required number of surveys established by the Division. We also conduct surveys of consumers concerning their satisfaction with the LME, Provider Network, identified needs, gaps, etc. The CFAC is used to gauge the consumer friendliness of all surveys.

Quality Assurance / Quality Improvement

Ongoing and frequent monitoring is an integral part of Quality Assurance. The Quality Management section reviews service providers in response to incidents, crises, and complaint issues. They report on service system compliance, trends, and analysis of these trends. They also monitor First Responder capability. This most recently was done as a part of our modeled First Responder mystery shopper program. Our Quality Management team through our basic and enhanced curriculum to address areas identified through monitoring and analysis efforts provides technical assistance. Quality Improvement involves continuous efforts for progress toward successful care, with measurable and obtainable goals. The QM department collaborates with many internal departments, such as Provider Relations, Customer Service, Information Technology, Compliance, Business Administration, along with CFAC, and external stakeholders, to achieve a total quality framework for every level, which assures that Quality Assurance and Quality Improvement work hand in hand. Quality measurements include consumer satisfaction surveys and assistance with consumer services through the complaint and incident review to assess satisfaction within our consumer community.

Five (5) QI Studies have been completed annually by the QA/QI Department and an analysis of each has been submitted to the Division, shared with CFAC and at provider meetings. To date, two provider mystery caller studies have been initiated to determine the percentage of clinical home providers in our network whose required after-hours crisis response plans were effective. The first study revealed approximately 40% of providers had effective first responder plans. After LME implemented strategies, a second study showed a net increase of 16% where approximately 60% of providers had an effective after hours/crisis response. Ongoing studies are planned in this area and strategies have been developed to increase the level of appropriate first responder response. Provider QI/QA studies and committee operations are a focus on monitoring during onsite visits. Trend analysis of our provider network reveals that providers have these activities on paper but struggle with actual operation. To assist with this issue the LME has developed a training curriculum that clarifies the requirements and strategies make move paper to practice.

The analysis of prevalence data indicates that the LME needs to increase service contact with substance abuse consumers, both adults and children/adolescents. We are working with our Substance Abuse providers to increase capacity by increasing recruitment incentives they can offer and by educating referral agencies on how to access services for these populations.

The LME's Management Team serves as the central point of review for the evaluation of current LME performance by its various Departments. Compliance areas that meet as well as those that do not meet expected outcomes are reported to the Area Board and the two advisory Boards, CFAC/Client Rights. The Management Team presents to the Area Board for review, plans of Correction for identified noncompliance areas.

The provision of more Evidence Based Services by the Provider Network is a strategic objective for the upcoming three years. The Quality Management Department will be developing reports and data driven surveys to assess the current level of these services to establish a base line. After completion of training models of Evidence Based Practice strategies monitoring will be done to assess the fidelity of these programs to the model and to assess the impact of the training on the number of providers available for these services.

Strategic Objectives:

Objective **Indicates an Objective tied to a Community Systems Progress Indicator	**Responsible Party (Bold) and other Participating Groups**	**Targeted Completion Date**
Develop and implement a "provider information tracking system", integrated with the IT systems to promote increased internal effectiveness of provider related activities.	**Provider Relations Director,** Information/Technology, Providers	12/1/08
Identify and address gaps in the local continuum of care by conducting ongoing services gap analysis and implementing data driven service planning and development with emphasis on not only behavioral health services treatment prevalence data, but also educational, employment and housing needs.	**Policy Compliance Director**, Quality Management, Provider Relations, Consumer Affairs, Care Coordinator, Consumer/Family Advisory Council, Medical Director	12/1/09 ** 1.4,1.5,1.6
Identify three quality measures that providers and consumers/families believe are critical indicators of organizational performance and/or consumer outcomes and implement regular measurement and reporting.	**Quality Management Director,** Provider Relations, Consumer Affairs, Consumer/Family Advisory Council, Providers	12/1/08
Develop and implement strategies to assess the timely submission of STR's, PCP's and incident reports from Providers.	**Screening/Triage/Referral Director,** Quality Management, Utilization Management, Provider Relations, Providers	12/1/08
Development and implementation of strategies for completion of Consumer Satisfaction surveys using trained volunteer advocates as facilitators.	**Consumer Affairs Staff,** Consumer/Family Advisory Council	71/08
Review the performance of the organization using the criteria identified in the Community System Progress indicators, Bed day usage and Performance Contract standards. For any area identified as falling below expected performance develop and implement a	**Quality Management Director,** Management Team members, CFAC, Area Board, Community Partners	4/1/08 and thereafter quarterly

Objective **Indicates an Objective tied to a Community Systems Progress Indicator	Responsible Party (Bold) and other Participating Groups	Targeted Completion Date
strategic plan to meet established performance benchmarks		

Resource Allocation

The staff in the Quality Improvement Section are supervised by a Department Head that also oversees the functions indicated in Provider Relations and Consumer Affairs. As stated in the Provider Relations section, this staff performs many but not all of the SB163 monitoring activities described in the Cost Model. variance. We have three QA Specialist II positions for this function and a .5 of an Office Assistant position that is shared with the Consumer Affairs section. The budget for QA is $167,879, the cost model for an LME the size of the Beacon Center is $136,606.

Business Rules

Rating LME performance based on provider compliance with reporting outcomes has been problematic when providers are not meeting basic requirements indicated for NCTOPPS, NCSNAP, etc.

Lack of a Statewide Quality Report Card results in differences in Quality measures between LME's and regional differences in measured performance of Providers.

More LME input is needed prior to development of State policies and procedures to assure that implementation is consistent, realistic in its focus, timeframes, etc.

Access to Paid Claims and Value Options authorization data has been helpful to many levels of the organization. Not having Substance Abuse paid claims and authorization data on a consumer level is a barrier.

The large majority of the Provider Network encompasses many providers who strive to provide services in an ethical, professional, caring and committed manner to our consumers. Staff time and resources are frequently spend disproportionaby on poorer quality providers when "highlighting" best emerging practices for other providers to replicate would be a more desired activity of the Quality Management staff.

Having a Management Team consisting of all Department Heads, Medical/Clinical Director and Administration results in a continues Quality review of the organizations currently level of service and the ability to quickly develop strategies to address identified areas of needed improvement.

QM required projects have been a valuable tool and resource in assuring that best practice standards of performance are met by the LME and the provider network.

Planning Process

The Beacon Center followed the general process outlined in the Pre-Plan. News Releases were sent to the local newspapers and public forums held in each of the Counties involved. At provider meetings, the Local Business Plan was on the agenda and discussed with input from the providers. The Local Business Plan was an item of discussion at each of the CFAC meetings. The interagency meetings addressed the Local Business plan as well as the Mental Health Association. A local peer group of consumers had a presentation and provided input. Drafting Committees had consumers participate and provide input. The Local Business Plan and our strategic objectives were discussed with our partnering community agencies and their input incorporated in this submitted document.

Most all of the input addressed the following:

1. Where do we go to access services?
2. Where do I go in case of an emergency or crisis?
3. We are referred to a provider and no one gets in touch with me, what do I do? Why does it take so long?
4. Travel is always an issue.
5. Whom do we complain to and are the complaints being investigated?
6. Why doesn't the LME make the provider do . . . .?
7. The Schools are having difficulty with providers coming unannounced and knowing who is appropriate and who is not.
8. Law enforcement expressed concerns about who to call and where to take the Criminals when they need care.
9. Law enforcement was concerned as to how the merger would affect them as far as transportation was concerned and their budget for the FY 07-08.
10. Providers were concerned about being paid promptly, about authorizations being timely, paper work, and about providers getting respect and cooperation from fellow providers when a consumer goes from one provider to another.
11. DSS, Juvenile Justice, Health Department and other agencies, all want to know how to navigate the system.

After listening to the community, it appears that a significant focus of our future activities will be educating the consumers, families, and the community as a whole about a service system that is not completely known to them, vastly different from what they have known in the past and in a great deal of flux.

In developing the process each of the Program Directors, in charge of the services involved in each of the Chapters, received consumer, community and provider input while and during the process of writing and preparing their particular chapter. This input was through one to one conversations, smaller focused groups, (i.e. Law Enforcement, Hospital representative), larger meetings, (i.e. provider meetings, CFAC) and written communication. During this task, we feel that we have received sufficient input from a diverse enough representation of our community to accurately identify strategies for the upcoming three years.

After receiving and reviewing feedback regarding our originally submitted plan with our community partners, consumers, staff, providers and Board we eliminated merger activities as the majority of them had been successfully completed, reassessed the current appropriateness of the previously submitted strategic objectives and timeframes and adjusted as indicated.

The focus areas identified in the originally submitted document continue to be the major focus that our partners want our organization to be committed to over the next three years. These are:

- Identify and develop strategies to address gaps in the local continuum of care.
- Reducing the current level of reliance on State Institutional services.
- Successfully implement a community education program that heightens awareness on how to access services and lessening the stigma associated with seeking services for mental health/developmental disabilities/substance abuse needs.
- Maintain financial viability of the organization.
- Provide rapid telephonic and face-to-face response to citizens in crisis.
- Stabilization of a fragile provider network.

Crosswalk of Key Functions to LME's Organizational Structure

LME Function	Per Cost Model Organizational Structure	Per LME Organizational Structure	Page # of Local Business Plan
CEO	General Governance	Governance	5
Board support and expense	General Governance	Governance	5-6
Policy analysis	General Governance	Governance	8
Human Resources	Business Management	Business Management	15-16
Accounting/Budgeting/Payroll	Business Management	Business Management	15
Financial reporting	Business Management	Business Management	13
Claims processing, billing, payment	Claims Processing	Business Management	13
CDW and IPRS reporting	IT	Business Management	12,33
Provider endorsement and monitoring	Provider Relations	Provider Relations	18
Provider recruiting and contracting	Provider Relations	Provider Relations	19-20, 22,24
Provider technical assistance	Provider Relations	Provider Relations & Quality Management	20
Handling provider complaints	Provider Relations	Provider Relations	22
24/7/365 Access, screening, triage and referral	STR	Service Management	34
Consumer registration	STR	Service Management	35
Person Centered Plan reviews	Service Management	Service Management Quality Management	32-33
State funded service authorization	Service Management	Service Management	32-33
Maintenance of waiting list for CAP-MR/DD Waiver	Service Management	Service Management	32-33
Care Coordination	Service Management	Service Management	31
Community Collaboration	Service Management	Service Management Provider Relations	8,32
System of Care and other interagency coordination/collaboration	Service Management	Service Management	8,33
Education to general public and activities to address stigma	Service Management	Service Management	2,9,10,34,46
Consumer appeals and grievances	Customer Service	Customer Service	27
CFAC staff and expenses	Customer Service	Customer Service	26
Consumer education and outreach	Customer Service	Customer Service	27,28
Internal data analysis and reporting	Quality Management	Quality Management /IT	14,38
Critical incident reporting	Quality Management	Customer Service Quality Management	28
Quality Improvement studies	Quality Management	Quality Management	41
Develop and stabilize a highly qualified provider system	Provider Relations	Provider Relations and Quality Management	19-22
Implement comprehensive crisis services	Service Management	Service Mgt/Service Management/Provider Relations	19-23,27,28,32,34,36
Assure a unified system and standardization	Service Management/ Provider Relations	Service Management and Provider Relations	2,16,19,25
Develop opportunities for consumer employment	Service Management	Service Mgt/Provider Relations	21,23,29,42
Develop opportunities for consumer housing.	Service Management	Service Mgt/Provider Relations	21,23,29,33,36,42

Appendix A

Endorsed Service Providers by Type

Service Type	Total
Crisis Services	9
Day Supports	3
Enhanced Personal Care	2
Enhanced Respite	1
Home & Community Supports	27
Individual Care Giver Education & Training	5
Personal Care	24
Residential Supports	20
Respite Non-Institutional	27
Specialized Consultative Services	2
Supported Employment	15
1300 Child Residential Level III	5
1700 Residential Treatment Level III	1
Assertive Community Treatment Team	2
Community Support Adults	43
Community Support Child	47
Community Support Team	7
Day Treatment	1
Diagnostic Assessment	16
Intensive N Home	5
Mobile Crisis	0
Multi Systemic Therapy	0
Partial Hospital	0
Psychosocial Rehab (PSR)	2
Substance Comprehensive Outpatient Treatment (SACOT)	0
Substance Intensive Outpatient (SAIOP)	1
Total	265

###Those highlighted services indicate CAP services