Mecklenburg County
Local Business Plan

People. Pride. Progress. Partnerships.

LME Vision Statement:

A Community System that empowers and supports individuals to lead healthy and productive lives.

Approved:	**Planning and Collaboration Committee**	**March 05, 2007**
Approved:	**Consumer and Family Advisory Committee**	**March 08, 2007**
Approved:	**Mecklenburg County Board of County Commissioners**	**March 20, 2007**

Mecklenburg County
Local Business Plan Executive Summary

The Mecklenburg County Local Management Entity (LME) functions as a Managed Behavioral Health Organization (MBHO) and is accredited by the National Committee for Quality Assurance (NCQA) – the Gold Standard for managed care entities.

The original Local Business Plan (LBP) was submitted in 2002. The plan continued to be updated and reviewed by the community. The current local business planning process originated in November 2005 when the community Planning and Collaboration Committee and the Consumer and Family Advisory Committee (CFAC) helped develop and then approve the LME's Strategic Plan. This plan laid the building blocks for the current Local Business Plan (LBP) development, which began in November 2006 by gathering significant consumer, provider and stakeholder input.

The Mecklenburg County Area Mental Health, Substance Abuse and Developmental Disability Authority separated into two functional entities – the Local Management Entity (LME) and the Provided Services Organization (PSO). The LME manages and oversees services (manager of care), while the PSO provides a limited scope of service (provider of care) acting as a 'safety net' for the more complex and complicated consumers. The local CFAC and the Planning and Collaboration Committee have supported this limited provision of service by the PSO.

The LBP identifies strategies and objectives that will further enhance the local mental health, substance abuse and developmental disability public system in partnership with stakeholders, consumers, providers, and advocates.

Key strategic objectives to strengthen the LME in its functioning as an MBHO include:

- Increasing the numbers of consumers served with particular focus of reaching under-represented populations;
- Increasing public awareness about the LME's mission by establishing a clearer presence in the community and working to decrease the level of stigma surrounding mental illness;
- Enhancing Information Technology systems to improve data reporting;
- Implementing single stream funding for state funds to increase effective and efficient utilization of state dollars. This will allow the LME to increase the number of consumers served and improve continuity of care;
- Creating additional education and training opportunities for consumers and family members to increase their knowledge of how to navigate the system and how to be more self-directed in the development of their Person Centered Plans;
- Increasing opportunities for consumer involvement and participation in activities of the LME and promote and facilitate additional opportunities for consumer participation within the community;
- Improving consumer-specific outcomes through the implementation of Best Practice services within the community through established Best Practice Committees (which include community providers, stakeholders and consumers) to address:
    - Adult Mental Health: Implement a Recovery Model training collaborative, expand Peer Bridger activities, establish a Warm Line and a Peer Drop In Center;

    - Developmental Disabilities: redirect state and county funding to supported employment and community activity and employment transition programs; expand supervised apartment and independent housing resources;
    - Adult Substance Abuse: implement Integrated Dual Diagnosis treatment continuums, expand vocational/employment and housing options and resources;
    - Child and Adolescent Mental Health: redirect funds from Residential Level III to Intensive In-Home service and MST; implement clinical service array for incarcerated males ages 12-17 including Diagnostic Assessment, Intensive In-Home, MST and/or Community Support; implement prevention/early intervention program for pre-adjudicated adolescents using the "Keeping It Real" Evidenced Based Practice Program.
- Continuing to refine and develop state funded benefit plans based on consumer need and provider input that will support Best Practice implementation and development;
- Developing a centralized facility based crisis service;
- Developing a Rapid Recovery Program for the actual and potential jail population;
- Implementing a LME satisfaction survey for consumers and families;
- Developing a Provider Performance Report to include monitoring and outcome data that will be accessible to consumers and the community;
- Implementing specific monitors in all disability areas tying funding decisions to outcomes data.

The LME will work to partner with the state around the implementation of a 1915B waiver which has been recommended by a nationally recognized consultant to help strengthen local management of the public system. This type of waiver would allow the LME to authorize and manage Medicaid services, right-size the provider network and reinvest any savings into the system.

Inherent in the LBP is a strong partnership with the CFAC, the Planning and Collaboration Committee, consumers, providers, advocates, stakeholders and the Board of County Commissioners (BOCC). These partnerships are critical for the successful implementation of the LBP. It is anticipated that by the end of the three-year plan, Best Practices will be a reality for consumers within the context of a person-centered framework, and that consumers and family members will truly be at the center of the system.

Mecklenburg County
LME Business Plan
Fiscal Year 2008-2010

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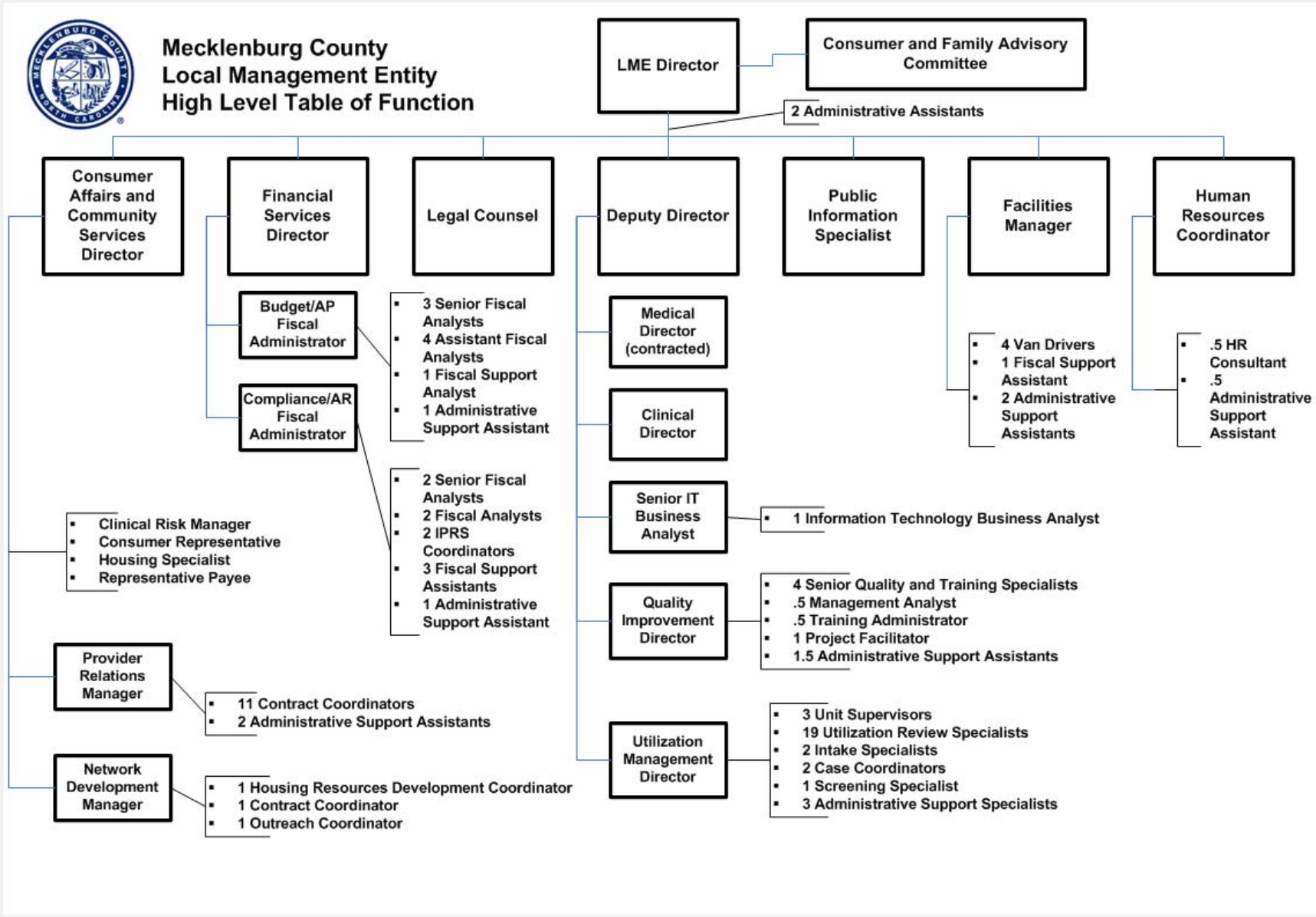
Mecklenburg County
Local Management Entity
High Level Table of Function
LME Director
Consumer and Family Advisory Committee
2 Administrative Assistants
Consumer Affairs and Community Services Director
Financial Services Director
Legal Counsel
Deputy Director
Public Information Specialist
Facilities Manager
Human Resources Coordinator
Budget/AP Fiscal Administrator
3 Senior Fiscal Analysts
4 Assistant Fiscal Analysts
1 Fiscal Support Analyst
1 Administrative Support Assistant
Compliance/AR Fiscal Administrator
2 Senior Fiscal Analysts
2 Fiscal Analysts
2 IPRS Coordinators
3 Fiscal Support Assistants
1 Administrative Support Assistant
Medical Director (contracted)
Clinical Director
Senior IT Business Analyst
1 Information Technology Business Analyst
Quality Improvement Director
4 Senior Quality and Training Specialists
.5 Management Analyst
.5 Training Administrator
1 Project Facilitator
1.5 Administrative Support Assistants
Utilization Management Director
3 Unit Supervisors
19 Utilization Review Specialists
2 Intake Specialists
2 Case Coordinators
1 Screening Specialist
3 Administrative Support Specialists
4 Van Drivers
1 Fiscal Support Assistant
2 Administrative Support Assistants
.5 HR Consultant
.5 Administrative Support Assistant
Clinical Risk Manager
Consumer Representative
Housing Specialist
Representative Payee
Provider Relations Manager
11 Contract Coordinators
2 Administrative Support Assistants
Network Development Manager
1 Housing Resources Development Coordinator
1 Contract Coordinator
1 Outreach Coordinator

#1

GOVERNANCE AND ADMINISTRATION LME FUNCTIONS

MISSION: To promote and achieve through the provision of services the wellness, recovery and independence for Mecklenburg County citizens with mental health, developmental disability and substance abuse challenges by managing resources through an accessible, quality provider network and a collaborative community system that partners with individuals and families.

PURCHASER STANDARDS: Mecklenburg LME operates in compliance with all applicable state and federal laws, rules and regulations, including, State Plan(s), Performance Contract(s), and Communication Bulletins and with all Local requirements.

CURRENT OPERATIONS: The LME's governance and administrative functions serve to support and provide leadership and management oversight for LME operations.

The Mecklenburg County Area Mental Health Authority has transformed itself into an effective Local Management Entity (LME) and has continued to grow and mature as a 'manager of care'. The Mecklenburg LME is the only local government agency accredited by the National Committee for Quality Assurance (NCQA) as a managed behavioral healthcare organization– the 'Gold Standard' for dependable and quality driven healthcare – for the second consecutive full term (2002-2005 and 2005-2008) accreditation. This level of recognition is founded on the LME's distinction in managing care with the following guiding principles:

Quality Driven – Quality Focused
Consumer Driven – Consumer Focused
Effective and Efficient Resource Management/Administration
Community and Stakeholder Involvement/Inclusion
Best Practice Supported Service Array
Effective and Efficient Information Technology

The overall functions of Governance and Administration include: partnership with the Consumer and Family Advisory Committee, Prevention initiatives, legal services, policy development, strategic planning, local business plan development and implementation, county government relations, clinical leadership and supervision, human resources, facilities management, public information and information technology.

Consumer and Family Advisory Committee (CFAC)

- Mecklenburg's CFAC was created in 2002 and from its beginning, through the initial development of its by-laws, established itself as a self-governing, self-directed committee with stated purposes to partner with the LME and to serve as a strong voice in developing policies and procedures that directly affect consumers and families and in monitoring activities designed to measure and improve quality and consumer satisfaction with services. CFAC provides reports directly to the LME Director and communicates annually or as needed with the BOCC. In 2006, all CFACs were instituted in State statute following much the same guidelines the Mecklenburg CFAC developed in 2002.

Prevention Initiatives

- Current Substance Abuse prevention initiatives are funded by State Block Grants and Safe and Drug Free Schools to provide youth and family science-based prevention programs within the schools and community. Models include: *Dare to be You*, *Keeping it Real*, *Gift of Parenting* and *I'm Special*. Mecklenburg County funds also support a

number of initiatives: Adult SA prevention activities to Latinos using models like Strengthening Families and Family Effectiveness Training and to Senior Citizens with programs that include Using Your Medications Wisely, and Coping Skills.

- The *Fighting Back* program provides science-based programs for Substance Abuse prevention, education, and information to 54 neighborhoods, schools, and community groups to prevent drug and alcohol abuse. There are three neighborhood coordinators and one drug education counselor. *Fighting Back* has working relationships with Charlotte-Mecklenburg Schools and with the Drug Free Coalition.
- *Child Development Community Policing* (CDCP) is a partnership between the Mecklenburg County Area Mental Health Authority, Charlotte-Mecklenburg Police Department, and the Mecklenburg County Department of Social Services that provides 24/7 on-call response to children impacted by violence, abuse, and trauma.

Legal Services

- The Mecklenburg LME retains legal counsel under the auspices of local county government. The LME's legal counsel is actively involved in reviewing provider agreements and clinical/financial risk management.

Policy Development

- Policies relative to operations and clinical services, such as evidence based practice guidelines, are developed by the responsible operating division with input from applicable provider, consumer and stakeholder organizations. The Consumer and Family Advisory Committee (CFAC) reviews and approves all consumer related policies.

Strategic Planning

- The Strategic Plan is developed in collaboration with CFAC and the local Planning and Collaboration Committee – a standing committee of the LME designed to guide the reformation of public mental health in Mecklenburg County. The LME routinely measures its performance and reports quarterly to the Mecklenburg County Board of County Commissioners and to the local CFAC. The plan is updated at least annually.

County Government Relations

- The Mecklenburg County Board of County Commissioners is the governing body for the LME. The Board receives regular operational information, including financial and other programmatic updates as required by NC GS 122C-117.
    - The LME partners with the Charlotte-Mecklenburg Hospital Authority through an inter-local agreement pursuant to NC GS 160A-461. The agreement, originally established in 1986, acts as the bridge for both governmental entities to function as an integrated partnership to improve access to high quality healthcare while at the same time managing costs.

Human Resources

- Mecklenburg County has centralized Human Resource functions as a more economic and strategic approach to providing human resource services. Each county department is assigned HR professionals and support staff who are devoted to understanding and meeting the human capital needs of the department's unique business through customer focused, innovative collaboration. Results are improved service and performance through a diverse, flexible, highly skilled workforce dedicated to meeting the needs of the citizens of Mecklenburg County.

Facilities Management

- Transportation services for consumers are provided within available resources with an emphasis on cost and timely response to requests. Existing transportation resources within the county are utilized when possible. Facilities management is also responsible for efficient use of space and equipment according to county guidelines. The Facilities Manager is actively involved in the overall Mecklenburg County emergency response and contingency planning.

Clinical Leadership and Supervision

- Clinical leadership and supervision are provided by a Board Certified Psychiatrist (Medical Director) as well as a Licensed Clinical Psychologist (Ph.D.). The Medical Director provides oversight for the utilization management process and is a member of the Quality Improvement Committee. The Clinical Director chairs the Quality Improvement Committee as well as the Practitioner Advisory Committee.

Information Technology

- Information technology functions at the Mecklenburg LME are managed both by the Mecklenburg County Information Services and Technology Department and an Information Management Unit within the LME. These two entities work together to support the LME's information technology needs. The overall goal is to provide the LME with high quality information capture and reporting systems to allow the LME to efficiently conduct day to day business and meet all governmental and accreditation requirements.
- IT functions include: database administration, server maintenance, software applications support, network administration, project management, telecommunications, security, privacy, procurement, help desk, customer relationship management and disaster preparedness specific to information technology. Additional functions include implementing, managing, querying and building processes around vendor supplied behavioral health software applications in order to give managers and staff what they need to conduct business. All systems are operated within standards set forth by HIPAA privacy and security rules.
- The Mecklenburg LME utilizes the following software components in order to conduct business:
    - A managed behavioral healthcare software package (eCura), a software vendor based in Philadelphia, PA, which includes a web-link for network providers to use to obtain authorizations and submit claims and;
    - Custom-built HIPAA transaction sets developed by the Mecklenburg County Information Services and Technology Applications Division.

Public Information and Communications

- Public Information and Communications functions are managed and performed by the LME's Public Information Specialist and supported by staff of Mecklenburg County's Public Service and Information (PS&I) Department. The Public Information staff develops and implements comprehensive public relations and communications plans centered around media relations, direct communications with external consumers and internal employee communications and designs and develops promotional/marketing materials which may include newsletters, brochures, news releases, public service announcements and related informational materials. In addition, the Public Information staff plans public relations campaigns including short and long term initiatives and

advises management on public relations and public information policy.

- Staffing at the Mecklenburg LME includes a Public Information Specialist whose primary role is to utilize available resources to educate consumers, providers, stakeholders and the community at large about mental health, developmental disabilities, and substance abuse, and ultimately, produce messages that support the transformation of mental health services in Mecklenburg County.

Cultural Competence

- As Mecklenburg County continues to expand in size, so too does the population's cultural diversity. The LME has been evaluating its readiness to manage these shifting demographics and consumer needs. Title VI of the Civil Rights Act of 1964 requires that agencies receiving Federal funding meet the statutory requirements for serving individuals with Limited English Proficiency (LEP).
    - The Mecklenburg LME Cultural Competence Committee was established to meet federal requirements and to evaluate the varying cultural needs throughout the LME and Mecklenburg County. The committee directs how the LME and the community of providers can better serve consumers from all different cultural backgrounds.
    - The goals of the Cultural Competence Committee are to increase LME employee awareness about cultural differences and expectations, to have staff examine their own personal stereotypes and assumptions about others, and to offer educational opportunities about Title VI and cultural competence expectations.
    - To ensure the community of providers is aware of culturally-informed Best Practices, and the Cultural Competence Committee plans to monitor and facilitate providers' delivery of culturally competent services, and validate that providers continue to educate themselves and adapt in accordance with the needs of a diverse and ever-changing community.
    - An overall baseline assessment of Mecklenburg County's population's cultural diversity is required. (See strategic objective *Cultural Competence Initiative*). Actions listed in the Strategic objective are in alignment with the overall vision of the Board of County Commissioners' strategic plan for 2015.

STRATEGIC OBJECTIVES: The following Stakeholder groups are involved in the planning process and in monitoring progress toward objectives within stated timelines using quarterly updates and reports: Consumer and Family Advisory Committee, the LME's Planning and Collaboration Committee, the four Best Practice Community Committees and the Financial Rules Committee. (comprised of a Board of County Commissioner member, CFAC chair and vice chair, advocates and providers).

Governance & Administration

Objectives	Strategies	Target Dates	Responsible Parties
Proceed with finalization of an Inter-local Agreement between Mecklenburg, Guilford and Smoky LMEs, with Piedmont Behavioral Healthcare as an advisory associate ("Consortium").	Using the DMH template, Consortium members will identify best practices for LME functions that can and should be standardized and develop principles and procedures that will be reflected in individual LMEs' Local Business Plans. Areas of the Local Business Plans in which Consortium LMEs will develop common strategies include: • Provider Relations and Development • Customer Service/Consumer Affairs • Service Management • Quality Management • Claims Adjudication • Access, Screening, Triage and Referral • Information Technology - It is anticipated that eventual integration of a common IT system for all three LMEs will facilitate Consortium – DMA development of a CMS application for expansion of the PBH Medicaid waiver to include all four LMEs of the consortium.	On-going; individual plans will be submitted to DMH in March 2007; inter-local agreement by June 2007	LME Management Team
Increase the number of consumers served (MH-SA-DD and any other under-represented populations).	Develop an integrated outreach campaign that specifically targets Medicaid recipients at sites such as DSS and Metrolina Health Clinic. • Develop a social marketing approach targeting underserved populations across all disability areas that incorporates the LME's Cultural Competence principles and goals. • Make available a high quality network of providers to reach all underserved populations	July 2007 and ongoing	LME Management Team, Public Information Specialist
Increase the number of consumers and stakeholders involved with Strategic Planning to ensure an inclusive model of community-driven services.	The LME is developing a process to educate and include potential partners to engage in decision-making and producing quarterly communication tools to engage partnership. • Focus on feedback-driven strategies and building quality, consumer-focused communication tactics that consider cultural diversity, ethical dimensions and content accessibility.	July 2007 and ongoing	Public Information Specialist

Increase community participation and engagement in the public system.	Provide PR/Marketing to improve public perception and encourage consumer participation in programs and decision-making. • Increase public awareness about the LME's vision and mission by establishing a deeper presence and work to decrease level of stigma surrounding mental illness. • Establish and maintain key relationships with government, business and community leaders, and media representatives. • Many of the tools currently in use that support these efforts include: o English and Spanish language brochures o marketing materials o ongoing updates to web site content o quarterly newsletters o annual reports/briefing book o special events o community education and outreach campaigns o media attention for programs and services o ongoing education to the public about vision and mission o development and production of a Communication Plan and Crisis Communication Plan for the LME to better centralize the flow of information and to clarify communication processes/roles o Focus groups, surveys and questionnaires to capture employee, stakeholder, provider, consumer, and community attitudes, motivation, and needs.	July 2007 and ongoing	Public Information Specialist
Continue to support the growth of a diverse and well-informed organization.	Using the LME's internal newsletter to inform employees about state news, changes, and updates. • Consistently featuring the LME vision and mission statements in materials, presentations, and mediated forms. • Increase employee engagement by improving internal web site content and design, though a new software format (SharePoint) to increase content posting and evaluate effectiveness. • Support the LME's efforts to recruit bi-cultural and bi-lingual staff by producing materials and resources to assist Human Resource efforts.	July 2007 and ongoing	Public Information Specialist
Explore alternatives and enhancements to the	The LME has begun an RFP project to identify potential vendors who may offer a software solution to replace eCura.	July 2008	Senior IT Business

managed behavioral healthcare software package used by the LME.	• Thorough documentation of business processes, specifications and requirements is near completion. • Funds have been secured, and the formal RFP process will begin by spring 2007, with vendor selection complete by the end of June 2007. • The claims adjudication function will occur with greater reliability and efficiency. • Positive impact will take place with network providers and in turn will set the stage for efficient claims submission by the LME to the state for IPRS funds. A more flexible authorization package will positively impact providers and consumers by more quickly and accurately reflecting person centered planning.		Analyst
Replace the billing software package used by the LME.	Mecklenburg County Information Services and Technology staff have built several HIPAA transaction sets as custom products to give the LME greater control over submission and enhanced ability to analyze and make adjustments for variance and exceptions. • This process is underway and includes a current claims solution project – the LME is hosting software demonstrations by billing software vendors in order to build the best blend of custom and vendor products. • Mecklenburg LME claims processes (submission to the state for IPRS funds) will increase in efficiency and timeliness. • With the recently developed 834 transaction set, the Mecklenburg LME will see improvements in compliance with report processes such as NCTOPPS and DD COI. • Impact will also be realized in improvements in IPRS claim submissions from Mecklenburg with a custom-built 837 transaction set approved by the state.	July 2007	Senior IT Business Analyst; Financial Services Director
Continually build and enhance all data reporting functions.	The LME has built and must continue to refine web-based report functions. • The goal is to increase the availability of real-time data that accurately reflects activity at all touch points in the business process and to make that data available at the desktops of managers and front-line staff. • The deployment of all health plan functions depends entirely on the availability of quality data. • Achieving this allows, utilization review staff to more quickly and accurately shape authorization packages to support person-centered plans; it allows finance staff to more quickly analyze and correct elements of the claims process – thereby supporting prompt payment rules; and it allows consumer affairs	July 2007 and ongoing	Senior IT Business Analyst

	functions to operate smoothly by offering a real-time map of the service experiences and needs of consumers.		
A business-oriented web site will exist for Providers to obtain data reports, submit applications (endorsement, etc.), complete surveys, etc.	Providers are dependent upon data generated by the LME and HIPAA-compliant 24/7 access to that data will assist providers in conducting business with the LME and will reduce data barriers. • This data will include authorization, claims and other information. • This site will be a submission tool for various applications (endorsement, etc.) and for the completion of provider satisfaction surveys.	July 2009	Senior IT Business Analyst
Maintain NCQA accreditation	Continue MBHO function consistent with NCQA guidelines. Resurvey visit in summer 2008.	2008	QI Director and LME Management Team
Cultural Competence Initiative	This project began in fiscal year 05-06 and continues into 06-07 and 07-08. The LME has contracted with a nationally recognized consulting group (Glover and Associates) that is providing procedural, as well as training guidance, in compliance with the state-wide cultural competence plan. • Introduce an integrated Cultural Competence Plan to increase awareness and promote cultural competence. • Focus on expanding organizational communication efforts. • Implement ongoing, mandatory cultural competence training for all LME staff. • The LME's Cultural Competence Committee will be expanded to include representation from stakeholder groups to provide input and guidance from consumers, the community of providers, and the community at large to ensure that cultural norms and needs are being addressed. The community will develop strategies for addressing gaps in culturally competent service delivery within provider agencies. • Actively recruit bi-lingual and bi-cultural staff, and continuously update all of the LME's Spanish language signage, brochures, and other materials. Build cultural awareness among staff across provider agencies by making targeted, specific efforts to provide a welcoming environment and competent service delivery for people with diverse cultural backgrounds. • Provide direction to the LME Provider Relations and Utilization Management staff for monitoring the community of providers on the sophistication and	2007- ongoing	Clinical Director and LME Management Team

	consistency of culturally competent treatment efforts, and also for compliance with the LEP component of the Civil Rights Act. • Collaborate with UNC Charlotte, outreach agencies, the Latin American Coalition, the Department of Social Services, the Governor's Council on Hispanic and Latino Affairs, and Title VI Collaborative teams. Future efforts include ongoing active participation in health fairs and community forums. • Require providers to receive cultural competence training, to recruit adequate bilingual/bicultural staff, and to translate materials for languages representing 5% or more of the local population. • Work with CFAC and consumer advocacy groups to establish a means for rating providers and for holding providers accountable for their cultural competence efforts. • Implement an Integrated Cultural Competence Social Marketing Plan; the goals are to: o Increase Awareness and Community Education o Encourage Community Engagement o Produce Improved Consumer Outcomes o Increase Penetration of Underserved Populations o Establish Provider Expectations and Accountability.		
Develop and Implement additional Clinical Practice Guidelines.	Distribute Clinical Practice Guidelines to providers and consumers in the areas of ADHD and Schizophrenia. • Research and develop additional guidelines (e.g. Affective Disorders and Conduct Disorders).	2007 and ongoing	Clinical Director and QI Director
Utilization Management of State Operated Facilities services	Develop a plan for bed days at State Operated Facilities in collaboration with Broughton State Hospital Clinical Director and Unit Managers. The LME Medical Director has direct oversight of utilization and works in conjunction with physician staff at Broughton to develop appropriate discharge plans. The UM staff has developed a plan to monitor consumers beyond the required "5 days after discharge" and will monitor consumers at 30, 60 and 90 day intervals to ensure continuity of care and coordination of services. Partner with CMC-Randolph to develop strategic solutions to increase inpatient bed availability.	2007 and ongoing	Deputy Director, Medical Director, UM Director
Child and Adolescent	Serve children, adolescents and their families within a *system of care* best practice model.	July 2007 and ongoing	LME

Service Continuum Initiatives	Collaborate with community agencies, such as Department of Juvenile Justice, Youth and Family Services, school systems, etc. The following are service initiatives currently being implemented: • Service delivery within Gatling Juvenile Detention Center • Service delivery to 17-18 year olds housed in the adult jails. • In-school therapy services • After School program • Intensive Therapeutic Foster Care program for high risk children/adolescents The LME will support system transformation and encourage collaboration between community agencies by: • Providing a consistent model of training for all levels of staff in all involved agencies, and training trainers in each agency, which will infuse and sustain the system of care model throughout agencies over time. • Providing resource developers who can coach staff and assist their building and utilizing informal supports and community resources among the faith communities, businesses, neighbors, and help staff connect with mainstream supports for adults and other children, helping build the capacity of the family. • Providing ongoing assessment and feedback regarding fidelity of implementation as a means of continuous improvement. • Identifying common outcomes of different systems, and develop integrated planning effort for all children and families across systems so there is "One Family, One Team, One Plan," for each family. • Capitalizing on local university efforts to integrate data across systems and agencies, enabling clear evaluation of the impact of the system change efforts on the system, practice and families. • Building a social marketing plan to broaden awareness of system of care principles and encourage providers, stakeholders and consumers, and community participation in the initiative.		Management Team

RESOURCE ALLOCATION:

Category	Cost Model *	Actual	Variance
FTE's	14.23	15	5%
Dollars	949,174	3,042,047	220%

*Note: Calculations based on 11-8-06 Cost Model Summary

Explanation:

The Governance and Administration functions include Human Resources, MIS, Facility Services and LME Administration. The variance is primarily due to the Board of County Commissioners allocating approximately $30 million this fiscal year for the provision of MH/DD/SA services. State allocated service dollars, other than those identified in the cost model, are not used to fund administrative and operational functions within the LME

BUSINESS RULES:

The following business rules enhance Mecklenburg LME's ability to function as efficiently and effectively as possible:

- The LME has been NCQA accredited since 2002. The LME adheres to NCQA's objective standards for quality and service, utilization management, access and coordination of care, consumer rights and responsibilities, and preventive health.
- Overall management philosophy is consistent with a 'data driven' organization. The LME routinely uses data to analyze gaps in service, customer/stakeholder satisfaction and strategic planning.
- The LME has achieved consumer, stakeholder, advocate and provider involvement in decision making process at all levels of the operation.
- The LME has established collaborative partnerships with other LMEs around exploration of innovative service as well as administrative strategies.

The following business rules inhibit Mecklenburg LME's ability to function as efficiently and effectively as possible:

- Due to a non-integrated system, the LME has challenges in managing continuity of care and provider performance. Daily authorization files and reports from DMA and Value Options would enhance the LME's ability to coordinate consumers' care.
- There are limited leverage points directly associated with monitoring direct bill Medicaid providers who do not also have a contract with the LME, such as submission of data (NC TOPPS, STR Registration, NC SNAP) and development of best practice service models. Strengthening the language within the MOA, to include financial penalties, would help ensure compliance.
- Current state funding does not support expansion of prevention initiatives in all disability areas. It is recommended that in addition to the allocation for Substance Abuse prevention services, Mental Health and Developmental Disabilities funding also be allocated for prevention and early intervention services.

#2

BUSINESS MANAGEMENT AND INFORMATION MANAGEMENT

MISSION: To align business systems that will support LME operations; to streamline processes for financial and business operations so that funds are used efficiently, effectively and in accordance with federal, state and local rules and regulations.

PURCHASER STANDARDS: Mecklenburg LME operates in compliance with all applicable state and federal laws, rules and regulations, including, State Plan(s), Performance Contract(s), and Communication Bulletins and with all Local requirements.

CURRENT OPERATIONS: The Financial Services division includes the functions of: budget development/maintenance, accounts payable, purchasing, financial reporting, claims processing, funds management and billing compliance. Human Resources and Information Management functions are carried out under Governance and Administration.

Financial Services

- The LME as a department of Mecklenburg County operates under the fiscal policies and procedures of Mecklenburg County. The County has primary responsibility for budget development asset management, cash management, general ledger maintenance, preparation of the annual audit, risk management, check processing and payroll within generally accepted accounting procedures. Mecklenburg LME Financial Services works closely with the County on issues that pertain to the LME. The LME pre-audits, prepares and processes all purchasing, payables, budget adjustments and accounting entries while the County has final approval for all entries, thus creating a separation of duties. The LME prepares all financial reports specific to the LME, obtaining approval from the County as required.

Claims Processing

- The Mecklenburg LME utilizes the eCura application to manage information and data. This system has a web based component (Provider Connect) by which providers can enter and transmit data including authorization and claim submission. Providers have the option of entering claims directly into Provider Connect or submitting an 837 claim file. Claims are pre-adjudicated on a daily basis to ensure the provider has submitted claims in the correct format, has included the required data elements and that the consumer is registered with Mecklenburg LME. All services billed to Mecklenburg LME require an authorization. Claims that fail pre-adjudication are reported to the provider through Provider Connect the next business day. Claims that pass pre-adjudication are then adjudicated against timely filing deadlines, authorizations, and contract setup. The results of adjudication are returned to the provider via paper remittance reports or electronically via an 835 file and includes paid and denied claims.
- The Mecklenburg LME generally processes provider payments on a weekly basis based on approved, clean claims and has established a schedule for providers that includes claims submission deadlines. This enables Mecklenburg to pay providers within the prompt pay requirement, often paying providers within three weeks. Technical assistance is offered to providers in researching claims denied by the Mecklenburg LME.
- The Mecklenburg does not utilize the eCura application for billing claims to IPRS. Prior to February 2007, provider claims approved and paid were transferred to a secondary system along with consumer information required for the 834 and 837. The 834 and 837 were generated from this system to submit consumer target populations and claims to

IPRS. Maintaining two separate systems was inefficient and created significant problems with submitting target population and claim data to IPRS. As of January 2007, the 834 eligibility file is generated directly from the data in the eCura application. This will reduce the amount of errors in 834 submissions and increase the acceptance rate of consumer target populations, thus allowing DHHS to have accurate information on Mecklenburg consumers. Additionally, as of February 2007, Mecklenburg began generating the 837 claim file directly from data in the eCura application. Providers in the Mecklenburg network are required to bill first and third party based on the Mecklenburg LME sliding fee scale. Mecklenburg reviews error reports and denials as soon as they are received in order to resubmit data as quickly as possible.

Funds Management

- The Mecklenburg LME monitors utilization of state and county funds using a cross divisional team approach. A Contract Review Committee comprised of managers from Finance, Provider Relations and Utilization Management meet on a regular basis to review authorization and paid claim percentages against the maximum amount stated in the provider contract. Contracts are amended based on these discussions and research with the provider. Consumer benefit plans may be adjusted based on information gathered and analyzed.

Billing Compliance

- The Mecklenburg LME has a Billing Compliance Unit within the Financial Services Division. Routine compliance reviews are conducted against paid claims with all network providers to monitor compliance with federal, state and county billing requirements. Monitoring activities include regularly scheduled reviews as well as billing complaints/concerns, provider report of billing errors, Attorney General requests, Division of Medical Assistance desk audits, state audits and the Mecklenburg County Single Audit. Claims are reviewed against federal, state and county requirements. Providers are required to pay back claims found to be out of compliance. A corrective action plan may be required. Funds are paid back as required by the Division of Medical Assistance and the Division of Mental Health within the established time frames. Training and technical assistance on service definitions and documentation requirements are given to new providers entering the network and thereafter based on identified needs.

STRATEGIC OBJECTIVES: The following stakeholder groups are involved in the planning process and in monitoring progress within stated timelines using quarterly updates and reports: the LME Planning and Collaborative Committee, the Best Practice Community Committees and the Financial Rules Committee.

Business Management and Information Management

Objectives	Strategies	Target Dates	Responsible Parties
Develop processes and mechanisms to use incurred but not reported (IBNR) data and other data sources to make benefit plan and contract allocation decisions.	Necessary reports developed. Historical authorization and claim data has been gathered and analyzed to determine completion rates based on service type and population. Establish procedures around the use of these reports. The data will assist in determining the financial outlook for the LME, adjust benefit plans to ensure consumers are getting the right level of care based on needs and improve continuity of care. This type of fiscal management allows for the broadest scope of well planned, data driven decision making.	July 2007 and ongoing	LME Management Team
Implement single stream funding with state funds.	Received approval from the Division of Mental Health to shift state service dollars to single stream funding. Single stream funding will allow the Mecklenburg LME to shift resources based on the service needs in this community. This will allow the LME to increase the number of consumers served and improve continuity of care.	July 2007	LME Management Team
Streamline billing compliance review activities	Historically, the Billing Compliance unit has reviewed a sampling of provider claims once per quarter. Mecklenburg will adjust policies and procedures to incorporate flexibility in the review process. This will include developing guidelines around reducing the frequency of reviews based on successful performance. Reducing the frequency of billing compliance reviews will allow the LME to provide more technical assistance to providers who need support.	July 2007 and ongoing	Financial Services Director and Compliance Administrator
Improve reporting of target population eligibility and claims data	• As of January 2007, the 834 eligibility file is generated directly from the data in the eCura application. This will reduce the amount of errors Mecklenburg has received from 834 submissions and increase the acceptance rate of consumer target populations, thus allowing DHHS to have accurate information on Mecklenburg consumers.	July 2007 and ongoing	Senior IT Business Analyst

	• As of February 2007, began generating the 837 claim file directly from data in the eCura application. • Post claim payments from the electronic 835 and will monitor compliance with payments and denials on a weekly basis.		
Explore implementing reimbursement alternatives.	Alternative reimbursement methodologies, such as case rates and risk-sharing, will be evaluated for implementation. Identify a beta pool of providers who are interested and willing to participate and have demonstrated movement toward Evidence Based Practice models. Delineate specific populations and services to be considered for alternative reimbursement methods.	July 2008 and ongoing	LME Management Team
Develop and implement a 1915b waiver with the support of DMA and DMH as recommended by the state consultant.	Support is needed from DHHS in order to move forward. The Mecklenburg LME is uniquely positioned to accomplish this due to a strong provider network and NCQA accreditation.	July 2008 - July 2009	LME Management Team
Develop financial incentives to redirect state and county dollars to support best practice services.	Work has already begun on this objective. Mecklenburg will increase these initiatives over the next three years. Explore moving funds from UCR to non-UCR to support these services during the implementation phase.	July 2007 and ongoing	LME Management Team

RESOURCE ALLOCATION:

Category	Cost Model *	Actual	Variance
FTE's	18.35	22	20%
Dollars	1,069,736	1,476,348	38%

*Note: Calculations based on 11-8-06 Cost Model Summary
2.0 FTE's for Human Resources included in the Governance and Administration Section

Explanation:
The variance is due to the Mecklenburg LME having approximately $30 million in county service dollars. Additionally, in the Mecklenburg LME, the Billing/Compliance function is incorporated within the Finance Division rather than the Provider Relations Division.

BUSINESS RULES:
The following business rules enhance Mecklenburg County's ability to perform as efficiently as possible:

- The Mecklenburg LME pays contract providers prior to billing services to IPRS. This allows providers to be paid for services more quickly than the prompt pay requirement.
- All new contracts and contract amendments must be approved by the Contract Review Committee prior to initiation. This committee includes Finance, UM and Provider Relations staff.
- The Mecklenburg LME reviews all registration data entry to ensure that CNDS entry is timely and CDW errors are minimal, thus enhancing data integrity submitted to DMH.

The following business rules inhibit Mecklenburg County's ability to perform as efficiently as possible:

- Mecklenburg must allow providers to submit claims consistent with the state's timely filing deadlines. Because providers submit billing with various frequencies, it becomes difficult to predict utilization patterns using real time data. The industry standard for timely filing deadlines is 45-90 days. It is recommended that the filing deadline be shortened to 180 days.
- The IPRS funding system has become complicated. For example, information about providers must be maintained in the local LME system and manually entered by LME employees into IPRS. It is recommended that mechanisms be developed so that provider data can more easily be electronically submitted to IPRS. Authorization information for specified services (inpatient hospitalization, residential treatment) in the local LME system must be manually re-entered into IPRS in order for claims to be paid. It is recommended that this requirement be eliminated from the IPRS requirements or that a mechanism be developed to electronically submit authorization data.
- Due to some Medicaid services being non-direct bill (Targeted Case Management, Therapeutic Foster Care), inefficiencies have been created for providers who must request authorizations from two separate entities. It is recommended that the LME be given an authorization file for services authorized by Value Options that must be billed by the LME or be allowed to authorize these services.

#3

PROVIDER RELATIONS AND DEVELOPMENT LME FUNCTIONS

MISSION: To develop and establish a community of quality providers and services through the recruitment of providers that consistently demonstrate evidence-based practices and best practice models in partnership with consumers and their families.

PURCHASER STANDARDS: Mecklenburg LME operates in compliance with all applicable state and federal laws, rules and regulations, including, State Plan(s), Performance Contract(s), and Communication Bulletins and with all Local requirements.

CURRENT OPERATIONS*:* The overall functions of Provider Relations include: Community and Provider Network Coordination and Development, Provider Communication and Information Dissemination, Housing Resource Development and Coordination, Community Outreach, Management and Monitoring of Provider Community, and Technical Assistance and Guidance:

Community/Provider Coordination and Development

- Continual analysis and assessment of provider services, service availability and service gaps through the LME's Planning and Collaboration Committee, four Best Practice Community Committees (System of Care, Mental Health Recovery Model, Developmental Disabilities Self Determination and Substance Abuse Recovery) Consumer and Family Advisory Committee, and various focus groups.
- Increase community capacity by developing new and enhanced services through a formalized Request for Proposal process which includes a community and consumer review team and requires CFAC's approval.
- Collaboration with Community partners, such as the Mecklenburg County Department of Social Services, Homeless Services Network, Mental Health Association, Charlotte Mecklenburg Drug Free Coalition, Vocational Rehabilitation, Central Piedmont Community College, University of North Carolina Charlotte. Collaborations are established to seek funding to support new initiatives, promote community partnerships and enhance and expand community resources and options.
- Leadership and facilitation of System of Care Collaborative. The SOC Collaborative was organized in 2003 and is a cross section of community leaders and stakeholders with a vested interest in the services and supports for children, youth, and families in Mecklenburg County. Its representation includes Community Providers, Faith Based Organizations, DJJDP, DSS-Youth and Family Services, Charlotte Mecklenburg Schools, and family members. It is an information sharing and governing body for SOC, whose work is accomplished through subcommittees including Best Practice and Service Gaps, Program Outcome and Evaluation, Independent Living, Cultural Competence, Informal and Natural Supports, Social Marketing and Care Review.
- Leadership and facilitation of Best Practice Committees: MH Recovery Model, DD Self Determination and SA Recovery. These committees were established by the LME's Planning and Collaboration Committee with the primary purpose of developing strategies to expand the number of agencies providing evidence based services and supports and identifying methodologies to improve the quality of treatment, services and supports through the adoption of best practice models. Each of the committees is comprised of consumers and family members, community providers, advocacy agencies, and community partners.

- The LME initiated regional crisis planning activities in September 2006 by conducting a Focus Group with key community partners and stakeholders. A Regional Crisis Planning Committee was then formed and is made up of representatives from the two local major hospital systems (Carolinas Healthcare System and Presbyterian/Novant), CFAC, service providers for each age and disability group and representing services that include community support, residential, inpatient, outpatient, ER, CSU, mobile crisis, MR/MI services, CAP/MR/DD, and diagnostic assessments. The committee works in collaboration with the Rapid Recovery Stakeholders Work Group, the Homeless Services Network, Charlotte Mecklenburg Schools, System of Care Collaborative, Mental Health Association of Central Carolinas and NAMI.
- Leadership and facilitation in a partnership with the Sheriff's Office, Charlotte Mecklenburg Police Department, Mental Health Court, Public Defender's Office, Carolinas Medical Center-Randolph, NAMI and the Homeless Services Network to develop a Rapid Recovery Model. The model includes a Crisis Intervention Team, Mobile Crisis services, a Crisis Center, Residential Stabilization and Housing and Treatment Services. The purpose of the model is to divert the mentally ill/substance abuser from incarceration to the appropriate services that will treat the illness in the least restrictive and most clinically appropriate setting while also addressing legal issues and criminal behavior.

Provider Communication and Information Dissemination

- A Hot Sheet is distributed electronically on a weekly basis to inform the community of providers of new and timely information that includes drawing attention to and providing electronic links to any and all State Communication Bulletins, announcements, training and other pertinent information. In addition, the Hot Sheet directs providers to Best Practice expectations and encourages users to access the LME's web site regularly.
- Provider InfoShare meetings are held on a quarterly basis as a forum to update providers on topics such as service definitions, utilization management, quality improvement, consumer rights, evidence based practices, cultural competency and reporting requirements. InfoShare is also utilized to gather information from the provider community.
- A web based directory is maintained which includes all providers within the Mecklenburg community of providers and additional community resources. This is a consumer oriented site where consumers can search, gather information and identify providers and related resources to meet their needs.
- Periodic informational meetings are held with groupings of providers, typically within specific consumer continuums, to provide information regarding new developments, system/collaboration issues and consumer concerns.
- Work closely with the Spanish-language media to disseminate information about MH/DD/SA services. The LME Outreach Coordinator has a monthly article in the Que Pasa newspaper providing basic information regarding signs and symptoms of depression, alcoholism, for example, and listing ways to access services.

Housing Resource Development and Coordination

- Management and ongoing monitoring of HUD Shelter Plus Care grants and Section 811 programs, includes determining consumer eligibility and coordination of placement.
- Collaborate with local community agencies, i.e., housing authorities, 811 supportive living developers, local landlords, HUD administrative agencies, Salvation Army, to identify housing gaps, identify potential resources and develop grant proposals for additional funding.

- Provide consultation and assistance to Community Support providers in securing safe and affordable housing for consumers.
- Provide education to consumers, families and service providers on accessing and maintaining affordable housing regarding N.C. Landlord-Tenant and Fair Housing Laws.
- Provide information and coordination to facilitate consumer occupancy of available housing units within the regulations and guidelines of funding sources.
- Participate in the County's 10 Year Plan to End Homelessness task force and in the Homeless Services Network by representing the needs of MH/DD/SA consumers.

Community Outreach

- Ongoing assessment and evaluation of availability of community resources and services with a focus on, but not limited to, services for Latino/Hispanic and other minority consumers.
- Provide education and information, through community workshops, health fairs, campaigns in the schools and faith-based organizations, on cultural competency, compliance with Title VI, community prevention and treatment resources and how to access services. There has been a 50% increase in the number of calls from Spanish speaking consumers coming directly to the STR staff member fluent in Spanish.
- Provide leadership in the development of cultural competence with the community of providers. At the end of last fiscal year there were 6 agencies who had a total of 16 bi-lingual, bi-cultural staff; there are currently 12 agencies with a total of 26 bi-lingual, bi-cultural staff.
- Provide leadership in the development of cultural competence with the System of Care, MeckCARES initiative. The number of Latino families participating has increased from a 2% participation rate last fiscal year to 9% currently.
- Develop and maintain partnerships among community services and providers to identify needs, gaps and availability in services.

Management and Monitoring of Provider Community

- Manage and monitor endorsement process to include initial reviews for corporate and service/site specific conditional endorsement, follow up to determine readiness for full endorsement, initiation of Memorandum of Agreement and subsequent monitoring for compliance with agreement and endorsement requirements. This includes all CAP MR/DD and Child Residential services.
- Develop, manage and monitor state contracts using State approved template and operations manual ensuring compliance with all State and Federal requirements, NC General Statutes, and rules and regulations set forth by the Division. Monitoring is conducted on a routine basis as well as in response to complaints and incidents. Monitoring includes desk and on-site reviews to determine compliance and when compliance is not met, corrective action plans are required and monitored until compliance is achieved.
- Monitor all licensed MH/DD/SA facilities including 24-hour residential facilities, day treatment, and outpatient services and all community based providers not requiring state licensure, including CAP-MR/DD waiver services.
- Conduct credentialing reviews of all new contract providers and of new services with current contract providers and re-credentialing with existing contract providers every three years.
- Staff are organized by consumer continuums to develop partnerships with providers, to promote collaboration and problem solving among providers in support of consumers in

their person centered plans and to ensure appropriate level of care coordination and continuity of care for consumers.

- Provider complaints, grievances and/or appeals are handled within existing policies and procedures, in accordance with G.S. 122C-151.4, ensuring timely resolution and commitment to resolving the dispute.

Technical Assistance and Guidance

- Technical assistance is provided to individual providers on an as-needed and requested basis to promote an understanding of basic roles and responsibilities re: consumer participation and involvement, community collaborations, best practice models and evidence based services, use of community and natural resources and supports.
- Technical assistance is provided around basic contact compliance issues and recommendations are made re: improvements in service provision, clinical documentation, policy and procedures specific to staff training and supervision, and consumer health and safety. This assistance is often done in conjunction with staff from consumer affairs, quality improvement, billing compliance and utilization management.
- Technical Assistance is provided in collaboration with Quality Improvement staff re: participation in quality improvement studies and performance measurement systems.

STRATEGIC OBJECTIVE: The following Stakeholder groups are involved in the planning process and in monitoring progress toward objectives within stated timelines using quarterly updates and reports: Consumer and Family Advisory Committee, the LME's Planning and Collaboration Committee, the four Best Practice Community Committees and the Financial Rules Committee.

Provider Relations and Development

Objectives	Strategies	Target Dates	Responsible Parties
Expand provider monitoring activities to include first responder capability, use of evidence based practices, development of consumer crisis plans and progress toward achieving national accreditation.	• Develop cross functional review teams to include Consumer Affairs, Provider Relations and Utilization Management staff. • Develop consumer and provider direct care staff interview questionnaires to validate level of consumer involvement. • Partner with CFAC regarding First Responder surveys and developing a provider report.	2007 - 2008	Consumer Affairs and Community Services Director Provider Relations Manager
Increase the number of providers that embrace best practice models and that demonstrate those models through inclusion of best practice philosophy and guiding principles in their overall vision and mission and service delivery.	Implementation has begun this fiscal year and the goal is to increase 1-2 best practice initiatives within each consumer continuum, i.e., Child and Adolescent MH/SA continuum, Adult MH continuum, Adult SA continuum, and the DD continuum, each year over the next three years.	2007 and ongoing	Consumer Affairs and Community Services Director and Network Development Manager
Redirect state and county dollars to support best practice models and evidence based services in the Child and Adolescent Continuum.	• Redirect funds from Residential level III to Intensive In Home and MST; implement clinical service array for incarcerated males ages 12-17 including Diagnostic Assessment, Intensive In Home, MST and/or Community Support; implement prevention/early intervention program for pre-adjudicated adolescents using the "Keeping it Real" Evidence Based Practice model. • Implement a comprehensive service array for Latino/Hispanic population including outreach, prevention and intervention with a specific focus on dual diagnosis; implement gender specific integrated dual diagnosis treatment for adjudicated females ages 12-17. • Implement community based Juvenile Sex Offender program for adolescents who would otherwise require level IV placement, utilizing Intensive In Home, Wraparound, family support and a combination of	2007 - 2008 2008 - 2009 2009 - 2010	LME Management Team

	individual and group therapy.		
Develop a continuum of services for consumers who age out of the Child system and are transitioning into the Adult system.	• Implement a supervised living program and age appropriate psychosocial clubhouse for adolescents aging out of level III and level IV placements with continued need for treatment. • Expand Community Support services to enhance capacity for specialized services for individuals ages 17-21. • Implement Independent Living initiative of the Community Collaborative which includes a centralized hub for access to all services for transition age adolescents including diagnostic assessment, crisis services, physical health, housing, supported employment and clinical services.	2007 - 2008 2008 - 2009 2009 - 2010	LME Management Team
Redirect state and county dollars to support best practice models/evidence based services in the Adult MH continuum, with emphasis on peer run, peer directed services.	• Continued implementation of a Recovery Model training collaborative, expand Peer Bridger activities, establish a Warm Line and a Peer Drop In Center. • Expand Supported Employment options including an option that is provider sponsored and peer run. • Expand Psychosocial Clubhouse services.	2007 - 2008 2008 - 2009 2009 - 2010	LME Management Team
Redirect state and county dollars to support best practice models/evidence based services in the Developmental Disabilities continuum.	• Continue to redirected funds from ADVP to Supported Employment and Community Activity and Employment Transition programs • Develop retirement alternatives for seniors, expand Supported Employment options including an option that is provider sponsored and peer run. • Expand supervised apartment, independent housing resources.	2007 - 2008 2008 - 2009 2009 - 2010	LME Management Team
Redirect state and county dollars to support best practice models/evidence based services in the Adult Substance Abuse continuum.	• Continue the implementation of Integrated Dual Diagnosis Treatment continuums, one of which is gender specific. • Expand vocational, employment and housing options and resources. • Explore and develop peer run, peer directed service	2007 - 2008 2008 - 2009 2009 – 2010	LME Management Team

	options.		
Develop monitoring protocol(s) around fidelity to best practices and in support of Person Centered Plans and Person Centered Thinking	Implementation began this fiscal year and protocols will be reviewed on an annual basis and will be modified as new services and programs are implemented.	2007 - 2010	Consumer Affairs and Community Services Director Provider Relations Manager
Facilitate collaboration of providers around individual person centered plans in context of continuity and care coordination and across "systems" within the community.	• Implementation began this fiscal year and will be an on-going process to include multi-agency team trainings and technical assistance around consumer specific cases. • Collaborate with Vocational Rehabilitation, DSS and Criminal Justice.	2007 – 2010	Network Development Manager and Consumer Affairs and Community Services Director UM Director
Establish a Provider Council	A Planning Committee was established in December 2006. The committee's purpose is to define organizational structure of the council, its membership, by-laws, mission and purpose, role and relationship with the LME.	2007 – 2008	Network Development Manager
Expand the availability of housing options to MH/DD/SA consumers	• Increase the availability of transitional housing units with support for persons with disabilities by 5% • Increase the rental subsidy capacity for chronically homeless individuals by 15% or 15 units • The LME Housing Resource Coordinator works in collaboration with Mental Health Association to pursue grant opportunities with HUD including 811's and Shelter Plus Care, with the Charlotte Housing Authority to increase the number of Section 8 subsides, with the State in the Housing 400 Initiative and with the Homeless Services Network Housing First grants.	2007 - 2008 2008 - 2009 Ongoing	Housing Resources Development Coordinator
Develop and implement a centralized facility based crisis service	The facility will operate as a "crisis central" point of entry 24/7 for telephone, walk-in and referral access to any and all MH/DD/SA crisis services. The facility will operate in conjunction with the pre-booking jail and detention diversion program for persons arrested by law enforcement who may have an MH or SA problem.	2007 - 2008	LME Management Team

Develop a MH/SA Rapid Recovery Continuum	• Secure a facility that will operate as "crisis central" (linked to above initiative), implement a crisis Intervention Team and improve linkages to other community services. • Develop a multi level program that provides residential housing and treatment services designed to promote independent living.	2007 - 2008 2007 – 2008	LME Management Team
Enhance and expand the LME's consumer/provider web site	• Site will post new announcements, updates to communication bulletins, current policies and procedures, all essential forms required by the State, provider performance reports, the provider guide and operations manual. • Site will allow for the direct electronic submission of all Endorsement and Request for Proposal information and for the electronic submission of consumer and provider satisfaction surveys.	2007 - 2008 2008 – 2009	Public Information Specialist; Senior IT Business Analyst Network Development Manager

RESOURCE ALLOCATION:

Category	Cost Model *	Actual	Variance
FTE's	8.4	19	126%
Dollars	662,004	1,394,243	111%

*Note: Calculations based on 11-8-06 Cost Model Summary

Explanation:
The variance is due to a number of factors; the primary factor directly relates to the Board of County Commissioners allocating approximately $30 million this fiscal year for the provision of MH/DD/SA services. Additional staff are needed to develop and manage contractual relationships with providers who receive county funds and to ensure that the use of those funds is in accordance with the balanced scorecard outcomes measures approved by the Board. In addition, based on local business needs to increase penetration into the Hispanic/Latino community, an outreach position was created to interface directly with that community and to identify ways to engage them in accessing care. The Planning and Collaboration Committee in conjunction with the local advocacy community places a high priority on providing monitoring. They have requested that these additional resources be allocated to this function.

BUSINESS RULES:
The following business rules enhance Mecklenburg County's ability to perform as efficiently as possible:

- Development of monitoring protocols and practices that are in alignment with best practice philosophies and person centered thinking. Interview check sheets for both provider staff and consumers have been developed (reviewed and approved by CFAC) that can validate the level of consumer participation, involvement and knowledge about their plan as well as the level of collaboration among providers in supporting the consumer and his/her plan.
- Using a team approach that partners staff from Provider Relations, Consumer Affairs, Quality Improvement and Financial Services in conducting agency on site reviews and audits. This integrates a number of different audit and review functions, minimizes the number of site visits at an agency and streamlines parallel processes.
- A Request for Proposal policy and process that includes community stakeholders and consumer and family members at each step and that gives the Consumer and Family Advisory Committee the final approval. This ensures consumers have a voice in shaping the provider network and in advising the LME on how funding should be allocated.

The following business rules inhibit Mecklenburg County's ability to perform as efficiently as possible:

- Best practice models and evidence based services do not always fall within current service definitions. If state funds could be converted to non-UCR in order to implement new best practice initiatives, it would speed up the overall development and implementation of new services. Currently consumer supported services such as a peer education and enrichment centers, or a non-traditional, non-VR supported employment service, or alternatives to ADVP services cannot draw down state IPRS funds.
- In order for an agency to receive endorsement, the endorsement process only requires a minimum set of standards to be met without the agency having to demonstrate the ability or capacity to perform the services for which they are endorsed. In order to ensure

quality services and consumer safety and rights protection, the bar should be raised and standards set more in line with national accreditation standards.

- The LME currently funds agencies versus funding consumers' plans. The LME needs to determine the appropriate balance between funding providers at a level that provides financial stability and quality care yet allows funds to be flexible enough to move with consumers and support their plans as they determine and choose their treatment and support needs. A variety of options should be explored such as flexible fund accounts, voucher system, employer of record; all of these would give more voice and control to the consumer in choosing providers and in being responsible for their care.

#4

CUSTOMER SERVICE/CONSUMER AFFAIRS LME FUNCTIONS

MISSION: To empower and support consumers in developing a voice in directing their care and in creating connections with their community.

PURCHASER STANDARDS: Mecklenburg LME operates in compliance with all applicable state and federal laws, rules and regulations, including, State Plan(s), Performance Contract(s), and Communication Bulletins and with all Local requirements.

CURRENT OPERATIONS*:* The overall functions of Customer Service/Consumer Affairs are: Support of the Consumer and Family Advisory Committee, Complaint Resolution, Clinical Risk Management and Consumer Rights, Consumer and Provider Education and Training, the Promotion of Consumer Empowerment and Participation, Housing Screening and Placement and Payee Services:

Consumer and Family Advisory Committee (CFAC)

- Mecklenburg's CFAC was created in 2002 and from its beginning, through the initial development of its by laws, established itself as a self-governing, self-directed committee with stated purposes to partner with the LME and to serve as strong voice in developing policies and procedures that directly affect consumers and families and in monitoring activities designed to measure and improve quality and consumer satisfaction with services.
- The Director of the Consumer Affairs Division is the staff liaison with CFAC and serves as the primary link between the LME's management team and the Committee. Other LME staff support the activities of the Committee as needed ranging from taking minutes at monthly meetings to preparing and presenting reports as requested.
- CFAC members receive a monthly stipend for attending meetings; travel and child care reimbursements are available to members as requested. The cost of trainings, workshops and conferences are covered by the LME per policy developed by CFAC.
- The CFAC chair and vice chair set monthly agendas that include education, reports and updates regarding quality improvement activities, consumer access to services, consumer satisfaction, best practices, provider endorsement, provider monitoring, care coordination, IPRS funding and provider allocations, housing initiatives, and crisis services.
- CFAC is actively involved in a variety of activities that directly impact consumer care; for example, CFAC developed the LME's Consumer Choice Policy, CFAC is the final

review body in the selection of all RFP awards. CFAC also implements its own QI activities, for example, it is engaged in an ongoing First Responder Survey.

- CFAC members serve on a number of LME Committees: Planning and Collaboration, Financial Rules, Quality Improvement, Best Practice(s), and RFP Community and Consumer Review.

Clinical Risk Management and Consumer Rights

- The LME Clinical Risk Manager reviews all critical incident reports as submitted by providers, according to State guidelines and timelines, and takes action as needed to ensure completeness and accuracy.
- All pertinent data is gathered and analyzed, trends are identified and quality improvement activities are initiated as needed; reports are prepared for the Consumer and Family Advisory Committee, the Human Rights Committee, the LME's Quality Improvement Committee and its Clinical Risk Management sub-Committee.
- The Clinical Risk Manager develops and recommends to providers policies and procedures that minimize clinical risk and promote adherence to clinical best practices.
- The Clinical Risk Manager monitors the provider network to identify and address clinical risk and safety issues, investigates adverse clinical events and critical incidents, and establishes and monitors corrective action plans where appropriate.
- The Clinical Risk Manager provides guidance and direction to the Human Rights Committee, recruits members for the Committee, and ensures adherence to state rules and NCQA accreditation standards. A primary function of the Committee is to monitor Human Rights activities at provider agencies and make recommendations for improvements in policy and procedures.

Complaint Resolution

- The LME Consumer Representative handles all complaints within policy and procedures that meet both State complaint guidelines and the accreditation requirements of NCQA.
- Complaints are handled in a timely, equitable manner and an attempt is made to resolve the complaint at the time of the initial contact. If that is not possible the complaint is investigated, recommendations are made and follow up occurs. Depending on the nature of the complaint, a site visit and/or consumer record review may occur. Investigations may be conducted by the Consumer Representative. The Clinical Risk Manager, a Provider Relations Contract Coordinator or the Clinical Director may also be involved in the investigation.
- Complaint data is maintained and analyzed on a quarterly basis and trends noted for improvement activities. Quarterly status reports are presented to the Consumer and Family Advisory Committee, Human Rights Committee, and the LME Quality Improvement Committee. Per State requirements, the "Quarterly Complaint Report" is sent to the Division of Mental Health's Customer Service and Community Right Team.

Consumer and Provider Education and Training

- Consumer Affairs staff provide training, consultation, and education to staff, consumers, family members, advocacy groups and provider agencies regarding all aspects of consumer rights and responsibilities. Information sessions are held on a quarterly basis; agency-specific on-site trainings and consultations occur as requested or as needed.
- Clinical Risk Manager provides on-site technical assistance to providers to promote the use of best clinical practices and in the areas of consumer protection, rights and risk reduction.

- Develop consumer related materials such as "You Have the Right to Complain" wallet size cards, an information sheet on "How to Select a Provider".
- Consumer Affairs staff attend consumer and family meetings at provider agencies to provide basic information and education about the LME and the Mental Health reform, how to access services, person centered planning and best practice approaches to treatment.
- A Consumer Rights Representative Network was created to improve provider's efforts to increase consumers' awareness of their rights and of complaint procedures. Twenty-three contracted providers are currently participating in the Network which meets on a quarterly basis.

Promotion of Consumer Empowerment and Participation

- Consumer Affairs staff conduct all interactions with consumers, family members and providers using the philosophy and principles of Person Centered Thinking
- Staff actively engage consumers in conversations around consumer choice, participation in the development of their Person Centered Plan and what they should expect from the providers working with them to develop and support their plan.
- Staff recruit consumer participation for a variety of LME committees and activities.

Housing Screening and Placement

- Maintain the waiting list for Shelter Plus Care, HUD 811 supportive living programs and group homes.
- Coordinate the Residential Selection Screening Committee and the placement of SPMI and Chronic Substance Abuse consumers who meet eligibility criteria.
- Maintain a housing locator list, liaison with property managers and private landlords and assist consumers in accessing housing resources.
- Provide information and training to providers in the referral, application and placement procedures for housing subsides administered by the LME and process all requests for assistance with community capacity funds.
- Complete consumer housing satisfaction surveys.

Payee Services

- Working with Community Support providers, the LME provides payee services to 94 adult Mental Health and Substance Abuse consumers.
- Activities include monitoring payments of bills against an approved budget, ensuring funds are utilized according to budget and within monies available, preparing consumer's yearly report to Social Security, receiving and dispersing consumer Medicaid cards, and being available for general trouble shooting to assist providers as they support consumers learning to manage financial problems and needs.

STRATEGIC OBJECTIVE: The following Stakeholder groups are involved in the planning process and in monitoring progress toward objectives within stated timelines using quarterly updates and reports: Consumer and Family Advisory Committee, the LME's Planning and Collaboration Committee, the four Best Practice Community Committees and the Financial Rules Committee.

Customer Service/Consumer Affairs LME

Objectives	Strategies	Target Dates	Responsible Parties
Create additional opportunities for consumers to engage in LME activities with an emphasis on recruiting a diversity of consumers representing the Mecklenburg community.	• Actively recruit consumers and family members participating on best practice committees. • Educate and develop a resource pool of consumers who can take on a leadership role in conducting consumer focus groups (rather than LME staff) • Have two key committees co-chaired by a consumer.	2007-2008 2008-2009 2009-2010	Consumer Affairs and Community Services Director, Consumer Representative
Develop annual consumer community events	In October 2006 the LME sponsored the first consumer conference called "Express Yourself"; based on feedback from consumers this will become an annual event. For '07-'08 the annual conference will focus on Best Practice models of Recovery and Self Determination.	July 2007 and ongoing	Consumer Representative, Training Administrator
Facilitate collaborations to improve the level of consumer involvement within the Provider Community	Increase consumer representation on Providers' Advisory Committees or on Boards of Directors.	July 2007 and ongoing	Consumer Affairs and Community Services Director
Increase the number of consumers who lead and facilitate the development of their person centered plan.	Based on monitoring conducted by Provider Relations, during 2007-2008, 25% of all consumers will be leading the development of their plan; by 2008-2009, the number will increase to 50% and to 75% by 2009-2010.	July 2007 and ongoing	Provider Relations Manager
Develop additional appropriate outcome measurement tools to assess a consumer's process toward recovery.	• The Recovery Model Best Practice Committee has selected the Mental Health Recovery Measure as the instrument providers will be required to use. • The Substance Abuse Best Practice Committee has selected the Outcome Rating Scale as the instrument for SA providers. • All contracted providers will be using the "approved" recovery-related instruments to promote recovery. • The results of data collected from the recovery-related instruments will be reshaping how services are provided and the number of consumers in the later stages of recovery will have increased.	2007- 2008 select pilot sites/providers and test selected measurement instruments 2008-2009 2009-2010	Consumer Affairs and Community Services Director, QI Director

RESOURCE ALLOCATION:

Category	Cost Model *	Actual	Variance
FTE's	4.97	4	-20%
Dollars	348,532	242,111	-31%

*Note: Calculations based on 11-8-06 Cost Model Summary

Explanation:

- Consumer Affairs has a total of four positions that include Director of Consumer Affairs and Community Services, a Consumer Representative, a Clinical Risk Manager and a Representative Payee.
- The variance is due to the non-Medicaid appeal function being handled in the Quality Improvement Division rather than in Consumer Affairs.

BUSINESS RULES:

The following business rules enhance Mecklenburg County's ability to perform as efficiently as possible:

- Involvement of consumers and family members on key committees like Best Practice Committees; the voice of individuals who have and are experiencing the system provides valuable insight into what and how changes need to be made within the system.
- Adoption of best practice models and evidence based services maintaining the focus on the consumer and his/her needs will ultimately support the consumer achieving real life goals towards self sufficiency and community integration.
- The County's Customer service philosophy of "We treat customers as we would like to be treated" helps keep staff focused on the basics of being timely in our response, showing courtesy and respect and doing what is fundamentally appropriate, being truthful, fair and honest.

The following business rules inhibit Mecklenburg County's ability to perform as efficiently as possible:

- Current state consumer satisfaction survey is not inclusive of all populations and was not designed within the context of best practice models or developed with consumer involvement and participation. Other models being used across the country, and being shown as effective, should be reviewed and considered as a replacement.
- Current service definitions do not include Certified Peer Support Specialists as a reimbursable part of staffing requirements, with the exception of the ACT Team. Persons recovering and working as certified Peer Support Specialists helping consumers currently in treatment, as in the Peer Bridger Model for example, should be integrated into the staffing pattern for a variety of consumer services, such as Psychosocial Clubhouse, Community Support, Supported Employment and Residential.
- The development and implementation of peer run support services are not IPRS reimbursable. There would be an increase in the number of consumer run services being developed if a certain percentage of State funding could be designated as non-URC for their initial development and implementation.

#5

SERVICE MANAGEMENT LME FUNCTIONS

MISSION: To provide 24-hour, 7 day per week customer-focused access to appropriate mental health, developmental disabilities and substance abuse services based on acuity of need; to directly monitor the provision of services to ensure that consumers are receiving appropriate services, focusing on best practice and quality outcomes, in the most cost effective manner.

PURCHASER STANDARDS: Mecklenburg LME operates in compliance with all applicable state and federal laws, rules and regulations, including, State Plan(s), Performance Contract(s), and Communication Bulletins and with all Local requirements.

CURRENT OPERATIONS: Policies and procedures related to Access and Utilization Management are in accordance with NCQA and DMH guidelines. The functions of Screening, Triage and Referral (STR) and Utilization Management (UM)/Care Coordination (CC) are combined under the umbrella of the "Utilization Management" Division.

The following functions are performed within the Utilization Management division:

Screening, Triage, and Referral

- The Screening, Triage and Referral (STR) Center functions as the primary point of enrollment to the LME's services. The LME provides 24-hour, 7 day per week access to all residents through both local and toll free published access lines. The unit is staffed with master's level, licensed clinicians, (Utilization Review Specialists-URS) who are qualified to make triage and referral decisions. For Developmental Disabilities services, all staff performing STR or UM functions are "Qualified Developmental Disabilities Professionals" per DMH standards. Consumers may access services by contacting STR telephonically or directly through the community of providers and receive a screening for appropriate services. Consumers are registered for services through the STR Unit.
- Utilization Review Specialists (URS) refer consumers to appropriate providers or crisis services, depending on the identified level of urgency. Consumers who do not meet target populations established by DMH are referred to community resources. Spanish speaking consumers have the option of speaking directly with an STR staff member fluent in Spanish. Other consumers with limited English proficiency are assisted using a telephonic language translation service. TTY services for the deaf and hard of hearing are also available.
- Callers identifying an urgent or emergency need are referred to mobile crisis, the crisis continuum of services or to the nearest emergency room. Types of services include: Mobile Crisis, Crisis Stabilization, Social Setting Detox and Psychiatric Emergency Room services.
- STR staff are responsible for data collection of Consumer Data Warehouse elements and entry into the Common Name Data System.

State Funded/Local Benefit Plan

- The Mecklenburg LME's Utilization Management, Finance and Provider Relations Divisions review funding and utilization of the services in the state funded and local continuum to develop the "LME Benefit Plan". The plan is reviewed at least annually to account for changes in funding, number of consumers and provider input.

Utilization Management of State and Local Resources

- Utilization Review Specialists (URS) within the UM Division review data submitted by providers and determines the appropriate target population for the consumer. The URS has the authority to approve service requests that meet medical necessity criteria from the North Carolina Division of Mental Health or the American Society of Addictive Medicine (ASAM). The URS reviews the information against medical necessity criteria and takes into consideration the local delivery system, local benefit plan and individual needs of the consumer. Requests for services are reviewed against the Person Centered Plan and the LME's State Funded Benefit Plan. Service requests that do not meet criteria and an acceptable alternative cannot be negotiated are forwarded to the Medical Director.
    - Only a licensed physician can make an adverse determination at the LME. These Physician Advisors may reach one of four determinations:
        - a denial (denial of a service),
        - a reduction (denial during a concurrent review),
        - a suspension (a time-limited and temporary denial of a current service), and
        - a termination (the total closing of a case.)

      The Medical Director or LME physician advisor conducts a telephonic review with the provider and makes a medical necessity decision to approve, deny, reduce or suspend the service. Consumers and providers are notified in writing by certified mail of the decision, including instructions regarding the appeal process, in accordance with the LME Policy "Timeliness of UM Decision Making". The notification includes instructions to the consumer regarding how to appeal an adverse determination and contains LME contact information.
    - Utilization Review Specialists (URS) authorize the utilization of state psychiatric hospitals and ADATC resources. Clinical reviews are conducted and requests for additional services that do not appear to meet medical necessity are forwarded to the Medical Director for review with the attending physician.
    - The Unit Supervisors are responsible for conducting a semi-annual assessment of inter-rater reliability. This includes an assessment of how accurately and consistently the criteria are applied by physician and non-physician staff. Findings are reviewed by staff during staff meetings. The unit supervisors, along with the staff, identify opportunities for improvement and take appropriate actions when performance goals are not met.
    - The Developmental Disabilities Utilization Review Specialists review and determine eligibility for CAP-MR/DD services based on the annual allocation provided by DMH.
    - Collection and data entry of NC SNAP for Developmental Disabilities consumers are handled through the DD-UM division.

Consumer Appeals

- Consumers or their representatives may initiate an appeal following a medical necessity adverse determination. Consumer Appeals are handled through the LME's Quality Improvement division.

Discharge and After Care Planning with State Operated Facilities (MH/SA)

- The LME State Facility Liaison is a master's level, licensed clinician (URS) and coordinates all discharges and aftercare planning for Broughton Hospital and Julian Keith. The LME liaison also reviews all admissions to State Operated Facilities to ensure the admission is appropriate and also follows up after discharge to ensure that consumers were seen by the provider chosen within the mandatory 5 day timeframe. Consumers are

referred to community support providers and those providers make contact within the 5 days. The LME makes every reasonable effort to reach consumers who are not seen within the initial 5 days after discharge to attempt to coordinate contact with the provider chosen by the consumer.

Compliance with Diversion Law

- The LME's Diversion Compliance staff (DD Liaison) is a "Qualified Developmental Disabilities Professional" and is available 24/7 to review any request for DD consumers' admission to psychiatric facilities. Additionally, the DD Liaison assists in locating community placement for consumers ready for discharge from state operated MR centers.

Consumer Choice

- The Mecklenburg LME has policies and procedures related to consumer choice. Consumers are offered choices of providers, when available, throughout the course of their treatment. Monitoring of consumer choice is done through reviews conducted by Provider Relations staff. The LME has identified the Consumer Representative to assist consumers with changing providers and monitor the trends in requests to change providers throughout the network

Care Coordination

- Current Care Coordination activities are:
    - *PCP Review*: Utilization Review Specialists review all Person Centered Plans for consumers using state funded services and review plans for consumers using Medicaid services when they are also accessing state or locally funded services. Additionally, plans for consumers using Medicaid services entirely are reviewed randomly or as needed. PCP's are reviewed for compliance with DMH guidelines as well as for evidence of positive outcomes based on Evidence Based Practices. Technical assistance is provided when necessary.
    - *Intensive Care Management (ICM) Program*: The ICM program was developed to closely monitor treatment and treatment planning for high risk and high cost consumers. ICM staff works directly with consumers and providers in treatment plan development and is available to participate in Child and Family Team meetings as needed. The ICM committee is made up of the LME Medical Director, Clinical Director, UM Director, UM Supervisor and ICM Care Manager(s), and meets at least monthly to review cases.
    - *Adult Guardianship Care Management*: The UM Division partners with the local Department of Social Services' Adult Guardianship division to monitor adult consumers with SPMI diagnoses. Coordination efforts focus on discharge planning with state operated facilities and assisting in locating appropriate housing.
    - Provide consultation to the community of providers to address issues related to continuum of services available, etc.
    - Provide follow up 30 days, 60 days and 90 days after discharge from a state institution to ensure continuity of care.
    - Review assessments completed by Treatment Alternative to Street Crime (TASC) for continued services for continuity of care and appropriateness of treatment recommendations.

Technical Assistance

- The URS provide training and assistance, to the community of providers (in completing authorization requests). The UM Division has developed a CD for providers to supply information specific to the authorization process and UM Policies and Procedures. The UM Division staff, including URS and supervisors, work in collaboration with the LME's Financial Services and Provider Relations Divisions to assist in problem solving with providers.

Community Collaboration

- The LME holds regular meetings with community leaders from Department of Social Services, the Sheriff's Office, Provider agencies, local hospitals, prevention programs, etc. in an effort to gain insight into the needs of the community and how the LME can assist to effect change within the community.
- The LME's Practitioner Advisory Committee provides regular input into policies and procedures and credentialing of independent practitioners.
- The System of Care Senior Leadership participates in the "Care Review Team" which includes representatives from various community agencies and serves as a resource for community support agencies throughout the provider network.
- The LME Medical Director participates in the "Western Region LME Medical Directors Meeting" on a regular basis as a means of providing input regarding state facility over-utilization and development of interventions to manage the over-utilization.
- The Utilization Management Director works in collaboration with the LME's Public Information Officer to develop and update the LME's social marketing plan to increase awareness within the community.

STRATEGIC OBJECTIVES: The following Stakeholder groups are involved in the planning process and in monitoring progress toward objectives within stated timelines using quarterly updates and reports: Consumer and Family Advisory Committee, the LME's Planning and Collaboration Committee, the four Best Practice Community Committees and the Financial Rules Committee.

Service Management

Objectives	Strategies	Target Dates	Responsible Parties
Increase number of consumers receiving services adhering to best practice models.	The UM Division, in conjunction with Provider Relations Division, will update the Local Benefit Plan at least annually over the next three years to encourage provider network to adhere to best practice models, thereby increasing positive outcomes for consumers. The initial phase will focus on reducing the number of consumers receiving ADVP services and increase the number of consumers in supported employment-type services. Additional phases will focus on Recovery Model (Adult MH), Self Determination Model (DD), System of Care (Child MH) and Substance Abuse Recovery Model (SA). The UM Division will assist Provider Relations and Quality Improvement Divisions in developing guidelines for review for fidelity to models and collaborate on the review/monitoring process.	July 2007 - ongoing	UM Director, Provider Relations Manager, Consumer Affairs and Community Services Director, Financial Services Director
Improve quality of Person Centered Plans	UM Division staff will: • Review Person Centered Plans using first-hand knowledge of trends in PCP development. • Meet monthly with Provider Relations staff to identify providers needing assistance in the development of plans, involvement of other service providers in the planning process, etc. • Provide technical assistance to providers and assist in providing training to the provider network. • Follow up with the provider on any Person Centered Plan that is 'pended' because of lack of information or quality of development and offer technical assistance. • Ensure that all providers or support systems are part of the plan development. • In collaboration with Provider Relations Division, will identify areas of improvement needed and develop plans for	July 2007 - ongoing	UM Director

	implementation, training and monitoring.		
Expand continuity of care opportunities for high risk consumers.	Use of authorization and claim data to identify over/under utilization of services will increase during fiscal year 2007. Areas of focus over the next three years include: • Review of admissions to ACTT or Community Support Team following discharge from state operated facilities, with an increase of 25% referrals into these programs each year for the next 3 years. • Admissions of adolescents to Substance Abuse Intensive Outpatient Programs following identification of substance abuse issues by the diagnostic assessment with an increase of 25% referrals into these programs each year for the next 3 years. • Use of intensive in home and MST services for children and adolescents prior to admission to residential levels of care or at discharge from residential levels of care with an increase of 25% referrals into these programs each year for the next 3 years. • Increasing services available to adolescents confined to detention with an increase of 25% referrals into these programs each year for the next 3 years. • Implementation of medical-behavioral health coordination with primary care physicians	July 2007 - ongoing	LME Management Team, UR Specialists, Contract Coordinators
Consortium LMEs will manage and will be at risk for utilization of state institution services.	• Work with state institutions to implement LME concurrent utilization review of admissions from Consortium LME service regions. • When appropriate, refer discharged Broughton consumers to Community Support Team and ACTT services. • Develop more effective community-based alternatives to inpatient services • Consortium LMEs to consider sharing physician resources for the Utilization Review process to increase cost efficiencies.	July 2008 - ongoing	Deputy Director, UM Director

Utilization Management of State Operated Facilities Services	• Develop a plan for managing bed days at State Operated Facilities in collaboration with Broughton State Hospital Clinical Director and Unit Managers. The LME Medical Director has direct oversight of utilization and works in conjunction with physician staff at Broughton to develop appropriate discharge plans. • Develop a plan to monitor consumers past the required "5 days after discharge". • Continue to monitor consumers at 30, 60 and 90 day intervals to ensure continuity of care and coordination of services.	July 2007 - ongoing	Deputy Director, UM Director, Medical Director, UR Specialists

RESOURCE ALLOCATION:

Category	Cost Model *	Actual	Variance
FTE's	58.09	31	-47%
Dollars	4,313,252	3,166,257	-27%

*Note: Calculations based on 11-8-06 Cost Model Summary

Explanation:

- The UM Division is able to meet performance standards with the current level of staffing, The LME has assigned resources to other divisions to address local business needs as identified in Local Strategic Plan approved by CFAC and Planning and Collaboration Committee.

BUSINESS RULES:

The following business rules enhance Mecklenburg County's ability to perform as efficiently as possible:

- Eligibility for Local and State Funded Developmental Disability (DD) services is determined by the DD-UM staff prior to starting services. Consumers who are deemed ineligible for services are not using resources that could be allocated for other eligible consumers.
- Any Medicaid provider can provide screening and registration of consumers without prior approval from STR. This enhances the access of citizens to service.
- All children and adolescents have a "Child and Family Team" meeting prior to entering residential levels of care, ensuring that all options within the home or community are exhausted prior to placement out of home or area.

The following business rules inhibit Mecklenburg County's ability to perform as efficiently as possible:

- The LME is unable to fully implement best practice models due to service definition constraints. Example: services provided to adolescents incarcerated in county detention facilities are not reimbursable services.
- Lack of information exchange between DMH/DMA, Value Options, and the LME causes a breakdown in the review of service delivery, over/under utilization review and coordination of care for consumers receiving Medicaid services.
- Providers of non-direct bill Medicaid services must get authorization from both Value Options and the LME for payment from the LME. This causes hardships for providers as they are forced to do 'double' work to be able to bill through the LME.

#6
QUALITY MANAGEMENT LME FUNCTIONS

MISSION: To ensure effective and high quality services are provided to consumers, families and the community in an efficient manner.

PURCHASER STANDARDS: Mecklenburg LME operates in compliance with all applicable state and federal laws, rules and regulations, including, State Plan(s), Performance Contract(s), and Communication Bulletins and with all Local requirements.

CURRENT OPERATIONS:

Quality Management

- Using the Juran Philosophy of Quality Improvement, the QI Division directly and indirectly supports the LME and the Community of Providers as it continuously improves services to consumers, families and the community. The three pronged approach of Quality Control, Quality Improvement and Quality Planning are integral to the success of the QI program and the public system overall. Three of the Quality Improvement Analysts are licensed clinicians; all QI staff have experience in data management and process improvement.

Measuring Consumer Outcomes and Satisfaction

- The QI Division provides oversight of the data collection and reporting for NC TOPPS and COI projects. QI staff manages the data collection and transmission to DMH of the annual MH and SA Consumer Satisfaction Survey. QI staff ensures collection of a far greater number of completed surveys than is required by the Performance Contract and manages that data on-site, producing a Mecklenburg specific report that is utilized locally for improving satisfaction.

Clinical Risk Management

- The QI Division provides support for data management, analysis, and reporting; and assists with statistical and clinical interpretation of incident reporting.

UM Appeals

- Staff in the QI Division manages the appeals of UM denials for state and county funded services and DD eligibility. This includes both the individual requests and the aggregate data reporting.

Process Improvements

- The QI Division facilitates numerous improvement projects on a continual basis. These include measurement of important aspects of evidence-based Practice guidelines. For example, rapid follow up with a practitioner following hospitalization is shown to reduce re-admissions. Measurement of the follow up rate, comparison to performance standards, and interventions to improve performance are ongoing activities. The interventions for any Process Improvement Activity may be community-wide or agency specific.
- In collaboration with CFAC and the Provider Relations Division, a reporting mechanism will be developed that will essentially serve as the foundation for a "provider report card". This outcomes-based measure will detail and profile provider performance.

Implementation of Evidence Based Practices

- The QI Division assists Provider Relations staff and the Clinical Director in the implementation of Evidence Based Practices. This includes measurement functions and training as needed.

Management of Complaints regarding quality of services

- The Consumer Representative, as part of the Division of Consumer Affairs, is the recipient of complaints from consumers, families and other interested parties. The Consumer Representative responds to complaints according to timelines set forth by DMH and NCQA. QI staff provide data management for this process and ensure that aggregate information is reported through existing QI Committee structure and appropriate actions are taken to cause improvements.

Practitioner Advisory Committee

- The LME's Practitioner Advisory Committee (PAC), chaired by the Clinical Director plays an important role in the Quality Management Process. QI staff support PAC through fact finding and reporting. The purpose of PAC is to:
    - Serve as a credentialing committee to review applications of Licensed Independent Practitioners.
    - Give input to decisions regarding practice guidelines and treatment record standards; quality improvement activities and actions for improvements.
    - Evaluate new technologies for inclusion into the continuum of care.

Credentialing of independently contracted Licensed Independent Practitioners

- QI staff, working with the LME's QI Committee (QIC) and PAC, develops process performance standards for the assessment and approval of Licensed Independent Practitioners (LIP). This credentialing process is limited to practitioners under contract for IPRS or county funded services.
    - QI staff manages the data collection, facilitate non-biased consideration of the applicants and process the committee's decisions.
    - Re-credentialing occurs at least every three years.
    - Performance monitoring occurs at least semi-annually.

National Accreditation

- QI staff is primarily responsible for ensuring ongoing and overall compliance with NCQA standards. This includes, but is not limited to credentialing of agencies and independent practitioners; at least three clinical and service improvement projects that show statistically significant improvement; utilization management functions that ensure timely responses and consistent implementation of authorization processes; availability and utilization of preventive health programs, consumer rights and responsibilities; objective standards for size and scope of network of practitioners and providers; measuring and improving satisfaction among consumers and contractors.

Data Analysis

- In addition to the areas mentioned above, QI staff provides data management, analysis and interpretation of various reports. These include utilization patterns, enrollment of new consumers into the LME; market analysis of the catchment area, needs and gaps in service continuum, and other internal business processes.

STRATEGIC OBJECTIVES: The following Stakeholder groups are involved in the planning process and in monitoring progress toward objectives within stated timelines using quarterly updates and reports: Consumer and Family Advisory Committee, the Planning and Collaboration Committee, the four Best Practice Community Committees, Practitioner Advisory Committee, QI project teams.

Quality Management

Objectives	Strategies	Target Dates	Responsible Parties
Investigate and implement use of different satisfaction survey instrument and expanded process so that acceptability of LME services (access to care, choice of providers, recognition of cultural issues, quality of provider network, consumer rights) is assessed and improved if needed.	Include all consumer groups (MH/DD/SA) in the survey process. QI will facilitate the implementation of ECHO, CAHPS or similar survey.	July 2008 - ongoing	Consumer Affairs and Community Services Director and QI Director
Maintain "full" accreditation by NCQA	Continue performance of LME functions at highest level of compliance, including newly added standards pertaining to use of internet and health screening and health promotion from NCQA.	July 2008 - ongoing	QI Director
Provide training and staff development for practitioners in LME community	Continue to arrange for the provision of high quality, local educational events so that staff of provider agencies may participate. These events will include topics such as System of Care and Wraparound concepts, Self-determination, Recovery Model and Motivational Interviewing; psychiatric diagnoses and medications; and trainings related to service definitions and Public System requirements. Training on Quality Improvement theory will also be available.	July 2007 - ongoing	Clinical Director, Consumer Affairs and Community Services Director and QI Director
Improve submission rate for NCTOPPS and COI	Develop system for informing Provider Agency CEO's of poor performance, alerting Provider Relations and consideration of corrective actions plans in cases of continued poor performance with this requirement.	July 2007	QI Director
Provider Performance Measurement	In collaboration with Provider Relations Division, a reporting mechanism will be developed that will essentially serve as the foundation for a "provider report card". This outcomes-based measure will detail and profile provider performance	July 2008 – ongoing	QI Director, Consumer Affairs and Community Services Director

RESOURCE ALLOCATION:

Category	Cost Model *	Actual	Variance
FTE's	4.5	8.5	89%
Dollars	316,433	583,068	84%

*Note: Calculations based on 11-8-06 Cost Model Summary

Explanation:
The variance is due to the appeal management function being incorporated in the Quality Improvement Division rather than the Consumer Affairs Division. There are also additional resources needed to maintain NCQA accreditation and the costs associated are reflected in the variance.

BUSINESS RULES:
The following business rules enhance Mecklenburg County's ability to perform as efficiently as possible:

- NCQA standards provide the LME with excellent guidance as a fully functioning LME.
- Mecklenburg County has implemented a county-wide Performance Improvement system based on the Balanced Scorecard model and the guidelines used by the Federal Office of Management and Budget. Because the LME must report measures of effectiveness in terms that are easily understood by the public, providers and the LME must translate jargon into human terms and focus on the consumer.
- Identification of Best Practices and implementation of clinical practice guidelines and measurements of these improves the overall system by encouraging a coordinated, system wide approach to mental illness, substance abuse and developmental disabilities issues.

The following business rules inhibit Mecklenburg County's ability to perform as efficiently as possible:

- The LME has the responsibility with limited authority to ensure a certain level of performance by endorsed, direct bill Medicaid providers. Significant LME resources are spent in asking and encouraging those non-contracted providers to complete reporting requirements (COI's, TOPPS, customer satisfaction, Core Indicators, NC-SNAP).
    - It is recommended that the statewide MOA be strengthened to include the specific responsibilities mentioned above with identified financial penalties.
- Many performance standards from NCQA are repeated in the DMH performance agreement with the LME. DMH & NCQA have slightly different methodologies for calculating compliance rates for the function (for example abandonment rates and call response time in STR). Since the LME has met the NCQA standard which is nationally recognized and has been subjected to numerous internal and external reviews, it is redundant and inefficient for DMH to measure the LME on the same performance dimension, as it is redundant for the LME to monitor, measure, report and evaluate the measure a second time.
    - It is recommended that DMH deem the LME to be in compliance for the accreditation period, for those measures that are duplicated by the NCQA process. This would be consistent with DMA's stance toward accredited providers.

ADDENDUM

Process Review Report

The Community Planning and Collaboration Committee (PCC) along with CFAC represent the core of our community planning process. These committees have a long history in Mecklenburg County and include consumers, providers, United Way, Mental Health Association, Council for Children's Rights, Vocational Rehabilitation and other key community stakeholders. The PCC and CFAC approved the Mecklenburg 3-year Strategic Plan in November 2005 and this represented the base document for the beginning of the current Local Business Planning process.

There are standing committees formed out of the PCC that identify gaps on an ongoing basis within the continuum of care and make recommendations for improvements and additions regarding Best Practices. These committees include: System of Care, Mental Health Recovery Model, Developmental Disability Self Determination and Substance Abuse Recovery. They have also been actively involved in the LBP process.

Based on experiences developing the original LBP, the LME made the decision for senior management staff to attend already existing groups within the community to gain their input rather than hold "public forums". CFAC did not support the public forum approach as it has historically reached very few consumers and stakeholders in Mecklenburg County.

The following groups provided input into the Local Business Planning Process:

Date	Group	Type	Number in attendance
November 6, 2006	NAMI	Consumers/family members	12
November 14, 2006	Mecklenburg Disability Network	Providers	18
November 29, 2006	InnerVision Psychosocial Clubhouse	Consumers	55
November 30, 2006	CFAC	Consumers/family members	15
December 1, 2006	Recovery Model Best Practice Committee	Providers/consumers/stakeholders	16
December 11, 2006	PCC	Providers/stakeholders	12
December 13, 2006	Provider InfoShare	Providers	100 participants representing 60 providers
January 4, 2007	Employee Focus Group	LME front line employees	14
January 10, 2007	Employee Focus Group	LME front line employees	12
January 10, 2007	Goodwill	Consumers	53
January 16, 2007	Employee Focus Group	LME front line employees	11

January 20, 2007	Mentor	Foster care Providers/consumers	55
January 30, 2007	Broughton staff	Dr. Esse, Clinical Director and Social Worker Supervisor, Utilization Management Supervisor and Admission Coordinator	5
February 8, 2007	Residential Support Services Family and Friends	Consumers/family members	34
February 13, 2007	Lifespan "Parents as Peers" Advocacy Group	Consumers/family members	35
February 13, 2007	Lifespan Parent Advisory Committee	Consumers/family members/staff	15
February 14, 2007	Partial Hospitalization Program	Consumers	35
February 15, 2007	Juvenile Court judges	Juvenile Court Judges and staff	5
February 27, 2007	Juvenile Crime Prevention Council	Community advocates	21
March 1, 2007	Autism Society	Consumers/family members	27

The plan was posted on the LME web site for comment from February 26, 2007 through March 20, 2007. It was approved by the PCC on March 5, 2007, by CFAC on March 8, 2007 and by the Mecklenburg County Board of County Commissioners on March 20, 2007.