

Operations Manual

Orange Person Chatham
Area Authority/LME

Revised 6/07, 10/07, 11/07, 1/08, 2/09, 7/09, 1/10

Forward

This manual is designed to try and bring a sense of true partnership to the MH/DD/SA service and support contracting process. It is not designed as a way to eliminate all potential problems, but rather as a way to begin the process of mutually identifying how we can go forward in our quest to seek best practice for the consumers of our services and in our business practices that we might be more effective and efficient. We hope that we can become true partners through demonstrating the mutual respect that is embodied in this effort. As we collaborate to seek quality and fairness in our relationships and business practices we can make the system more “friendly” to all of the participants in it. Let us each take responsibility for our own behavior. Let us be willing to not just seek the status quo, but rather a new and better way.

part-ner-ship (pärt'nər-ship')*n.* A relationship between individuals or groups that is characterized by mutual cooperation and responsibility, as for the achievement of a specified goal. (Webster's).

TABLE OF CONTENTS

Introduction.....	4
Overview of OPC/LME	5
Including Brief Overview of OPC System of Care	
Section I Provider Relations.....	9
Problem Resolution (Disputes and Appeals)	
Technical Assistance/Training Collaboration	
Who to Contact for Questions	
Notification of Change of Address	
Section II Comprehensive List of Requirements	19
Section III Authorization Process (MH/DD/SA).....	24
Section IV Claims.....	29
Electronic Connectivity Requirements	
Claims Adjudication	
Prompt Pay (excerpt from 05-06 Performance Agreement)	
County Funds	
Sliding Scale Fee Schedule	
Section V Provider Documentation Submission Requirements.....	34
Section VI Quality Improvement & Performance Monitoring.....	37
Provider Monitoring (AP surveys, reporting on Performance Indicators)	
Client Rights Reporting	
Incident Reporting	
Person-Centered Planning	
Model Fidelity	
Treatment Protocols	
Clinical Outcome Measures	
Deficit Reduction Act	
Red Flag and Address Discrepancy Rule	
Section VII Area Authority-Specific Policies/Forms/ Local Governance Requirements (<i>not included Elsewhere</i>).....	49
Care Review in Orange-Person-Chatham Counties	
OPC Care Coordination Referral Information	
OPC Crisis Services	
Disaster Preparedness and Recovery	
Section VIII Glossary of Terms (Division and LME).....	56
Appendix A Family Support and Advocacy Groups in Orange, Person & Chatham Counties.....	66
Appendix B OPC Person Centered Plan (PCP) Quantitative/Qualitative Review Tool.....	68
Appendix C Request for Care Coordination Form and Instructions.....	72
Appendix D Sample Billing Ticket (attached Excel Spreadsheet).....	74

INTRODUCTION

This Operations Manual is a binding part of the contract or “Purchase of Services Agreement between the Area Authority and the Provider.” The intent of this manual is to provide detailed information and procedures required as part of the purchase of service agreement and to organize this information in a common manner that is “user friendly” to all parties. It is also hoped through this process that increased standardization can begin to occur with business practices among Area Authorities.

Standardization should not be confused with uniformity. Specific Area Authorities currently have differing systems within their internal organizations just as private providers do, even though they may offer the same range of services. Some Area Authorities must operate under different or additional requirements and/or constraints than other Area Authorities due to local governance. This is similar to private Providers who have differing entities to whom they are responsible even though two or more private Providers may offer the same range of services. Some of these differences may begin to diminish as Area Authorities transition to LME’s.

This manual does not include information about Area Authority policies or procedures that take place prior to contracting with a Provider, such as procedures for getting on the Area Authority’s Provider community, or compliance verification, or checklists of items needed in order to begin the contracting process, etc. Rather, it includes only information pertinent to the performance of the Agreement.

This manual contains eight major sections. Please refer to the Table of Contents.

Overview of the OPC Area Authority

Mission Statement

Our mission is to work in conjunction with consumers, their families, and our providers so that consumers can lead satisfying lives as integral, valued, and contributing members of the community.

Vision Statement

The OPC Area Authority is person-centered and outcome focused and is a responsible agent of the taxpayers by deploying public resources as efficiently as possible while supporting citizens with severe disabilities in their efforts to live as fully contributing members of the community. We will continue to work collaboratively with consumers, family members and community systems in order to maximize natural supports and minimize institutional dependence for both our existing consumers and any future consumers. Although we may encounter challenges along the way, we will work to promote a fully person-centered, efficient and responsive system that the community will be proud to support.

We will:

- Support individuals to make meaningful choices and to achieve their personal and family goals.
- Respect the dignity and diversity of those we serve.
- Promote human and civil rights for our consumers.
- Assist our provider community in serving individuals most in need.
- Support our providers to make services readily available in our community.
- Support our provider community to assist individuals in their pursuit and maintenance of housing and employment.
- Recognize the importance and complex interaction of families.
- Advocate for the appropriate use of natural supports, such as family, friends, neighbors, and community organizations.
- Allocate resources wisely in a professional and ethical manner.
- Promote the use of best practices in a culturally sensitive manner to facilitate positive outcomes for consumers.

OPC System of Care

System of Care is a coordinated system of supports and services for children with significant emotional or behavioral challenges and their families. The coordinated system emphasizes family and community strengths and assists youth in becoming capable and responsive community members.

Values

- Put the needs of the **child and family FIRST**.
- Services and supports are developed to best **ensure the safety and success of the child in their family, at school, and in the community**.
- Services and supports are **tailored to the unique situation, strengths, and needs** of each child, family, and community.
- Keeping services **based in the community**.
- Interactions between service providers and families are conducted in a **mutual 'no shame no blame'** fashion.
- **Collaboration** between agencies, schools, community resources, and families is the best way to **build effective services and supports for individuals and families** with complex needs.
- Respect and appreciate **cultural diversity**.
- Focuses on **building and strengthening social networks and informal community resources**.
- Services and supports are **outcome-based** with clear accountability.

Purpose

Purpose of System of Care is better outcomes for children and their families

- Staying in school or getting some type of vocational training
- No legal trouble
- Permanent supportive relations
- Skills to live and work independently
- Fulfilling the dreams of the child and family

Structure

OPC System of Care includes:

- Coordination at the agency level (**Community Collaboratives**)
- Coordination at the individual child level (**Child and Family Teams**). Child and Family Teams coordinate a range of flexible, formal and informal resources that fit a family uniquely.
- **Family Support and Advocacy** (each county has a Family Support Organization)

Each County based **Community Collaborative** strives to have a system of care that increases collaboration for the benefit of children with complex and multiple emotional needs and their families and demonstrates improved outcomes for these children. The Community Collaborative creates a

framework for agencies, families, and the natural resources of the community to work together to meet the needs of children with emotional disturbance and their families.

Child and Family Teams are formed when the young people are involved with multiple agencies. Child and Family Teams include:

- Young person
- Parents/caretaker
- Agency staff involved with the family (DSS worker, court counselor)
- School staff (teacher, special education staff)
- Informal supports of the family (extended family, family friend, neighbors, minister)

Child and Family Teams are the vehicle for Person Centered Planning for children and adolescents. OPC Area Program expects that Child and Family Teams meet monthly to develop, monitor, and adapt plans for children and their families. When Children have an enhanced service, the clinical home is responsible for facilitating the Child and Family Team. Teams meet at times and locations convenient for families. Facilitators may need to assist families address issues of transportation and childcare to ensure family participation. The purpose of the Child and Family Team is to develop an action plan to meet families' goals and then to monitor that plan to make sure it is working. The best strategy to build a plan that is useful and effective is to use the family's strengths, culture, interests as well as their needs.

See Appendix A for a list of Family Support and Advocacy Groups in the OPC catchment area.

SECTION I

Provider Relations

Problem Resolution/Disputes and Appeals:

If problems arise between the Provider and the Area Authority in the delivery of services, the parties shall attempt whenever possible to resolve these problems informally in a reasonable and timely manner. Complaints may be presented orally or in writing to the OPC Customer Service Representative, following the process outlined in OPC's Provider Complaint Policy and Procedures summarized below.

Definition:

A complaint is any verbal or written expression of concern with the LME's management of public mental health, developmental disabilities or substance abuse services that the complainant perceives as a problem.

Examples of complaints may include, but are not limited to the following:

1. concerns about contract allocations;
2. concerns regarding billing and reimbursement issues;
3. disagreement with OPC monitoring procedures or decisions;
4. concerns regarding the authorization decisions;
5. concerns about training provided by OPC

Procedures:

1. A complaint may be presented orally or in writing to an OPC Customer Service Representative (CSR). The CSR will assist a complainant who requests assistance in filing the complaint and will provide information describing the complaint process and how to contact advocacy groups. Interpreters will be made available as needed for complainants with limited English proficiency, as well as for those who are deaf or hearing impaired.
2. Should the CSR receiving the complaint have a conflict of interest, he or she will refer the case to another CSR who does not have prior knowledge or conflict of interest.
3. The CSR will inquire as to whether the concern has been communicated to the OPC provider representative assigned to the provider and, if not, will encourage the complainant to do so. If the complainant has already contacted the OPC provider representative OR does not feel comfortable in doing so, the complaint will be processed by the CSR.
4. The CSR will ask the complainant for permission to use his/her name during the complaint process. In the event the complainant does not grant permission to use his/her name, every effort will be made to protect the identity of the complainant.
5. The CSR will document the following information on the Provider Complaint Form:
 - ◆ Complainant's Demographic information – name, telephone number, address...etc.
 - ◆ The complainant's concerns in his/her own words and what the complainant believes is necessary to resolve the complaint
 - ◆ Indication of whether the complainant agrees to be identified during the complaint process
 - ◆ Information about OPC staff involved in the complaint

Informal Review Process

1. The CSR will remain the point of contact for the complainant and will provide the complainant with information regarding how to contact the CSR to provide the complainant full opportunity to represent his/her concern during the review process.
2. During the review process the CSR may confer with one of more of the following internal OPC divisions:
 - ◆ Quality Improvement/Provider Relations

- ◆ Service Systems Manager
 - ◆ Care Management
 - ◆ Finance Office
3. The CSR will work with the assigned person from the appropriate division(s) to resolve the complaint to the satisfaction of the complainant. The CSR will complete a review of the complaint within 30 calendar days from the date the complaint was received and will document actions taken during the review process.
 4. A decision regarding the complaint will be dated and mailed to the complainant by the CSR within two working days of the date the review was completed.
 5. The CSR will include information regarding how the complainant can access the next level of review.

Local Appeal Process

1. If the issue is not resolved, or the complainant is not satisfied with the decision resulting from the Informal Review Process, or if the complainant feels that there has been any retaliation related to the filing of the original complaint, the complainant may file an appeal with Customer Services within 15 working days from the date of the Informal Resolution letter.
2. The Customer Service Manager or his/her designee will deliver the appeal to the OPC Area Director along with all documentation regarding the original complaint, including a copy of the written decision from the Informal Review Process.
3. The OPC Area Director or his/her designee will review the appeal.
4. The Customer Service Manager or his/her designee will send the written decision of the OPC Area Director to the complainant within 20 working days from the date the appeal was received by the Customer Service Manager.

In the event that informal resolution is not appropriate or is unsuccessful, the process outlined in GS 122C-151.4 shall be followed.

§ 122C-151.4. Appeal to State MH/DD/SA Appeals Panel.

- (a) Definitions. – The following definitions apply in this section:
 - (1) "Appeals Panel" means the State MH/DD/SA Appeals Panel established under this section.
 - (1a) "Client" means an individual who is admitted to or receiving public services from an area facility. "Client" includes the client's personal representative or designee.
 - (1b) "Contract" means a contract with an area authority or county program to provide services, other than personal services, to clients and other recipients of services.
 - (2) "Contractor" means a person who has a contract or who had a contract during the current fiscal year.
 - (3) "Former contractor" means a person who had a contract during the previous fiscal year.
- (b) Appeals Panel. – The State MH/DD/SA Appeals Panel is established. The Panel shall consist of three members appointed by the Secretary. The Secretary shall determine the qualifications of the Panel members. Panel members serve at the pleasure of the Secretary.
- (c) Who Can Appeal. – The following persons may appeal to the State MH/DD/SA Appeals Panel after having exhausted the appeals process at the appropriate area authority or county program:
 - (1) A contractor or a former contractor who claims that an area authority or county program is not acting or has not acted within applicable State law or rules in imposing a particular requirement on the contractor on fulfillment of the contract;
 - (2) A contractor or a former contractor who claims that a requirement of the contract substantially compromises the ability of the contractor to fulfill the contract;
 - (3) A contractor or former contractor who claims that an area authority or county program has acted arbitrarily and capriciously in reducing funding for the type of services provided or formerly provided by the contractor or former contractor;
 - (4) A client or a person who was a client in the previous fiscal year, who claims that an area authority or county program has acted arbitrarily and capriciously in reducing funding for the type of services provided or formerly provided to the client directly by the area authority or county program; and
 - (5) A person who claims that an area authority or county program did not comply with a State law or a rule adopted by the Secretary or the Commission in developing the plans and budgets of the area

authority or county program and that the failure to comply has adversely affected the ability of the person to participate in the development of the plans and budgets.

(d) Hearing. – All members of the State MH/DD/SA Appeals Panel shall hear an appeal to the Panel. An appeal shall be filed with the Panel within the time required by the Secretary and shall be heard by the Panel within the time required by the Secretary. A hearing shall be conducted at the place determined in accordance with the rules adopted by the Secretary. A hearing before the Panel shall be informal; no sworn testimony shall be taken and the rules of evidence do not apply. The person who appeals to the Panel has the burden of proof. The Panel shall not stay a decision of an area authority during an appeal to the Panel.

(e) Decision. – The State MH/DD/SA Appeals Panel shall make a written decision on each appeal to the Panel within the time set by the Secretary. A decision may direct a contractor, an area authority, or a county program to take an action or to refrain from taking an action, but it shall not require a party to the appeal to pay any amount except payment due under the contract. In making a decision, the Panel shall determine the course of action that best protects or benefits the clients of the area authority or county program. If a party to an appeal fails to comply with a decision of the Panel and the Secretary determines that the failure deprives clients of the area authority or county program of a type of needed service, the Secretary may use funds previously allocated to the area authority or county program to provide the service.

(f) Chapter 150B Appeal. – A person who is dissatisfied with a decision of the Panel may commence a contested case under Article 3 of Chapter 150B of the General Statutes. Notwithstanding G.S. 150B-2(1a), an area authority or county program is considered an agency for purposes of the limited appeal authorized by this section. The Secretary shall make a final decision in the contested case. (1993, c. 321, s. 220(o); 2001-437, s. 1.17(c).)

Technical Assistance/Training Collaboration:

Providers shall give reasonable notice to the Area Authority for any and all requests for technical assistance. Requests for technical assistance may be made by submitting the OPC Request for Technical Assistance form included as a part of this document or found at www.opcareaprogram.com via e-mail, fax or mail to the assigned Provider Relations Representative. Requests will be fulfilled based on the availability of resources within OPC. Please note that the inability of OPC to provide specific technical assistance or training does not release the Provider from the responsibility of fulfilling the terms or requirements of the Contract or Memorandum of Agreement.

OPC will provide timely and reasonable technical assistance regarding new State initiatives, or as the result of monitoring activities as related to the services covered in the Agreement, subject to the State's timeliness and availability of the information necessary to provide the technical assistance. Technical assistance may also be offered and/or required by OPC in conjunction with any quantitative/qualitative review findings; as a result of a monitoring or endorsement site visit; and/or in conjunction with any plan of correction that may be required after any local, state or federal audit or license review.

Training collaboration shall be done whenever feasible between the Area Authority, or groups of Area Authorities, and Providers, or groups of Providers, in order to effectively and efficiently utilize the resources available to each party. OPC will offer regularly scheduled provider meetings as well as training courses based on needs determined by Providers and LME staff.

OPC AREA AUTHORITY

REQUEST FOR CLINICAL AND TECHNICAL ASSISTANCE TRAINING

Date: _____

Provider Agency: _____

Address: _____

Contact Person: _____

Telephone Number: _____

E-mail Address: _____

What kind of training is needed? _____

Is this technical assistance/training required as part of a corrective action plan?

No Yes (specify or attach) _____

*Please return completed form to Senga Carroll
via e-mail scarroll@opc-mhc.org or fax to her attention at (919) 913-4038*

OPC CONTACT INFORMATION:

TOPIC	CONTACT PERSON	PHONE	E-MAIL
Agreement Questions	Assigned Provider Relations Representative: Zach Lutwick Phyllis Williams	(919)913-4061 (919)913-4085	zlutwick@opc-mhc.org pwilliams@opc-mhc.org
Authorizations	Katherine Hudson STAR and Authorizations Manager Authorization Question Line	919-913-4140 919-913-4105	khudson@opc-mhc.org
Care Review	Lisa Lackmann Child & Family Planner	919-913-4011	llackmann@opc-mhc.org
Client Enrollment & Registration	April Walker Data Entry/Analyst	919-913-4148	awalker@opc-mhc.org
Client Rights & CFAC	Michael Norton Client Rights Coordinator	919-913-4079	mnorton@opc-mhc.org
Clinical Concerns and Treatment Plans	Andy Mulcahy Clinical Lead Care Coordinator	919-913-4141	amulcahy@opc-mhc.org
Clinical and Technical Assistance Training Requests	Senga Carroll Clinical Specialist	919-913-4146	scarroll@opc-mhc.org
Contracts	Kris O'Keefe Contracts Manager	919-913-4069	kokeefe@opc-mhc.org
Customer Service Line	Peter Kramer Customer Service Representative	919-913-4120 Toll free number: 888- 277-2303	Customerservice@opc-mhc.org
Endorsement	Debbie Santucci Endorsement & Credentialing Specialist	919-913-4075	dsantucci@opc-mhc.org
General Concerns	Phyllis Williams Provider Community Manager	919-913-4085	pwilliams@opc-mhc.org
Incident Reporting	Michael Norton Client Rights Coordinator	919-913-4079	mnorton@opc-mhc.org
Invoices and Payment	Claims Adjudicators: Rachel Williams Five County LME Vicki Edmonds Five County LME	252-430-3057 252-430-3017	rwilliams@fivecountymha.org vedmonds@fivecountymha.org
Letters of Support	Lisa Lackmann (child) Child & Family Planner	919-913-4011	llackmann@opc-mhc.org

OPC Area Authority/LME

Effective July 1, 2009 to June 30, 2010

TOPIC	CONTACT PERSON	PHONE	E-MAIL
	Peggy Yonuschot (adult) Community Planner	919-913-4144	
Liability Insurance	Assigned Provider Relations Representative	See above	See above
Monitoring	Paula Newman Clinical Specialist	919-913-4133	pnewman@opc-mhc.org
Outcomes (NC-TOPPS & Core Indicators)	Michael Norton Client Rights Coordinator	919-913-4079	mnorton@opc-mhc.org
Quality Assurance Medical Records Title VI HIPAA Corporate Compliance	Lynne Hamlet Quality Improvement Director	919-913-4037	lhamlet@opc-mhc.org
Screening, Triage & Referral (STAR)	919-4100 800-233-6834 TDD: 866-598-6459		
Technical Assistance	Assigned Provider Relations Representative	See above	See above
Screening, Triage & Referral (STAR)		919-913-4100 800-233-6834	TDD: 866-598-6459

IMPORTANT FAX NUMBERS

OPC Fax Number	What to Send
919-913-4038 (QI/PR)	<ul style="list-style-type: none"> • Incident Reports • Training Registration • Endorsement/Monitoring Materials • Provider Relations Information
919-913-4004 (Care Management)	<ul style="list-style-type: none"> • Authorization Requests • Enrollment Packets • Initial Insurance/Target Pop/Diag Forms
919-913-4001 (OPC Main)	<ul style="list-style-type: none"> • Housing Materials • Customer Service • System of Care • Crisis Services
919-913-4009 (Care Coordination)	<ul style="list-style-type: none"> • Clinical Consultation Requests • Care Coordination Materials

Notification of Change of Address: *Formal notification of change of address of either party shall be given to the other.*

Provider will notify Area Authority of change of address by using the CHANGE OF CONTACT INFORMATION form on the next page. The completed form can be returned to:

Phyllis Williams, Provider Community Manager

Fax: 919-913-4038 E-mail: pwilliams@opc-mhc.org
Mail: OPC Area Authority/LME
100 Europa Drive, Suite 490
Chapel Hill NC 27517

Area Authority will notify Provider of change of address via United States postal service. Your primary contact will be your provider relations representative. Kris O'Keefe may also be contacted regarding contract related questions. (919)913-4069.

CHANGE OF CONTACT INFORMATION FORM

<u>Provider Name</u> (Name originally listed on contract)	
	NEW INFORMATION <i>(Please be specific if this information does not apply to your entire agency.)</i>
New name as it should be listed on contract	
Tax Identification Number	
<u>For Contract Issues:</u> Contact Person for Contracts	
Phone Number	
Fax Number	
E-mail Address	
Mailing Address	
<u>For Billing/Payment Issues:</u> Contact Person	
Phone Number	
Fax Number	
E-mail Address	
Mailing Address	
<u>For Clinical/Service Note Issues:</u> Contact Person	
Phone Number	
Fax Number	
E-mail Address	
Mailing Address	

If you have questions, please contact Phyllis Williams at pwilliams@opc-mhc.org or 919-913-4085.

Fax completed form to: Phyllis Williams 919-913-4038 **OR**

Mail completed form to: Phyllis Williams, OPC Area Authority,
100 Europa Drive, Suite 490, Chapel Hill, NC 27517

OPC Area Authority/LME

Effective July 1, 2009 to June 30, 2010

SECTION II

Comprehensive List of State and Federal Requirements

The document below serves as sufficient and necessary direction to Providers for accessing pertinent rules, regulations, standards, and other information referenced in Article I, Section 1.2 of the Agreement.

These documents change based on legislative action, change in federal and state policy, and state procedures. There is a mutual responsibility for Providers and Area Authorities to each routinely check these items for updates on requirements. If a Provider is uncertain how a State or Federal change will be implemented, or if an Area Authority has concerns about how a change will be implemented, then the Area Authority shall make a good faith effort to get further information or resolution regarding implementation and share this with the Provider. However, the Provider shall not exclusively rely upon only the Area Authority for information. If a Provider has problems obtaining or understanding the information referenced in this section, please contact the following department/individual at the Area Authority: Lynne Hamlet, QI Director, 919-913-4037.

Comprehensive List of State and Federal Requirements for The Area Authority and Provider

REQUIREMENT	SUGGESTED ACCESS	WEB SITE, IF AVAILABLE
APSM 30-1 (Rules for MH/DD/SA- Core rules for services and also includes State-covered services definitions) APSM 45-1 (Confidentiality) APSM 45-2 (Service Record Manual) APSM 95-2 (Client Rights) APSM 10-3 (Records Retention and Disposition Schedule) APSM 75-1 (Retention of Financial Records)	Contact: Gail Byron Mail Service Center, 3002 Raleigh, NC 27699 (919) 420-7995	Contact Web Master for the NC Division of MH/DD/SA Services and NC Division of Medical Assistance http://www.dhhs.state.nc.us/mhddsas/statpublications/manualsforms/index.htm
CAP-MR/DD Manual –(CAP Providers and Core Competencies Training Requirements for MR/MI service providers)	Contact: Gail Byron Mail Service Center, 3002 Raleigh, NC 27699 (919) 420-7995	http://www.dhhs.state.nc.us/mhddsas/cap-mrdd/index.htm
Medicaid-Related Documents Medicaid-covered services definitions A. Medicaid Services Guidelines Medicaid Communiqués	Contact: Gail Byron Mail Service Center, 3002 Raleigh, NC 27699 (919) 420-7995	http://www.dhhs.state.nc.us/mhddsas/medicaid/index.htm
NCAC 16 A 0400 (Single Portal Requirements)	Contact: Gail Byron Mail Service Center, 3002 Raleigh, NC 27699 (919) 420-7995	Not currently available on-line
Residential Licensure Requirements	NC Division of Health Service Regulation – Mental Health & Certification Section (919) 855-3765	http://www.ncdhhs.gov/dhsr/index.html
Health Care Personnel Registry	(919) 733-8500 or (919) 715-0562	http://facility-services.state.nc.us/hcarpage.htm and www.ncnar.org

STATE LEVEL

<p style="text-align: center;">General Statutes</p> <p>122-C Mental Health, Substance Abuse, Developmental Disabilities Act of 1985</p> <p>Applicable sections include but are not limited to:</p> <ul style="list-style-type: none"> ▪ 122C-3 Definitions ▪ 122C-4 Use of phrase “client or his legally responsible person ▪ 122C-51 Declaration of Policy on clients rights ▪ 122C-52 Right to confidentiality ▪ 122C-53-56 Exceptions... ▪ 122C-57 Right to treatment and consent to treatment ▪ 122C-58 Civil Rights and civil remedies ▪ 122C-59 Use of Corporal punishment ▪ 122C-60 Use of physical restraints or seclusion ▪ 122C-61 Treatment rights in 24-hour facilities ▪ 122C-62 Additional rights in 24-hour facilities ▪ 122C-63 Assurance for continuity of care for individuals with mental retardation ▪ 122C-64 Human rights Committees ▪ 122C-65 Offenses relating to clients ▪ 122C-66 Protection from abuse and exploitation; reporting ▪ 122C-67 Other rules regarding abuse, exploitation, neglect, no prohibited ▪ 122C-(116,141,142,146) Local Government Entity ▪ 122C-151.3 and 151.4 Resolving Disputes with Contractors, etc ▪ 90-21.4 Treatment of Minors ▪ 7A 517, 452-553 Abuse and neglect of Minors ▪ 108A 99-111 Abuse and Neglect of Disabled Adults ▪ 122C-151.3 and 151.4 Resolving Disputes with Contractors, etc. 		<p>All of the NC general statutes can be located on-line at the following site. Just type in the statute number you wish to review in the search box that is in this site.</p> <p>http://www.ncleg.net/gascripts/statutes/Statutes.asp</p>
<p>DHHS Disaster Preparedness, Response and Recovery Plan</p>		<p>http://ncdhhs.gov/mhddsas/disasterpreparedness/disasterplan04-05.pdf</p>
<p>SB 163- Monitoring of Providers</p>		<p>http://www.ncdhhs.gov/mhddsas/statpublications/archives/sb163/index.htm</p>
<p>Performance Agreement(05-06) between DMH and Area programs-Attachment 12-prompt pay</p>		<p>www.dhhs.state.nc.us/mhddsas/performanceagreement/index.htm</p>
<p>Contract between the Area Authority and the NC division of MH/DD/SAS</p>		<p>http://www.dhhs.state.nc.us/mhddsas</p>

FEDERAL LEVEL		
Drug Free Workplace Act of 1988 as revised	Library-Federal Laws	http://www.dol.gov/elaws/dugfree.htm
Section 503 and 504 of the Rehabilitation Act of 1973	Library –Federal Laws	http://www.dol.gov/dol/compliance/compliance-majorlaw.htm#eeo
Civil Rights Act of 1964	Library-Federal Laws	www.eeoc.gov http://www.eeoc.gov/policy/vii.html
Non-Profit Agencies-Conflict of Interest 1993 Session Laws: Chapter 321, Section 16	Library-Federal Laws	www.dol.gov
Public Law 99-319, May 1986 Protection and Advocacy for Mentally Ill Persons	Library-Federal Laws	http://thomas.loc.gov/bss/d099/d099laws.html Search for 99-319
<ul style="list-style-type: none"> ▪ Title I Protection and Advocacy Systems ▪ Title II Reinstatement of Rights for Mental Health patients 		http://www4.law.cornell.edu/uscode/42/ch114.html
Public Law 100-509 Protection & Advocacy for Mentally Ill Individual Amendments Act of 1988, October 1988	Library-Federal Laws	http://thomas.loc.gov/bss/d100/d100laws.html Search for 100-509 http://www.oxfordhouse.org/fairhouse.html
Public Law 101– 496 Developmental Disabilities Assistance and Bill of Rights Act of 1990	Library-Federal Laws	http://thomas.loc.gov/bss/d101/d101laws.html Search for 101-496
42 CFR Part 2 Confidentiality Regulations 45 CFR Part 160 & 164 HIPAA Standards for Privacy of Health Information	Library-Federal Laws	Federal Regulations search: http://www.gpoaccess.gov/cfr/index.html
Office of the Inspector General (Exclusions - “Lower-tier Transactions and disbarment”) Pro-children Act	Library – Federal Laws	http://oig.hhs.gov/fraud/exclusions.html
Section 1041-1044 of the Educate America Act of 1994 prohibiting smoking in areas used by children.	Library – Federal Laws	http://www.ed.gov/legislation/GOALS2000/TheAct/intro.html
Americans with Disabilities Act	Library – Federal Laws	http://www.usdoj.gov/crt/ada/adahom1.htm
OTHER		
North Carolina Council of Community MH/DD/SAS Programs		www.nc-council.org
Service Definitions		http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/index.htm
Endorsement Policy & Procedure, Application, MOA, Service Specific Check		http://www.dhhs.state.nc.us/mhddsas/stateplanimplementation/provendorse.htm

Sheets, Core Rules Self-Study Check List		
Incident Reporting Manual and Forms		http://www.dhhs.state.nc.us/mhddsas/statspublications/manualsforms/index.htm
NC TOPPS Instructions, training, forms and web submission		http://nctopps.ncdmh.net/
DMH Service Definition Trainings		http://www.ncdhhs.gov/mhddsas/training/medicaidenhancedbenefitservices.htm
Person-Centered Planning		http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/updates/update8-pcp/pcp5-8-06protected.doc and http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/updates/pcpforminstructions-5-4-06final.pdf
Area Authority/LME-Specific		
Local forms, instructions, policies and procedures		www.opcareaprogram.org

SECTION

III

Authorization Process (MH/DD/SA)

Authorization Overview

Authorization is the means by which OPC monitors and manages service utilization by consumers. Staff review and approve or deny the appropriateness of services, scope, amount and duration of services based on levels of care guidelines. Incorporated in this plan by reference are tools which constitute the platform for the authorization of service. These include

- Medical Necessity Definition

The Centers for Medicaid Services and The NC Division of MH/DD/SAS has specified broad evidenced based tests of medical necessity. OPC Area Program has specified the following medical necessity definition that addresses federal and state requirements:

1. The service is necessary to meet the basic needs/health of the consumer
2. Services are rendered in the most cost effective and least restrictive manner that weighs safety and effectiveness,
3. Services must be sufficient in scope, frequency and duration to make a difference
4. Services must be consistent with what is required for the diagnosis of the condition,
5. Services must be provided for reasons other than the convenience of the consumer or his/her caretaker or provider,
6. Services are reasonable to reduce significant disability
7. Services assist in maintaining the functional capacity of the individual.

- Service Definitions

NC DMH/DD/SAS approves service definitions that describe the services providers can be paid for in the state's public system of mh/dd/sas services. The definitions include descriptions of:

- Required components
- Provider requirements
- Staffing requirements, including experience, training, education
- Service types/settings
- Program requirements
- Utilization management
- Entrance criteria
- Continued stay criteria
- Discharge criteria
- Expected outcomes Service exclusions

- Levels of Care Guidelines

UM staff utilize a tool that is designed to determine based on diagnosis, severity of symptoms and available supports and other criteria depending on the population; what the usual scope, amount and duration of care is expected to produce the outcomes desired by the consumer.

Authorization Process: the process for authorization includes:

- An effective date for the service authorized
- The scope of service (definition and route of delivery) authorized

OPC Area Authority/LME

Effective July 1, 2009 to June 30, 2010

- The amount-frequency and duration of service authorized
- A process for triage for immediate authorization for initial services designed to facilitate a thorough evaluation for emergent and urgent care and necessary treatment or for a routine assessment by a provider
- A procedure for choice of provider within the provider community
- A procedure for timely (within 14days) response to routine authorization request that result in an approved, pending, rejected notice pursuant to a Service Plan or PCP that has clearly stated outcomes
- A procedure for authorization of new services pursuant to an amended Service Plan or PCP
- A procedure for reauthorization that takes into account review of functional outcomes and community and natural supports (preferably electronic)
- A procedure for notification to the consumer of the denial or reduction of requested services and their rights to appeal
- A procedure for authorizing services pending the need to gather additional information or pending an appeal or a denial or reduction of service.
- A procedure for notifying state vendor of authorization to permit claims payment
- An authorization number that providers use when submitting claims for service

Authorization procedures

Providers submit authorization requests to the Care Management department after completing the initial assessment. Providers must submit the appropriate Service Authorization Request. It is expected that request fall within the OPC IPRS Benefit Plans which is broken out by age and disability groups and in some instances, diagnoses. For all enhanced services, the PCP must be submitted prior to the end of the initial authorization period. Further authorizations for enhanced services are based upon the appropriateness of the PCP, the assessment and the current criteria for authorization of the service. Additional documentation such as a psychiatric evaluation and detailed history of prior treatment is required prior to the authorization of high cost services including ACTT, MST and In-home Therapy, etc. These requirements are listed on the published OPC IPRS Benefit Plans.

1. Inpatient Services

- a. Individuals in need of emergency services are directed to outpatient clinics or a crisis walk in center for evaluation prior to authorization for an inpatient stay. An assessment is required and diversion options must be considered prior to authorization for an inpatient bed. Authorization of state funded psychiatric beds and substance abuse beds are completed initially by the STR with concurrent authorizations performed by care coordinators. After hours, ProtoCall, OPC's after hours STR provider reviews all request for authorization to the state hospital to facilitate the appropriate diversion of consumers to less restrictive levels of care when appropriate Inpatient admissions to the local hospital (UNC) are automatically authorized. County funds are used to support this level of care as a means of diverting individuals from state psychiatric hospitals.
- b. The Hospital Liaison coordinates discharge planning with the consumer, staff in the treatment setting and clinician or agency who provides treatment after inpatient. Hospital Liaison will facilitate consumer referral to appropriate agency. The LME must authorize any continued inpatient stay for payment to be assured.

- c. Authorizations for individuals who are dually diagnosed MR/MI are granted by OPC employees only.

2. Initial Authorization Request

- a. Initial basic services, designed to facilitate a thorough assessment of an individual's strengths, presenting problems, and needs are authorized by STAR upon submission of the Consumer Admission & Discharge form, a Service Authorization Request. Authorization verification is forwarded to providers.
- b. Initial authorizations are given for up to 2 months from the date of the screening
- c. Basic Benefits - the provider submits a Service Authorization Request requesting additional services if the consumer is found eligible for a Target Population and diagnosis. The Authorizers utilize their clinical skills to assess for need based upon information provided in the written authorization request. Authorizations are based upon the most current OPC IPRS Benefit Plan.
- d. Basic Benefits providers submit authorization requests for Enhanced Services. Such requests must be accompanied by required documentation as listed in the OPC IPRS Benefit Plans. If consumer qualifies for services, an authorization will be made for two months or the consumer will be placed on a waiting list for the enhanced service.
- e. Enhanced Benefits-Providers submit Initial PCPs with their authorization request forms following the initial authorization . The provider then submits the Complete PCP and a request for additional services, Services are to be requested and according the limits of the Benefit Plans and the authorization is granted based upon the clinical documentation presented in the PCP.

3. Concurrent Request

- a. Services not included in the Person Centered Plan will not be authorized.
- b. Urgent needs for authorization that are based on consumer emergency:
 - These requests shall be authorized within 48 hours
 - Should be for immediate needs only and must be supported by documented consumer need
- c. Authorization verification is forwarded to providers and consumers.
- d. If services are denied, reduced, or suspended OPC follows the procedures prescribed by the Division of Mental Health/Developmental Disabilities/Substance Abuse Services related to Non-Medicaid Appeal Process.
- e. The required documents related to the Non-Medicaid Appeal Process are sent to the consumer and a copy is sent to the providers.

4. Pre-authorized Crisis Services

The authorization process for emergent and urgent crisis services has been streamlined to encourage the use of such services as an alternative to hospitalization. Mobile Crisis Services, detox and Facility Based Crisis services are pre-authorized. Rapid Response services are authorized by contacting STAR 24/7/365.

5. Additional Requirements

- a. Copies of forms and Benefit Plans are available via the OPC website. Copies of these forms may also be obtained by contacting the STAR/ Authorizations manager.

6. Choice of Providers

OPC Area Authority/LME

Effective July 1, 2009 to June 30, 2010

- a. Consumer choice of available providers is honored at any point in the treatment process.

7. PCP Reviews

- a. PCP Reviews: When reviewing the PCP, the Authorizer conducts a quantitative and qualitative review of the PCP, providing written feedback to the provider. See appendix B for OPC PCP Quantitative/Qualitative Review Tool.

8. Denial/Reductions of IPRS Funded Services

OPC follows the procedures prescribed by the Division of Mental Health/Developmental Disabilities/Substance Abuse Services related to the Non-Medicaid Appeal Process using standardized procedures and prescribed forms.

When requested services are outside the Benefit Plan for a consumer of IPRS funded Basic Benefits: Authorizer reviews authorization request and all clinical documentation including but not restricted to the Service Plan, PCP, psychiatric evaluation, etc., to determine if there is sufficient clinical evidence to approve more services than the benefit plan allows. Qualifying services may still be denied due to administrative reasons. If the Authorizer determines that the additional services cannot be authorized due to clinical or administrative reasons, the Authorizer follows standardized procedures to inform the provider and the consumer of the denial.

SECTION IV

Claims

Electronic Connectivity Requirements:

Provider is required to have computer capacity deemed sufficient by the LME to process, send and receive any electronic data necessary to conduct business with the LME. Electronic data exchange may be accomplished via e-mail, facsimile, file transfer or by any other industry standard methods adopted by the LME. Provider is required to adhere to HIPAA guidelines for the exchange of health information, medical billing and client eligibility data, including but not limited to the 834, 835 and 837 transaction sets. Information providers email to OPC that identifies consumers will be password protected with the established OPC password. Provider will comply with all requests made by the LME for any electronic data exchange necessary to meet audit, utilization management, outcome measurement, performance standard or other reporting requirements established by the North Carolina Department of Health and Human Services or by any federal agency.

Claims Adjudication:

Transaction-Based Services

OPC Contract Providers must send claims for Transaction-Based Services (formerly known as UCR services) on an OPC-formatted Excel spreadsheet that is based on the State's recommended billing ticket. This requires access to a computer, e-mail, and Excel. For FY09-10 (claims with dates of service 7/1/09 and later), OPC will not accept any paper claims. Per the State IPRS Contract, Providers must submit billing to OPC within 60 days from the date of service, and OPC may require Providers to submit billing in less than 60 days in order to meet IPRS deadlines for July - April services and May - June services.

Providers who are new to submitting claims on the Excel spreadsheet may contact OPC's Claims Adjudication Unit (Assigned Claims Adjudicator or Contracts/Claims Coordinator) for assistance. Provider will need to designate an e-mail contact address for the provider agency to receive the OPC-formatted Excel spreadsheet. OPC will instruct Provider about the required format and password. Thereafter, Excel spreadsheet (and optional Invoice in Word or Excel document only) should be submitted to OPC's Claims Adjudication mailbox OPCTickets@opc-mhc.org. For the purpose of Prompt Pay Requirement (Refer to section below), the date of the e-mail will count as the date of receipt. Electronic claims can be submitted weekly, bi-monthly, or monthly.

There are some providers who have to continue to bill particular Medicaid services through OPC LME until it is possible to direct-enroll and bill Medicaid for those services. Providers who bill both Medicaid and IPRS services through OPC LME must separate Medicaid claims from IPRS claims and send on separate spreadsheets. E-mail to OPCTickets@opc-mhc.org with the Subject Line listed like the examples below.

For agency billing Medicaid weekly:

SUBJECT: YOUR AGENCY NAME, MEDICAID, WEEK OF 7/2/09

For agency billing Medicaid monthly:

SUBJECT: YOUR AGENCY NAME, MEDICAID, JULY 2009

For agency billing IPRS weekly:

SUBJECT: YOUR AGENCY NAME, IPRS, WEEK OF 7/2/09

For agency billing IPRS monthly:

SUBJECT: YOUR AGENCY NAME, IPRS, JULY 2009

See Appendix C FOR SAMPLE SERVICE EVENT TICKET FOR FY09-10 CLAIMS
OPC Area Authority/LME Effective July 1, 2009 to June 30, 2010

Expenditure-Based Reimbursement (Non-UCR Funds):

Providers whose contract includes an expenditure-based component (Non-UCR funds) should submit invoices monthly, along with documentation supporting the expenditures as specified in the contract. General ledger printout, copies of receipts, and payroll records are examples of acceptable documentation of expenditures. Invoices and supporting documentation should be sent to contact person specified in the provider's contract or :

Jolene Meyer, Accounting
OPC Area Program Administration
100 Europa Dr., Suite 490
Chapel Hill, NC 27517

Invoices and supporting documentation can also be emailed to the contact person specified in the provider's contract or to Accounting Manager, Jolene Meyer, at jmeyer@opc-mhc.org.

Prompt Pay Requirements:

Contract providers will submit claims for covered services to Orange Person Chatham Area Authority/LME (OPC) at least monthly. OPC will pay claims in accordance with the Division of Mental Health, Developmental Disabilities and Substance Abuse prompt pay requirements set forth as follows:

Within eighteen (18) calendar days after OPC receives a claim from a provider, OPC will either (a) approve payment of the claim, (b) deny payment of the claim, or (c) determine that additional information is required for making an approval or denial. If OPC approves payment, the claim shall be paid within thirty (30) calendar days after making approval. OPC will disallow claims in the event and to the extent the claim is incomplete, does not conform to the applicable service authorization, or is otherwise incorrect. Any claim disallowed shall be returned to the provider with an explanation for the disallowance. OPC will allow providers to re-submit a disallowed billing for re-consideration, so long as the re-submission occurs within the general claims filing timeframes outlined above. OPC will cooperate with its providers in the prompt reconciliation of disallowed billings. OPC will not pay claims submitted after the time period allowed by DHHS billing requirements. All payment for services to providers shall be provisional and subject to review and audit for conformity with DHHS requirements.

OPC and its providers will not charge or receive any payment from an eligible Medicaid person for covered services except for co-payments and sums payable to third party payers under coordination of benefits provisions.

County Funds:

Providers will have a separate Contract for County Funds. The amount of funding in this Contract for County Funds will be determined by OPC LME and specific designations by Orange, Person, and Chatham Counties. Providers should submit invoices monthly, along with documentation supporting the expenditures as specified in the contract. General ledger printout, copies of receipts, and payroll records are examples of acceptable documentation of expenditures. Invoices and supporting documentation should be sent to contact person specified in the provider's contract or:

Jolene Meyer, Accounting
OPC Area Program Administration
100 Europa Dr., Suite 490
Chapel Hill, NC 27517

Invoices and supporting documentation can also be emailed to the contact person specified in the provider's contract or to Accounting Manager, Jolene Meyer, at jmeyer@opc-mhc.org.

OPC/LME Fee Collection Policy and Minimum Fee/Sliding Fee Scale Schedule

The Provider agrees to assist in the coordination of each individual's health care benefits so as to avoid undue delay in the provision of service and to ensure that Federal, State and local funding shall be used only if and when other sources of first and third party payment have been exhausted. The Provider shall collect all available first and third party reimbursement for which a client may be eligible prior to billing OPC/LME. Revenue received on behalf of a client shall not be included in the amount billed to OPC/LME for that client. OPC/LME is the payor of last resort. It is the responsibility of the Provider to maintain current financial information. During an emergency, Provider shall provide the necessary services and then assist to coordinate payment.

Sliding Scale Fee Schedule:

Income		Family Size									
Minimum	Maximum	01	02	03	04	05	06	07	08	09	10
\$1.00	\$10,830.00	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
\$10,831.00	\$14,570.00	10%	5%	5%	5%	5%	5%	5%	5%	5%	5%
\$14,571.00	\$18,310.00	20%	10%	5%	5%	5%	5%	5%	5%	5%	5%
\$18,311.00	\$22,050.00	30%	20%	10%	5%	5%	5%	5%	5%	5%	5%
\$22,051.00	\$25,790.00	40%	30%	20%	10%	5%	5%	5%	5%	5%	5%
\$25,791.00	\$29,530.00	50%	40%	30%	20%	10%	5%	5%	5%	5%	5%
\$29,531.00	\$33,270.00	60%	50%	40%	30%	20%	10%	5%	5%	5%	5%
\$33,271.00	\$37,010.00	70%	60%	50%	40%	30%	20%	10%	5%	5%	5%
\$37,011.00	\$40,750.00	80%	70%	60%	50%	40%	30%	20%	10%	5%	5%
\$40,751.00	\$44,490.00	90%	80%	70%	60%	50%	40%	30%	20%	10%	5%
\$44,491.00	\$48,230.00	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%
\$48,231.00	\$51,970.00	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%
\$51,971.00	\$55,710.00	100%	100%	100%	90%	80%	70%	60%	50%	40%	30%
\$55,711.00	\$59,450.00	100%	100%	100%	100%	90%	80%	70%	60%	50%	40%
\$59,451.00	\$63,190.00	100%	100%	100%	100%	100%	90%	80%	70%	60%	50%
\$63,191.00	\$66,930.00	100%	100%	100%	100%	100%	100%	90%	80%	70%	60%
\$66,931.00	\$70,670.00	100%	100%	100%	100%	100%	100%	100%	90%	80%	70%
\$70,671.00	\$74,410.00	100%	100%	100%	100%	100%	100%	100%	100%	90%	80%
\$74,411.00	\$78,150.00	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%
\$78,151.00	\$999,999.99	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2009 Federal Poverty Guidelines											
Persons in	48 Contiguous										
Family Unit	States and D.C.										
1	\$10,830.00										
2	\$14,570.00										
3	\$18,310.00										
4	\$22,050.00										
5	\$25,790.00										
6	\$29,530.00										
7	\$33,270.00										
8	\$37,010.00										
For each additional person add:											
\$3,740.00											

SECTION V

Provider Documentation Submission Requirements

NOTE: This is a summary only and not intended as a comprehensive review of documentation requirements.

Documentation of Service Delivery

All MH/DD/SAS services must be documented in accordance with North Carolina Division of Medical Assistance and North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services rules. The rules related to documentation requirements are outlined in the North Carolina Records Management and Documentation Manual, APSM 45-2 available on the Division of Mental Health's website <http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm>

The service record maintained by the Provider will be considered an "original" medical record and must be maintained in a secured location, with access to protected health information limited to appropriate personnel. The Provider must comply with all State Record Retention Schedule for Client Records, available on the Division of Mental Health's website <http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm>

The Provider must comply with all State and Federal requirements related to the confidentiality of protected health information, regardless of format.

Documentation for all contracted services and services provided under a Memorandum of Agreement is subject to quantitative and/or qualitative monitoring at the discretion of the Local Management Entity (LME). The Provider will submit all required corrective action plans that result from quantitative or qualitative monitoring events.

Forms and instructions that the provider is responsible for submitting for consumer registration and enrollment may be found at www.opcareaprogram.com. . Completed forms should be faxed to the Care Management Dept. (919)913-4004 or mailed to 100 Europa Drive, Suite 490, Chapel Hill NC, 27517.

Endorsement, Licensure, Compliance Verification, Credentialing and Privileging of Provider(s)

All Providers of enhanced benefit services must be endorsed according to the policies and timelines set forth by the Division of Mental Health. This includes providers of Community Intervention Services (Intensive In-Home, Community Support Team, Child/Adolescent Day Treatment, etc.), Residential Treatment Services for Children and CAP MR/DD Services. See <http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm>. More detailed information on the OPC endorsement process can be found in the provider section of the OPC website located at www.opcareaprogram.com.

Other specific requirements include:

- A. For all licensed facilities and services the Provider is expected to submit a copy of the initial and subsequent licenses. The Provider must notify the Local Management Entity (LME) of any suspensions, plans of correction, or fines and non-compliance issues related to their license within twenty-four (24) hours of notification.
- B. All non-licensed services not requiring endorsement are required to have successfully completed compliance verification by the North Carolina Council of Community Programs, or compliance verification conducted by the LME, and submit all requested application paperwork as part of the provider community enrollment process. Additionally, these services are required to complete a full compliance verification update every three years for services included in the contract.
- C. Licensed or certified solo practitioners must complete and submit all required paperwork required for credentialing and privileging/competency review, as well as all other requested paperwork as part of the provider enrollment process. A copy of all new and renewals of licenses for practice, and/or any suspensions, debarments, revocations, or any other action, must be submitted to the LME prior to expiration or at the point of the action and before submitting claims for services.

SECTION VI

Quality Improvement and Performance Monitoring

1. Written Agreement - Audit and Evaluation Activities

As part of its duties as a health oversight agency, Orange-Person-Chatham Area Mental Health/ Developmental Disabilities/Substance Abuse Authority, hereinafter "OPC", may request access to restricted records of providers, for the following audit and evaluation activities:

- Monitoring Activities (see #2 below)
- Processing of Complaints
- Financial Audits
- Program Evaluation
- Incident Reporting (see #3 below)
- Reviews of Person Centered Plans

Information to be reviewed or observed as part of these audit and evaluation activities may consist of written records, electronic information, and verbal communications between or among staff members and other parties engaged in the mission of the provider agency. Any disclosure made between the provider and OPC is subject to Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse records. Except as provided in paragraph (c) of 42 CFR § 2.53, patient identifying information disclosed under this section may be disclosed by OPC only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by a court order entered under 42 CFR [§ 2.66](#).

Any patient identifying information contained in records that are copied or removed from the program as part of the above audit and evaluation activities shall be:

- (1) Maintained in accordance with security requirements at least as stringent as required by 42 CFR 2.16; and
- (2) Destroyed upon completion of the audit or evaluation.

The signature of a provider on an IPRS Contract and/or Memorandum of Agreement, which incorporates this document by reference, indicates that the provider has read this information, agrees with its contents, and that the individual signing and the entity represented by said individual is bound by its terms.

2. Provider Monitoring

The Local Management Entity (LME) will monitor covered services to promote compliance with the rules of the North Carolina Commission for Mental Health, Developmental Disability, and Substance Abuse Services (the "Commission"), the Secretary, The Department of Health and Human Services, and G.S. 122C. The LME will also conduct local monitoring to promote compliance with State, Medicaid, and other applicable federal rules and statutes.

Local Monitoring:

1. The frequency and intensity of local monitoring will be based upon the LME's level of confidence in a provider as determined by the following criteria set forth in the Provider Monitoring Frequency Tool:

- The number and severity of incidents reported by the provider, including Level II and III as well as the quarterly reporting of Level I incidents. Note: An extremely low number or no reported incidents can generate concern for a monitoring also.
 - The provider's response to the incidents.
 - The provider's compliance with the reporting requirements as set forth in the state rules.
 - The number and types of complaints received concerning a provider.
 - The provider's response to complaints.
 - The conclusions reached from complaint investigations.
 - The results of reviews conducted by the Division of Health Service Regulation (DHSR), Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), or the Department of Social Services (DSS).
 - The provider's compliance with the requirements of the provision of public services (See G.S. 122C).
 - The provider's addition of a new service or newly endorsed service
 - The accreditation of the provider by a national accrediting body and the results of any accreditation reviews.
 - The provider's quality improvement activities as required by state rule and any trends in improvement.
 - The provider's compliance with the contract or Memorandum of Agreement with OPC.
2. Once a provider has been identified for local monitoring, the provider will be contacted in writing and provided with the following information:
- The reason they have been identified for a local monitoring review.
 - The date for which the monitoring has been scheduled.
 - A copy of any local monitoring tools that may be used during the monitoring review.
 - Contact information for the monitoring team leader and/or team member that has been assigned to the review process.
3. After completion of the local monitoring, OPC will communicate the results of the local monitoring to the provider within 10 business days. The communication of the results will constitute a local monitoring report that includes:
- The identification of each service monitored.
 - Identification of any suggestions or recommendations made by the Monitoring Team as well as any issues requiring correction.
 - The timelines for developing corrective action plans AND implementing any corrections.
4. Once a monitoring review is completed along with any follow-up reviews (if required), OPC will notify the provider in writing that the local monitoring is complete.

Targeted Monitoring

In some instances, serious complaints, incident reports (including any Level III incident), deficiency reports from other oversight agencies such as DHSR, DMH/DD/SAS or DSS, performance data, results of audits or other reviews, or other concerns related to quality of care require that the OPC Provider Monitoring Team respond immediately. In these instances, the following procedures may be followed.

1. A representative from the Provider Monitoring Team will contact the provider to discuss the concern and set a date for the monitoring. The setting for the monitoring and the

composition of the review team will be based on the concern that triggered the monitoring. Areas to be monitored will also be based on the specific concern(s).

2. If other agencies (ex. DSS, DHSR or DMH/DD/SAS) are involved, OPC will coordinate its monitoring activities with those agencies.
3. At the conclusion of the monitoring, OPC will communicate the results of the monitoring to the provider within 10 business days, including:
 - identification of any suggestions or recommendations made by the Monitoring Team as well as any issues requiring correction.
 - timelines for developing corrective action plans AND implementing any corrections
4. Once a monitoring review is completed along with any follow-up reviews (if required), OPC will notify the provider in writing that the local monitoring is complete.

Unlicensed Alternative Family Living (AFL) Home Reviews

OPC will conduct annual health and safety reviews for unlicensed AFL providers located in the OPC catchment area that are seeking to provide Residential Supports under the CAP-MR/DD waiver. These reviews will be conducted using the required guidelines and protocol provided by DMH. In accordance with DMH guidelines, OPC may also review additional items, as OPC determines are appropriate, and will incorporate any future rules or guidelines into the reviews as provided by DMH.

Plans of Correction

1. OPC will follow current state rules and/or DMH policy regarding submission and implementation of plans of corrections resulting from any monitoring activity.
2. The corrective action plan must include all items required as indicated in the current Division of MH/DD/SAS Plan of Correction Policy.
3. An appeal of an out-of-compliance finding does not negate the requirement for a plan of correction. Should the appeal be decided in favor of the provider, the results will be noted in the provider's file and the provider will be notified that the action is closed. If the provider is unwilling to submit, revise or implement a plan of correction in the specified timeframes, OPC LME may take action to withdraw endorsement and/or to report the provider to the appropriate oversight agency (see Referrals below).
4. Submitted plans of correction will be reviewed in accordance with criteria outlined in applicable state rule and/or DMH policy, and OPC will notify the provider whether the plan of correction has been accepted or rejected and will provide information regarding the provider's next steps in the plan of correction process.
5. A follow-up review will be conducted in approximately 60 calendar days following the full acceptance of the plan of correction to determine if the plan has been implemented and whether the out of compliance finding(s) are minimized or eliminated. This follow up review may be a desk review or may take place at the provider's site(s). When issue(s) addressed in the plan of correction pertain to items in a client record or a personnel record, the complete record should be present for the follow-up review. The reviewer will randomly select a sample of documentation to review to verify that the out-of-compliance finding(s) are minimized or eliminated.

6. Timelines for any subsequent reviews conducted to determine implementation of a plan of correction will also be followed in accordance with applicable state rules and/or DMH policy. An appropriate oversight agency may choose to accompany OPC LME to a follow-up review to assist in the review process.
7. Possible consequences for failure to submit and/or implement a plan of correction sufficient to minimize or eliminate out of compliance issues include referral to the appropriate oversight agency (see Referrals below), increased monitoring of the provider and/or withdrawal of endorsement.

Referrals to other Oversight Agencies

The referral of a provider to other oversight agencies such as the Division of Social Services, the Division of Health Service Regulation, the Division of Medical Assistance and/or the Division of MH/DD/SAS shall be based on the following:

1. Refusal of a provider to participate in the monitoring process.
2. A monitoring visit identifies concerns about health, safety, and welfare (including abuse or neglect) or potential fraud.
3. A monitoring visit identifies concerns required to be reported to other agencies. Example - physical plant issues will be reported to DHSR for Category A providers.
4. A plan of correction resulting from a monitoring is not submitted to the OPC within the designated time frame.
5. The provider does not correct issues identified in a monitoring report and/or does not fully implement their plan of correction within the required timeframes.

Dissemination of Monitoring Results

OPC will provide, upon request, results of monitorings to other LMEs whose consumers are also served by the provider. These results will be provided within 10 calendar days of completion of the monitoring. OPC may also request other LMEs to provide local monitoring results of providers serving OPC consumers in other catchment areas.

Monitoring results may also be shared with consumers and/or family members, upon request.

Appeal Process

Providers may appeal the results of any monitoring conducted by OPC. Please see OPC's Provider Complaints Policy and Procedures.

3. Client Rights Reporting

- A. Provider shall conduct activities in a manner that shall deter, prevent, and avoid abuse, neglect, and/or exploitation of Individuals while in its care and to ensure compliance with all State and Federal requirements. Additionally, Provider shall provide clients and legally responsible persons with a written summary of client rights as specified in NCGS 122C, Article 3 and in administrative rule. Resources related to client rights include the manual of Client Rights Rules (APSM 95-2) found at www.ncdhhs.gov/mhddsas/statspublications/manualsforms/aps/apsm95-2clrights7-03.pdf and the NC DMH/DD/SAS Consumer Handbook found at www.ncdhhs.gov/mhddsas/announce/2008/consumerhandbook-0608.pdf and the OPC Consumer Resource Guide found at www.opcareaprogram.com/forms/consumers/ConsumerHandbook.pdf

- B. The Provider agrees to maintain complaint and grievance policies and procedures as well as policies, procedures and monitoring as required in the State Client Rights rules and all subsequent revisions. See APSM 95-2, GS 122C - Article 3, and the Division's client rights policies and standards. OPC will encourage clients to communicate with providers to resolve any complaints. In the event the complaint is not resolved at the provider level or the client does not wish to communicate with the provider, OPC will respond to the complaint as required by State regulations (see 10A NCAC 27G).
- C. On an annual basis, the provider shall submit a report to the LME containing summary information of the activities of its Client Rights Committee or the Committee that serves in that capacity. Until such time as DMH develops a standardized form, OPC will provide a format for providers to meet this requirement.

4. Incident Reporting

All incidents pertaining to Area Authority clients shall be reported to the Area Authority as required in APSM 95-2(Client rights) and APSM 30-1 (Rules for MH/DD/SA Services & Facilities).

The Provider shall report and respond to all client incidents as outlined in State rules (See 10A NCAC 27G.0600). Incidents shall be reported in the manner prescribed by said rules and outlined in the DHHS Incident Reporting Manual found at <http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/incidentmanual11-04.pdf>

A. Definitions:

- Incident:** Any happening which is not consistent with the routine operation of a facility or service or the routine care of a client and that is likely to lead to adverse effects upon a client (see 10A NCAC 27G .0103(b)(32))
- Level I incident:** Any incident that does not meet the definition of a level II incident or level III incident. Typically, these incidents do not significantly threaten the health or safety of an individual.
- Level II incident:** Any incident that results in a threat to a client's health, safety; or a threat to the health, safety of others due to client behavior and does not meet the definition of a level III incident.
- Level III incident:** Any incident that results in:
 - a death, permanent physical or psychological impairment to a client;
 - a death, permanent physical or psychological impairment caused by a client; or
 - a threat to public safety caused by a client; or
 - any incident of a consumer absence when an Amber or Silver Alert has been issued.

B. Reporting Forms/Timelines

The provider shall report all Level II and III incidents (as defined by State rule and outlined in the Incident Reporting Manual referenced above) to the appropriate LME(s) within 72 hours of the incident for Level II incidents. The provider shall make an immediate verbal report to the LME(s) of any Level III incident. The report shall be submitted on the standardized State form QM02

(<http://www.dhhs.state.nc.us/mhddsas/statspublications/manualsforms/forms/dhhsincidentdeathreport-formqm02-rev3-8-06.dot>) and may be submitted via mail, in person or by facsimile. Incident Reports should never be submitted via email.

In addition, when reporting the use of a restrictive intervention, (physical restraint, seclusion or isolation time), the Provider shall complete and submit to the LME the Restrictive Interventions Details Report (QM04), found at <http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/forms/dhhsrestrictiveinterventionformqm0411-18-04rev.dot>. If the Provider opts to use a different form, it must include all of the elements contained in form QM04. Any report of a restrictive intervention must include, at a minimum, the following information required by NC G.S. 122-60:

- Type of procedure used
- Length of time employed
- Alternatives considered or employed
- Effectiveness of the procedure or alternative employed

If an incident is likely to be reported in a newspaper, on television or in other media, the Provider is to verbally report the incident to the Host LME and the DMH/DD/SAS Advocacy Team (919-715-3197) **immediately** upon learning of the incident.

All required incident reports and reports of restrictive interventions should be sent to:

**Client Rights Coordinator
OPC Local Management Entity
100 Europa Drive
Suite 490
Chapel Hill, NC 27517**

Phone #: 919-913-4079

Fax #: 919-913-4038

C. Quarterly Reports

As required in 10A NCAC 27G.0604, the provider shall submit a quarterly report to the LME via electronic means. The report shall be submitted on Form QM11

(<http://www.dhhs.state.nc.us/mhddsas/statspublications/manualsforms/forms/providerquarterlyreport-formqmQM11rev1-06.doc>) and shall include summary information regarding:

- Planned use of Restrictive Interventions
- Medication errors that do not meet the definition of a Level II or III incident
- Searches of a client or his living area, and
- Seizures of client property or property in possession of a client or any other criteria subsequently issued by the Division of MH/DD/SAS

Quarterly reports should be submitted to the Client Rights Coordinator at: Mnorton@opc-mhc.org Reports are due on the 10th of the month following the end of the quarter. For FY 09-10, the reporting schedule will be as follows:

October 10, 2009
January 10, 2010

April 10, 2010
July 10, 2010

D. Reports to Other Agencies

Category A providers must submit a copy of all Level III incident reports to DMH/DD/SAS and DHSR. Category B providers must submit a copy of Level III incident reports to DMH/DD/SAS.

E. Death Reporting

The Provider must follow the current state requirements regarding client death reporting. The Provider must notify the LME within 24 hours of the death of a client unless the cause of death is terminal illness or other natural cause. Deaths due to terminal illness/natural causes must be reported to the LME within 72 hours.

5. Person Centered Planning

Person Centered Planning is a process that enables the individual to take the lead in identifying preferences and goals on how they want to live and what services and supports they need to do it. Factors such as health and safety should be considered as a part of the planning process. Information and support are provided to assist individuals and their families in making informed choices regarding service options and providers. In addition, individuals have the authority and responsibility to participate in the evaluation of progress towards completion of their identified goals. Person centered planning should work to include natural supports, generic community resources, in addition to specialized services and paid supports. A list of state and community resources can be found in OPC's Consumer Resource Guide located at www.opcareaprogram.com.

Providers are responsible for initiating a person-centered process in the development of all plans and for carrying out the interventions and supports as identified on the person centered plan. **See the Person Centeredness Page of the DMH website for forms, instructions, and training materials:** <http://www.ncdhhs.gov/mhddsas/pcp.htm>.

6. Model Fidelity

Providers shall adhere to the service standards prescribed by the Division of MH/DD/SAS and included within each service definition. The definitions can be found at <http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/index.htm>

For providers utilizing the following evidence-based practices, fidelity scales may be found at <http://www.ncs2s.org>

- Assertive Community Treatment (ACT)
- Supported Employment (SE)
- Illness Management and Recovery (IMR)
- Family Psycho education (FPE)

- Integrated Dual Disorder Treatment (IDDT)
- Medication Management According to Protocol (MedMAP)

7. Treatment Protocols

Providers will adhere to the treatment protocols specified by the Division of Mental Health, Substance Abuse, and Developmental Disabilities.

8. Clinical Outcomes Measures/Satisfaction Surveys

The Provider will be responsible for collecting and submitting outcomes information on consumers served by the Provider, utilizing the appropriate outcome instrument developed by DHHS and following sampling rules and survey methodology. For FY2009-2010 this includes participation in the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS) <http://nctopps.ncdmh.net/> for mental health and substance abuse consumers and the National Core Indicators Project for consumers with developmental disabilities. The Provider also agrees to participate in any additional outcome system subsequently developed by the LME to measure clinical or functional outcomes for its consumers.

The Provider is also responsible for conducting consumer satisfaction surveys no less often than twice a year and for reporting the results of such surveys to the LME on an annual basis. The Provider is required to participate in the annual State Consumer Satisfaction Survey.

9. Core Performance Indicators for Providers of State Funded MH/DD/SA Services

All providers of state funded MH/DD/SA services shall also be subject to Attachment B of the 09-10 State Contract. Attachment B requires providers to meet the following Core Performance Indicators:

- A.** Providers shall be responsible for full participation in an Area Authority/County Program monitoring/review process that includes the Division of MH/DD/SA Confidence Assessment Criteria and the Local Monitoring discussion guide. Frequency of reviews and corrective requirements are determined by demonstration of acceptable compliance with quality indicators and scores from the Confidence Assessment.
- B.** 100% of all Level I Incidents as defined by the NC Division of MH/DD/SAS shall be recognized, adequately responded to, and reported/documented internally by the Provider, and reported in aggregate form quarterly to the Area Authority/County Program.
- C.** At least 85% of all Level II Incidents as defined by the NC Division of MH/DD/SAS shall be recognized, adequately responded to, and reported to the Area Authority/County Program and the Department within 72 hours via the *DHHS Incident & Death Form*. An aggregate total for the quarter will be part of the Provider's quarterly report to the Area Authority/County Program.
- D.** At least 85% of all Level III Incidents as defined by the NC Division of MH/DD/SAS shall be recognized, adequately responded to, and reported verbally immediately to the Area Authority/County Program, and in written form to the Area Authority/County Program and the Department within 72 hours via the *DHHS Incident & Death Form*. The Provider shall convene

an incident review committee within 24 hours. Deaths that occur within 7 days of seclusion or restraint are reported immediately to the Area Authority/County Program. An aggregate total for the quarter will be part of the Provider's quarterly report to the Area Authority/County Program.

E. Providers shall implement policies, procedures, and practices to attempt to achieve 0% client rights violations. 100% of all substantiated client rights violations shall be reported through the Incident reporting process to the Customer Services/Consumer Affairs Unit of the Area Program/County Program Quality Management Department, and show evidence of being acted upon.

F. 100% of quality of care issues, as noted through Area Authority monitoring, shall promptly begin to be addressed through the development and initiation of a corrective action plan submitted for approval to the Area Authority/County Program within the time limits specified in the Area Authority/County Program's Quality Management Plan.

G. A representative sample of consumers shall be given the opportunity to express their *perception of satisfaction* for services received through the implementation of an empirical process no less often than twice a year. Survey results are submitted to the Area Authority/County Program. Providers may meet this requirement by full participation in the Area Authority/County Program's Quarterly Consumer Satisfaction Survey. The Provider is also required to participate in the Division of MH/DD/SAS's annual Consumer Satisfaction Survey.

H. When applicable, Providers shall meet no less than 85% of established time frames for initial face-to-face consumer contact (Emergent: within 2 hours; Urgent: within 48 hours; Routine: 7 calendar days.).

I. Providers shall meet 100% compliance with Operations Manual administration protocols for established Outcome Measures for each eligible consumer (NC-TOPPS, COIs). As applicable to the service population, Providers shall participate in the annual Core Indicators survey (DD consumers and families).

J. Providers shall demonstrate a Continuous Quality Improvement (CQI) process by identifying a minimum of 3 improvement projects acted upon per year. Projects and results will be reported to the Area Authority/County Program in any quarter of completion.

Compliance with these performance indicators and other requirements of this Operations Manual and state standardized contract will be monitored by the "Annual Provider Status Report". This report will be sent to the Provider annually with an expected timeframe for completion and submission to the LME.

10. Deficit Reduction Act of 2005

Providers who receive annual Medicaid payments of \$5 million or more are subject to Section 6032 of the Deficit Reduction Act of 2005 (DRA). This section requires providers to educate employees, contractors, and agents about Federal and State fraud and false claims laws and the whistleblower protections available under those laws. Compliance with Section 6032 of the DRA is a condition of

receiving Medicaid payments.

All providers, however, are responsible for preventing and detecting fraud and abuse of federal and state funds and should be familiar with applicable federal and state laws and regulations. A summary of this information may be found in OPC's Deficit Reduction Act policy and related PowerPoint presentation on the OPC provider website <http://Providers/News.htm>.

OPC providers are responsible for reporting concerns regarding actual or potential violations of state and federal laws and regulations related to fraud, waste and abuse. A provider who perceives or learns of an act of non-compliance should report or seek guidance from his/her supervisor or the Quality Improvement Department. Any provider found to have known of such acts of non-compliance but failed to report them may be subject to termination of the contract or memorandum of agreement with OPC.

Reports may be made in person, by telephone or in writing to the OPC Quality Improvement Director or to any of the following:

1. NC CARE-LINE at 1-800-662-7030 and ask for the DMA Program Integrity Section; or
2. Health Care Financing Administration Office of Inspector General's Fraud Line at 1-800-HHS-TIPS; or
3. State Auditor's Waste Line at 1-800-730-TIPS; or
4. Attorney General's Medicaid Investigations Unit at 919-881-2320.

No adverse action or retribution of any kind will be taken against a provider because he or she reports a suspected violation of federal or state laws or regulations. However, if a provider reports his or her own non-compliance, he or she may still be subject to disciplinary or other administrative proceedings to the extent of his or her personal involvement in the reported activity.

Monitoring and Oversight:

OPC conducts local monitoring of providers in its catchment area including, but not limited to, routine monitoring, endorsement reviews, level III incident reviews, complaint investigations and post payment reviews. If, through the course of any of these type of reviews, potential fraud, waste or abuse is discovered or suspected, OPC will take action appropriate to the specific situation, including, but not limited to the following interventions: conducting a more thorough review of the agency, requesting a systemic plan of correction to address cited deficiencies, referring the provider to the DMA Program Integrity Section and/or the DMH Program Accountability Section, requiring training in specific areas identified during the review, withdrawal of endorsement, and/or termination of the contract or memorandum of agreement with OPC.

11. Red Flag and Address Discrepancy Rule

The Red Flag and Address Discrepancy Rule was developed pursuant to the Fair and Accurate Credit Transactions (FACT) Act of 2003 and requires financial institutions and "creditors" with "covered accounts" to implement a written Identity Theft Prevention Program designed to identify, detect, and respond to patterns, practices or specific activities that could indicate identity theft.

A "creditor" as defined by federal law is any entity that regularly extends, renews, or continues credit; any entity that regularly arranges for the extension, renewal, or continuation of credit; or any assignee
OPC Area Authority/LME Effective July 1, 2009 to June 30, 2010

of an original creditor who is involved in the decision to extend, renew, or continue credit. A “covered account” is a consumer account that allows multiple payments or transactions or any other account with a reasonably foreseeable risk of identity theft. A health care provider can be subject to this rule if it meets the definition of creditor.

OPC providers are responsible for assessing the applicability of this rule to their operations and agree to take such action as is necessary to comply with the requirements of the rule. Providers for whom the rule is determined to be applicable are required to develop, implement, and administer a written Identity Theft Prevention Program. This program must 1) include reasonable policies and procedures to identify the “red flags” of identity theft that may be encountered during normal operations 2) be designed to detect any identified “red flags” 3) delineate appropriate actions to be taken when “red flags” are detected and 4) must address how the program will be periodically re-evaluated.

SECTION VII

Area Authority-Specific Policies/Forms/Local Governance Requirements

OPC-LME Forms required for enrollment, registration, and billing can be found at www.opcareaprogram.com.

Care Review in Orange-Person-Chatham Counties

OPC LME and the Community Collaboratives in each of our counties believe that the majority of youth with emotional, behavioral, and substance abuse challenges can be most effectively treated in their home communities. If a Child and Family Team is considering an out of home placement or an increase in the youth's level of care, that Team, including the parent/guardian, must meet with a Care Review Committee in the family's home county.

The Care Review Committee will explore with the Child and Family Team whether the Team meetings have been occurring regularly, whether members are participating, if the family has a crisis plan, and whether less restrictive services have been tried in the community. In addition, if a young person does go to a residential placement, the Care Review Committee is interested in whether the Team has developed an adequate step down plan, a practical plan for the family to be engaged in the child's treatment and Child and Family Teams during the placement, and a way for the child to maintain meaningful connections in their home community during placement.

The clinical home is expected to complete the Care Review application and coordinate with OPC LME for a Care Review time. The clinical home is also expected to invite Child and Family Team members to the scheduled meeting. The clinical home has an expectation to explain Care Review to the parent/guardian and obtain the consent for release of information. Care Review Committee will not meet for an initial review without the parent/guardian present. Additional information to assist the clinical home in explaining Care Review to the parent/guardian may be found at www.communityandproviderservices.org. If a child is placed out of county, the clinical home is also responsible for completing and delivering the Notification of Placement forms to the receiving county's LME, school, and DSS.

Room and Board payment is linked to Care Review Committee's approval.

To schedule a Care Review, please contact Lisa Lackmann at 919-913-4011.

OPC Care Coordination Referral Information

Care Coordination: Care coordination is an OPC LME function that provides a time-limited case management-like intervention on behalf of the LME, to assure that LME identified consumers receive timely targeted attention to achieve specific outcomes.

Consumers Referred: Consumers can be referred for Care Coordination by involved community providers, or by LME staff, by faxing a completed "REQUEST FOR OPC CARE COORDINATION FORM" to OPC's Lead Care Coordinator at (919) 913-4009. Received forms will be reviewed, and phone contact from an OPC Care Coordinator (OPC/CC) to the referring party will be initiated by OPC/CC to determine if one of the following services would be appropriate in response to the request.

- 1) Consumer is not connected to an appropriate community provider, is a priority consumer for the LME, and qualifies for active OPC/CC intervention to ensure an LME priority outcome. An example of this is a State Hospital/high end Crisis Service consumer NOT connected with an enhanced benefit service provider. OPC/CC goal would be to assist in discharge planning, help connect the consumer to an enhanced benefit service provider, and encourage effective crisis planning.
- 2) Consumer is connected to an enhanced benefit community service provider, and is cycling through state hospital and/or high-end crisis services. OPC/CC would consult with provider and advocate for improved crisis planning, and possibly additional or different services.
- 3) Consumer is connected to an enhanced benefit community provider, and due to exceptional circumstances (e.g., entrenched disagreement between consumer and provider, or between two involved providers about appropriate services), the provider agency wants the LME involved in shaping the direction of future services. This Care Coordination request would be accepted by OPC/CC as a request for a Clinical Consultation.

Referral Priority: Each referral will be staffed within the Care Coordination Unit to assign a priority to the referral. If accepted, the LME employee or provider making the referral will be informed of the referral priority and the estimated date for initiating Care Coordination and/or Clinical Consultation. If not accepted, the provider or LME employee will be given this information.

- 1) Consumer safety: If the consumer's safety is endangered or in serious question, a Care Coordination Referral will be given highest priority. Care Coordination will be initiated to ensure short term safety, an appropriate referral to provider, crisis planning by provider, and provider follow-through on plan.
- 2) The most efficient and clinically appropriate use of State Hospital Bed Days (i.e., assisting in discharge planning).
- 3) Consumer access to appropriate community services.
- 4) Appropriate management of OPC's State Service Dollars (IPRS).
- 5) OPC LME's reporting and other obligations to DMH/DD/SAS.

Note; combinations of these referral priorities in any one consumer referral will likely elevate the referral priority above a comparable consumer referral with a single priority.

Wait List: All referrals accepted for Care Coordination will be placed on a wait list based on referral priority. Those referrals accepted with imminent consumer safety issues will receive a response as an urgent or emergent referral; to receive Care Coordination within 48 hours if urgent, and 2 hours if

emergent. Referrals with lower priority will be placed on a Unit waitlist, and date of Care Coordinator response will be determined based on the other priorities listed; higher priority rating will result in quicker response. If it appears that the priority of the referral is such that it is unlikely that the referral will make it to the top of the list, the referring party will be informed that the referral is not accepted for Care Coordination.

Please see Appendix C for Request for OPC Care Coordination Form and Instructions.

OPC Crisis Services for Consumers of Mental Health/Developmental Disabilities & Substance Abuse Services

OPC maintains a 24-hour a day, seven day a week crisis response service.

OPC Screening, Triage, Access and Referral "STAR" can be contacted at 919-913-4100 or 1-800-233-6834. Crisis response includes telephone and face-to-face capabilities by contracted Provider Agencies. Crisis phone response includes triage and referral to appropriate face-to-face crisis providers and is initiated within one hour of call. Crisis services are designed for prevention, intervention, and resolution. Crisis services do not require prior authorization and are provided in the least restrictive environment, consistent with individual and family need and community safety.

For Active Consumers of Mental Health/Developmental Disabilities or Substance Abuse Services:

Contact the agency providing services. If worker is unavailable or unknown, ask to speak with On-Call or Program Manager. The Clinical Home Provider has First Responder duties and should be contacted by active consumers with any non life threatening crisis 24-hour a day, seven day a week.

Mobile Crisis For consumers of any age who are not already receiving enhanced services.

- Up to six hours of face-to-face crisis counseling provided in the community for mental health, developmental disabilities or substance abuse consumers of any age.
- Telephone consultation/counseling also available through this service.
- To access Mobile Crisis, call Freedom House 967-8844 (or main number at 919-942-2803.)

NC START – For adult consumers 18 years of age and over with a primary diagnosis of a developmental disability &/or are dually diagnosed with a co-occurring mental illness and have significant challenging behaviors.

Call: NC START Central Region Team at 919-865-8730 or 1-800-662-7119 ext. 8730

Facility Based Crisis For adults over 18 years of age – **Mental Health Facility Based Crisis**

For adult consumers with mental illness, or dually diagnosed with MH/DD or MH/substance dependence who are in need of crisis services AND can contract for safety.

Call: Freedom House 919-967-8844

Or

Call: Residential Treatment Services of Alamance (RTS) 336-227-7417.

Psychiatric care is available at both facilities.

Transportation can be provided, but is not always available. (Contact Mobile Crisis)

Detox: For adults over 18 years of age. To access Detox:

Call: Freedom House 919-942-2803 or 919-967-8844,

Or

Call: Residential Treatment Services of Alamance (RTS) 336-227-7417

UNC Dept. of Psychiatry Crisis Service Walk-in Clinic – For consumers of any age

Monday – Friday 8:30 – 2:30 – **Call** 919-966-2166 before sending consumer.

UNC Hospital Emergency Department - For consumers of any age

Call 919-966-4131. Ask to speak with Psychiatrist On-Call before sending consumer.

Rapid Response – For children or adolescents younger than 18 years of age.

A brief stay in a Level II – Therapeutic Foster Home contracted with OPC for "Rapid Response".

OPC Area Authority/LME

Effective July 1, 2009 to June 30, 2010

CSS worker must secure authorization from Value Options within first 3 days, in order for Medicaid or Health Choice kid to stay for a total of 30 days. If the child does not qualify for Medicaid or Health Choice, OPC may pay for a total of 10 days of placement, but the child will have to leave Rapid Response at the end of the 10 days. No extensions can be granted.

See Rapid Response Worksheet for Procedures for accessing Rapid Response:

Clinic Based Crisis Services are available in all three counties from 8 – 5 on workdays as follows:

Orange – Chapel Hill Outpatient Clinic of Freedom House - 919-913-4200

Chatham – Chatham Counseling Center of Freedom House - 919-542-4422

Person – Person Counseling Center of Freedom House - 336-599-8366

Access Crisis Services 24 Hours a Day

OPC Screening, Triage, Access and Referral “STAR”: 919-913-4100 or 1-800-233-6834

If deaf or hard of hearing dial 711 for NC Relay or TTY number 1-866-587-6459

Disaster Preparedness Response and Recovery

OPC/LME requires that all community Providers develop and implement proactive emergency and Disaster Preparedness Plans. Our goal is to ensure that our consumers and their medical records are protected while maintaining service integrity during emergencies, fire, natural disasters, terrorism and various other community crisis situations. OPC/LME expects Providers to include in their Disaster Preparedness Plans written agency instructions for staff ensuring that persons enrolled (including the family of minors) with the Providers Agency (a) receive assistance in making preparation in advance of an expected emergency, and (b) have access to necessary supports management throughout the period of any declared emergency.

OPC/LME recommends that the following elements be included in Disaster Preparedness Plans:

- Statement of Purpose
- Agency Overview and General Assumptions
- Provider Agency Staff Operations
- Organization and Assignment of Responsibilities
- Continuity of Operations
- Pre-Disaster Planning
- Protocols Once a Forecast of Severe Weather or Other Disaster is Announced
- Steps to Take When an Emergency is Declared

All Provider emergency/disaster plans must adhere to State and Federal laws/regulations, i.e. Critical Incident Reporting Guidelines and OSHA. Providers must address the aforementioned emergency/disaster areas, but should not consider themselves restricted to these areas. They may elect to enhance emergency/disaster plans in order to ensure optimal community oriented consumer care.

A Provider can incorporate disaster and emergency preparedness planning into treatment. For example, a Provider may include disaster planning in the course of formulating a crisis plan. The DHHS Family Disaster Plan workbook can be found at:

<http://www.ncdhhs.gov/mhddsas/disasterpreparedness/familydisaster2007plan.pdf>.

SECTION VIII

Glossary of Terms

Definitions included in this section are primarily for clarification of terms used in the body of this Agreement, its attachments and manual. However many of these definitions are also used in existing State and Area Authority documents and are included here to be helpful but are not to be considered comprehensive. Where similar definitions apply to multiple terms, the terms are grouped. Broad categories are defined with specific elements detailed as a part of the entire definition.

ACCESS – An array of treatments, services and supports is available; consumers know how and where to obtain them; and there are no system barriers or obstacles to getting what they need, when they are needed.

ACCREDITATION – Certification by an external entity that an organization has met a set of standards.

ACT-Assertive Community Treatment

ADULT- means a person 18 years of age or older, unless the term is given a different definition by statute, rule, or policies.

ADMINISTRATIVE SERVICES- means the services other than the direct provision of MH/DD/SA services (including case management) to eligible or enrolled persons, necessary to manage the MH/DD/SA system, including but not limited to: provider relations and contracting, provider billing accounting, information technology services, processing and investigating grievances and appeals, legal services (including any legal representative of the Contractor at Administrative hearings concerning the Contractor's decisions and actions), planning, program development, program evaluation, personnel management, staff development and training, provider auditing and monitoring, utilization review and quality management.

ADVOCACY – Activities in support of, or on behalf of, people with mental illness, developmental disabilities or addiction disorders including protection of rights, legal and other service assistance, and system or policy changes.

AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) - An international organization of physicians dedicated to improving the treatment of people with substance use disorders by educating physicians and medical students, promoting research and prevention, and informing the medical community and the public about issues related to substance use. In 1991, ASAM published a set of patient placement criteria that have been widely used and analyzed in the alcohol, tobacco and other drug field.

AOC - Administrative Office of the Courts.

APPEAL- means a formal request for review of a decision made by the Contractor or a subcontracted provider related to eligibility for covered services or the appropriateness of treatment services provided.

APPEALS PANEL - The State MH/DD/SA appeals panel established under NC. G.S.371.

ASSESSMENT – A comprehensive examination and evaluation of a person's needs for psychiatric, developmental disability or substance abuse treatment, services and/or supports according to applicable requirements.

AUTHORIZATION - The process by which Utilization Management agrees to a medically necessary specific service or plan of care based upon best practice. The granted request of a provider is assigned a number for tracking and linked to the subsequent claim that will be made for reimbursement. *PRE-AUTHORIZATION/PRIOR AUTHORIZATION* is the process of approving use of certain resources in advance rather than after the service has been requested. Approval for admission to hospitals in an emergent situation is one example. *RE-AUTHORIZATION* is the process of submitting a request for services for a consumer who has already received authorized services. The request shall specify the scope, amount and duration of service requested and shall indicate the consumer's progress toward outcomes, the use of natural and community supports, and how the requested services will support the outcome the individual is seeking.

RETROSPECTIVE AUTHORIZATION is authorization to provide services after the services have been delivered.

BASIC SERVICES – Mental health, developmental disability or substance abuse services that are available to North Carolina residents who need them whether or not they meet criteria for target or priority populations.

BENEFIT PACKAGE OR PLAN – An array of treatments, services and/or supports intended to meet the needs of target or priority populations. *BENEFIT LIMITATIONS* are any provision, other than an exclusion, which restricts coverage, regardless of medical necessity. *Covered Benefits* medically necessary services that are specifically provided for under the provisions of Evidence of Coverage. A covered benefit shall always be medically necessary, but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered. **BEST PRACTICE (S)** – Interventions, treatments, services or actions that have been shown by substantial research or professional consensus to generate the best outcomes or results. The terms, *EVIDENCE-BASED*, or *RESEARCH-BASED* may also be used.

BLOCK GRANT – Funds received from the federal government (or others), in a lump sum, for services specified in an application plan that meet the intent of the block grant purpose. Also referred to as *CATEGORICAL FUNDING*.

CARE COORDINATION – The methods utilized to notify other providers of significant events in the course of care and to enable multiple providers to give integrated care to an individual. Professionals with a broad knowledge of the resources, services and programs supported by the public MH/DD/SA system and the community at-large advocate for access and link individuals to entitlements and services. It is an administrative Service Management Function performed by the Contractor for individuals

not enrolled or not meeting target population definitions.

CARF - Council on Accreditation of Rehabilitation Facilities

CATCHMENT AREA - The geographic part of the state served by a specific Contractor. The *GEOGRAPHIC AREA* can be a specific county or defined grouping of counties that are available for contract award. The Contractor is responsible to provide covered services to eligible residents of their area.

CENTERS FOR MEDICAID AND MEDICARE SERVICES (CMS) - The federal agency responsible for overseeing the Medicaid and Medicare programs. Formerly, it was known as the Health Care Financing Administration, (HCFA).

CERTIFICATION – A statement of approval granted by a certifying agency confirming that the program/service/agency has met the standards set by the certifying agency. The Contractor or the NC Council may be the certifying agency for subcontracted **Providers**.

CFAC - Consumer and Family Advisory Committee

CHILD-means an eligible person who is under the age of 18, unless the term is given a different definition by statute, rule or policies.

CLAIMS MANAGEMENT – The process of receiving, reviewing, adjudicating, INVESTIGATING, paying, and otherwise processing service claims submitted by network and facility providers. *CLAIM* – An itemized statement of services, performed by a provider community member or facility, which is submitted for payment. *CLEAN CLAIM*- means a claim that successfully passes all adjudication edits. **CLIENT** - An individual who is admitted to or receiving public services. "Client" includes the client's personal representative or designee and the terms *CONSUMER*, *RECIPIENT* and *PATIENT* are often used interchangeably.

CLIENT OUTCOMES INVENTORY (COI) – DMH/DD/SAS measurement system for assessing treatment/services outcomes of mental health and substance abuse service consumers.

CLIENT DATA WAREHOUSE - The DHHS's source of information to monitor program, clinical and demographic information on the clients served. The data are also used to respond to Departmental, Legislative and Federal reporting requirements.

CLINICAL PRACTICE GUIDELINES – Utilization and quality management mechanisms designed to aid providers in making decisions about the most appropriate course of treatment for a specific clinical case. The guidelines or *TREATMENT PROTOCOLS* are summaries of best practice research and consensus. They include professional standards for providing care based on diagnostically related groups. NC has adopted protocols for MH and DD. NC uses ASAM Guidelines for substance abuse.

COA -Council on Accreditation

CO-MORBID CONDITION- CO-OCCURRING DISORDERS, DUAL DIAGNOSIS –

Terms that reflect the presence of two or more disorders at the same time (e.g. substance abuse and mental illness; developmental disability and mental illness; substance abuse and physical health conditions, etc and require specialized approaches.

COMPLAINT – A report of dissatisfaction with some aspect of the public MH/DD/SA system. The term *DISPUTE* is used to indicate a specific complaint about a service or a provider that requires attention and joint resolution.

CONFLICT OF INTEREST – A situation where self interest could negatively impact the best interests of the person being served or the system.

CONSENSUS - Majority opinion regarding a group decision. It is not the same as total agreement.

CONSUMER- An individual who is admitted to or receiving public services. "Consumer" includes the consumer's personal representative or designee and the terms *CLIENT*, *RECIPIENT* and *PATIENT* are often used interchangeably.

CONSUMER/FAMILY ADVISORY COMMITTEE (CFAC) – A Board appointed group of persons receiving services/ families of persons receiving services, who participate in meaningful decision making relative to the local service system. The CFAC meets regularly in a public forum to review data, practices, policies and plans of the Contractor and make recommendations to the Board from the consumer/family perspective.

CONTRACT- A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is time limited. A contract is defined as a document that governs the behavior of a willing buyer and a willing provider. In this case the Contract is the 2004 Performance Agreement between the Department and the LME.

CONTRACTOR - an organization or entity agreeing by signature to provide the goods and services in conformance with the stated contract requirements, NC statute and rules and federal law and regulations.

CONTRACT YEAR-a period from July 1 of a calendar year through and including June 30 of the following year.

COPAYMENT- The portion of the cost of services which the enrolled person pays directly to the Contractor or the subcontracted providers at the time-covered services are rendered.

CORE SERVICES – *BASIC SERVICES* such as screening, assessment, crisis or emergency services available to any person who needs them whether or not they are a member of a target or priority population. The term also includes universal services such as education, consultation and prevention activities intended to increase knowledge about mental illness, addiction disorders, or developmental disabilities, reduce stigma associated with them and/or prevent avoidable disorders. **CORPORATE COMPLIANCE** – The systematic local governance plan for detection of fraud and abuse as defined in the Balanced Budget Act.

CREDENTIALING – The process of approving providers for membership in a network to provide services to consumers. This term can also refer to a peer competency-based credential such as a license for professionals.

CRISIS – Response to internal or external stressors and stressful life events that may seriously interfere with compromise a person's ability to manage. A crisis may be emotional, physical, or situational in nature. The crisis is the perception of and response to the situation, not the situation itself. *CRISIS RESPONSE* is the immediate action to assess for acute MH/DD/SA service needs, to assist

with acute symptom reduction, and to ensure that the person in crisis safely transitions to appropriate services. These services are available 24 hours per day, 365 days per year. These services may be referred to as *EMERGENCY* services as well. NC requires a *CRISIS PLAN* for consumers to promote recovery and to lessen the trauma of emergency events.

CULTURAL COMPETENCE/PROFICIENCY – A process that promotes development of skills, beliefs, attitudes, habits, behaviors and policies which enable individuals and groups to interact appropriately, showing that we accept and value others even when we may disagree with them.

CUSTOMER – Customers may be *ULTIMATE CUSTOMERS* who are the intended and actual recipients of the services provided by the public system, *INTERNAL CUSTOMERS* are those individuals internal to the system who rely on each other to provide the service to the ultimate customer; and *EXTERNAL CUSTOMERS* are those groups and individuals outside the system that have a take in the outcomes and products produced by the system. The concept is critical to proper implementation of

DD - Developmental Disability

DEFAULT – The breach of conditions agreed to in this Contract and/or failure to perform based upon defined terms and conditions the scope of work specified in the Contract.

DE-INSTITUTIONALIZATION – Release of people from institutions to care, treatment and supports in local communities. De-institutionalization became national policy with the Community Mental Health Centers Act of 1963. The 1997 Supreme Court decision in *OLMSTEAD V. LC* has given new momentum to development of community based services for individuals who have remained in state hospitals and mental retardation centers because community services were not available. This movement is often referenced as movement to least restrictive care or to lower levels of care where safety and community integration are balanced and supported through the community system of services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, (DHHS) – North Carolina agency that oversees state government human services programs and activities.

DEVELOPMENTAL DISABILITY - A severe, chronic disability of a person which: a) is attributable to a mental or physical impairment or combination of mental and physical impairments; b) is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22; c) is likely to continue indefinitely and, d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self sufficiency; and e) reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or f. when applied to children from birth through four years of age, may be evidenced as a developmental delay.

DHHS- Department of Health and Human Services.

DIAGNOSTIC AND STATISTICAL MANUAL (DSM IV) – A book, published by the American Psychiatric Association, of special codes that identify and describe MH/DD/SA disorders.

DISABILITY RIGHTS NORTH CAROLINA (DRNC) – The organization designated by the Governor to ensure the rights of all state citizens with disabilities through individual advocacy and system change.

DISASTER – A disaster is any natural or human-caused event, which threatens or causes injuries, fatalities, widespread destruction, distress, and economic loss. Disasters result in situations that call for a coordinated, multi-agency response. A disaster calls for a response and resources that usually exceed local capabilities.

DIVERSION – Choosing lower cost and/or less restrictive services and/or supports. For example, choosing a community program instead of sending a person to a state hospital. The term is also used when preventing arrest or imprisonment by providing services that restore functioning and avoid detention. In North Carolina diversion programs are in place in response to SB859 that prohibits admission of persons with mental retardation to public psychiatric hospitals.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES (DMH/DD/SAS) - A division of the State of North

Carolina, Department of Health and Human Services responsible for administering and overseeing public mental health, developmental disabilities and substance abuse programs and services.

OPC Area Authority/LME

Effective July 1, 2009 to June 30, 2010

DJJDP - Department Of Juvenile Justice and Delinquency Prevention.

DOMAINS - Major areas of concern to the NC public MH/DD/SA system and its mission, goals, and strategies and for which indicators and measures are developed to examine outcomes of service in the lives of people served.

DPI -Department of Public Instruction

DSS - Department of Social Services

EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

EPSDT – Early and Periodic Screening, Diagnosis and Treatment is a Medicaid program for Title XIX individuals under the age of 21. This mandatory preventive child health program for Title XIX children requires that any medically necessary health care service identified in a screening be provided to an EPSDT recipient. The MH/DD/SA component of the EPSDT diagnostic and treatment services for Title XIX members under age 21 years are covered by this contract.

EDUCATION – Activities designed to increase awareness or knowledge about any and all aspects of mental health, mental illness, developmental disability or substance abuse to individuals and/or groups. Education and training are also activities or programs delivered to staff to ensure that service providers are competent to provide services identified as best practices.

ELIGIBILITY – Determination of the service and/or benefit package an individual may be entitled to or determination of a class membership that allows entry to certain services and supports. The determination that individuals meet prescribed criteria for a particular program, set of services or benefits.

EARLY INTERVENTION - The provision of psychological help to victims/survivors within the first month after a critical incident, traumatic event, emergency, or disaster aimed at reducing the severity or duration or event-related distress. For mental health service providers, this may involve psychological first aid, needs assessment, consultation, fostering resilience and natural supports, and triage, as well as psychological and medical treatment.

EMERGENCY- Means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following apply: o The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally. o The individual is unable to provide himself or herself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing or ambulating, and this inability may lead in the near future to harm to the individual or to another individual. o The individual's judgment is so impaired that he or she is unable to understand the need for treatment and, in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

ENROLLED – Individuals are admitted for service and have been provided at least one service and assigned a unique identifying number.

FAIR HEARING RIGHTS – Advance and Adequate Notice - The Contractor notice in accordance with DHHS policy and procedure using prescribed forms when denying, reducing, suspending or terminating covered services that require prior authorization. The Contractor shall comply with all notice, appeal and continuation of benefits requirements specified by state and federal law and regulations. **FEE FOR SERVICE** – A method of payment for health care. A payer pays the Contractor or a service provider for each reimbursable treatment, upon submission of a valid claim, and according to agreed upon business rules. The *FEE SCHEDULE* is a list of reimbursable services and the rate paid for each service provided.

FEMA - Federal Emergency Management Agency

FORENSIC – Term used to describe a person with mental illness, developmental disability or substance abuse who is involved in the criminal justice system. This includes persons found Not Guilty by Reason of Insanity (NGRI), those who are Incompetent to Stand Trial, or who are in jails or prisons or referred to the mental health system by criminal courts for evaluation and treatment.

FORMULARY – A list of drugs that are considered preferred therapy for a given condition and cost effective and are to be used by providers in prescribing medications. **FUNCTIONAL OUTCOMES** - The extent to which individuals receiving services and supports reach their goals. These outcomes generate from *DOMAINS* as defined earlier related to desirable life developments that all people wish to achieve, such as safe and affordable housing, employment or a means of support, meaningful relationships, participation in the life of the community, etc.

GENERAL FUND – State funds used by the General Assembly for public programs and initiatives.

GEOGRAPHIC ACCESSIBILITY – A measure of access to services, generally determined by drive/travel time or number and type of providers in a service area. The Contract standard is 30 minutes/30 miles.

GRIEVANCES – A formal complaint by a service recipient that shall be resolved in a specified manner detailed in this Contract.

HEALTH CHOICE – The health insurance program for children in North Carolina that provides comprehensive health insurance coverage to uninsured low-income children. Financing comes from a mix of federal, state, and other non-appropriated funds.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) –Public Law 104-191, 1996 to improve the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information. The Act provides for improved portability of health benefits and enables better defense against abuse and fraud, reduces administrative costs by standardizing format of specific healthcare information to facilitate electronic claims, directly addresses confidentiality and security of patient information - electronic and paper-based, and mandates “best effort” compliance.

HIPAA - Health Insurance Portability and Accountability Act

HUD - Housing and Urban Development

HUMAN RIGHTS COMMITTEE – The body established by statute for hearing grievances and appeals related to rights violations guaranteed by law and under this contract.

INCURRED BUT NOT REPORTED (IBNR)- means liability for services rendered for which claims have not been received. Refers to claims that reflect services already delivered, but, for whatever reason, have not yet been reimbursed. Failure to account for these potential claims could lead to inaccurate financial estimates.

INTEGRATED PAYMENT AND REPORTING SYSTEM (IPRS) - An electronic, web-based system for reporting services and making payments that will eventually replace the Willie M., Thomas S., and Pioneer systems of claims processing. The IPRS system will be built on the existing Medicaid Management Information System (MMIS) currently processing Medicaid claims for the Division of Medical Assistance, (DMA). The goal of the IPRS project is to replace the existing UCR systems with one integrated system for processing and reporting all MH/DD/SAS and Medicaid claims.

IPRS-Integrated Payment Reporting System

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) –Agency that reviews the care provided by hospitals and determines whether accreditation is warranted.

LBP - Local Business Plan

LEAST RESTRICTIVE CARE – The service that can be provided in the most normative setting while insuring the safety and well being of the individual.

LENGTH OF STAY (LOS) – The amount of time that a person remains in a service program, including hospitals, expressed in days.

LEVEL OF CARE (LOC)- A structured system for evaluating acuity and *INTENSITY OF NEED* against the amount, duration and scope of service required by a consumer. For substance abuse programs, As used in the ASAM criteria for substance abuse, this term refers to four broad areas of treatment placement, ranging from inpatient to outpatient.

LICENSURE – A state or federal regulatory system for service providers to protect the public health and welfare. Licensure of healthcare professionals and hospitals are examples.

LME - Local Management Entity

LOCAL BUSINESS PLAN – In the reformed MH/DD/SA system, a comprehensive plan required of local management entities for mental health, developmental disabilities and substance abuse services in a certain geographical area.

LOCAL MANAGING ENTITY (LME) - The local administrative agency that plans, develops, implements and monitors services within a specified geographic area according to the terms of this Contract including the development of a full range of services and/or supports for both insured and uninsured individuals.

LOCAL QUALITY MANAGEMENT COMMITTEE – A cross system group of stakeholders including the LME, providers, consumers, and family members that reviews data and trends to make recommendations for continuous improvement in the system of care and supports.

MANAGEMENT REPORTS – Collections of data that are benchmarked to enable the agency to compare performance against standards and to seek continuous improvement. The reports should be comprehensive incorporating timeliness, utilization and penetration rates, customer satisfaction, functional outcomes and compliance with various standards and terms inherent in this Contract.

MEDICAID – A jointly funded federal and state program that provides medical expense coverage to low-income individuals, certain elderly people and people with disabilities. The Federal government requires that the state/local government match the federal government funds. In North Carolina, this is approximately 60% federal/40% state/local match. People qualifying for Medicaid are “entitled” to supports and services based upon a State Medicaid Plan that is approved by the Federal Government. That Plan describes the services and benefits the individual is entitled to receive and the conditions of service provision.

MEDICAL DIRECTOR – A Board Certified Psychiatrist responsible for establishing and overseeing medical policy throughout the system under the terms of this Contract.

MEDICAL NECESSITY - Criteria established to ensure that treatment is essential and appropriate for the condition or disorder for which the treatment is provided. The criteria reference the scope, amount and duration of service appropriate for levels of acuity and rehabilitative care.

MEDICARE – A federal government hospital and medical expense insurance plan primarily for elderly people and people with long term disabilities.

MEMBER HANDBOOK – A document developed and disseminated by the Contractor according to parameters established in this Contract to inform potential eligibles, eligibles, and enrolled persons of their rights, responsibilities and treatment coverages.

MEMORANDUM OF AGREEMENT (MOA) or MEMORANDUM OF UNDERSTANDING (MOU) – A written document, signed by two or more parties, containing policies and/or procedures for managing issues that impact more than one agency or program.

MH - Mental Health

MMIS - Medicaid Management Information System.

MST - Multi-Systemic Therapy

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA)-A non-profit organization created to improve patient care quality and health plan performance in partnership with system management plans, purchasers, consumers, and the public sector.

NATIONAL PRACTITIONER DATA BANK (NPDB) – A database maintained by the federal government that contains information on physicians and other medical practitioners against whom medical malpractice claims have been settled or other disciplinary actions that have been taken.

NATURAL AND COMMUNITY SUPPORTS - Places, things and, particularly, people who are part of our interdependent community lives and whose relationships are reciprocal in nature.

NCQA - National Council for Quality Assurance

NEEDS ASSESSMENT - A process by which an individual or system (e.g., an organization or community) examines existing resources to determine what new resources are needed or how to reallocate resources to achieve a desired goal.

NORTH CAROLINA SUPPORT NEEDS ASSESSMENT PROFILE (NC-SNAP) – Assessment instrument used to determine the care or supports needed by a person with developmental disabilities.

OPERATIONAL AND FINANCIAL REVIEW-means the review of the Contractor conducted by DMH/DD/SAS to assess compliance with contract requirements. **OUTREACH** - Programs and activities to identify and encourage enrollment of individuals in need of MH/DD/SA services and/or to encourage people who have left service prematurely to return.

PATIENT PLACEMENT CRITERIA (PPC) - Standards of, or guidelines for, alcohol, tobacco and other drug (ATOD) abuse treatment that describe specific conditions under which patients should be admitted to a particular level of care (admission criteria), under which they should continue to remain in that level of care (continued stay criteria), and under which they should be discharged or transferred to another level (discharge / transfer criteria). PPC generally describe the settings, staff, and services appropriate to each level of care and establish guidelines based on ATOD diagnosis and other specific areas of patient assessment.

PCP - Person Centered Plan

PCPM – Per Citizen Per Month. The basis on which the Contractor is paid for administrative functions under the terms of some contracts.

PEER REVIEW – The analysis of clinical care by a group of that clinician’s professional colleagues. The provider’s care is generally compared to applicable standards of care, and the group’s analysis is used as a learning tool for the members of the group.

PENETRATION – The extent to which the system serves those individuals expected to have a specific medical condition, in this case persons with developmental disabilities, persons with mental illnesses and persons with substance abuse disorders. **PERFORMANCE INDICATORS** - Measurable evidence of the results of activities related to particular areas of concern as indicated in this Contract. The measures are quantitative indicators of the quality of care provided that consumers, payers, regulators and others could use to compare the care or provider to other care or providers.

PERFORMANCE STANDARDS- Benchmarks an agency or provider is expected to meet. The standards define regulatory expectations and in meeting them the agency or provider may meet a required level for “certification” or “accreditation”.

PERSON-CENTERED PLANNING - A process focused on learning about an individual’s whole life, not just issues related to the person’s disability. The process involves assembling a group of supporters selected by the consumer who are committed to supporting the person in pursuit of desired outcomes. Planning includes discovering strengths and barriers, establishing time-limited and identifying and gaining access to supports from a variety of community resources prior to utilizing the community MHO/DD/SA system to assist the person in pursuit of the life he/she wants. Person-centered planning results in a written plan that is agreed to by the consumer and that defines both the natural and community supports and the services being requested from the public system to achieve the consumer’s desired outcomes. The plan is used as the basis for requesting an authorization for services. **PHYSICAL DEPENDENCE** - A condition in which the brain cells have adapted as a result of repeated exposure to a drug and consequently require the drug in order to function.

If the drug is suddenly made unavailable, the cells become hyperactive. The hyperactive cells produce the signs and symptoms of drug withdrawal.

PLAN OF CORRECTION – A written response to findings of an audit or review that specify corrective action, time frames and persons responsible for achieving the desired outcomes.

PP - Primary Provider

PREVALENCE – The estimated degree of incidence of a condition in a given population.

PREVENTION – Activities aimed at teaching and empowering individuals and systems to meet the challenges of life events and transitions by creating and reinforcing healthy behaviors and lifestyles and by reducing risks contributing mental illness, developmental disabilities and substance abuse. Universal Prevention programs reach the general population; Selective Prevention programs target groups at risk for mental illness, developmental disabilities and substance abuse; Indicated Prevention programs are designed for people who are already experiencing mental illness or addiction disorders.

PSR - Psychosocial Rehabilitation

RESPONSIBLE CLINICIAN - An assigned professional deemed competent and credentialed by the Contractor to serve as a fixed point of accountability for the consumer's PCP, monitoring and outreach.

PRIMARY CARE- (a) Basic or general health care usually rendered by general practitioners, family practitioners, internists, obstetricians and pediatricians—often referred to as primary care practitioners. (b) Professional and related services administered by an internist, family practitioner, obstetrician-gynecologist or pediatrician in an ambulatory setting, with referral to secondary care specialists, as necessary. **PRIMARY SOURCE VERIFICATION** – A process through which an organization validates credentialing information from the organization that originally issued the credential to the practitioner.

PRINCIPLE DIAGNOSIS-The medical condition that is ultimately determined to have caused the consumer to seek care. The principal diagnosis is used to assign every consumer to a diagnosis-related group. This diagnosis may differ from the admitting diagnosis.

PRIORITY POPULATIONS – Groups of people within target populations who are considered most in need of the services available within the system.

PRIVILEGING – Process for determining, usually through training and supervision that an individual provider has the necessary skills and knowledge to offer designated services and can provide them without supervision.

PROMPT SERVICES - Services provided when needed. For target or priority populations, routine appointments within 14 days, initial hospital discharge visits within 3 days, urgent visits within 2 days, emergent visits immediately and no later than 24 hours qualify as prompt.

PROVIDER – In this Contract, a person or an agency that provides MH/DD/SA services, treatment, and supports under a subcontract to the LME.

OPERATIONS MANUAL – A document attached to a subcontract for the purpose of explaining how to work with the local system, the requirements for service delivery, authorization, claims submission, etc.

PROVIDER PROFILING – The process of compiling data on individual provider patterns of practice and comparing those data with expected patterns based on national or local statistical norms. The data may include medication prescribed, hospital length of stay, size of caseload, and other services. Some data may be compiled for use by consumers in choosing preferred providers based on performance indicators.

PUBLIC MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE

ABUSE SERVICES SYSTEM – The network of managing entities, service providers, government agencies, institutions, advocacy organizations, and commissions and boards responsible for the provision of publicly funded services to consumers.

QA - Quality Assurance

QI - Quality Improvement

QIC - Quality Improvement Committee

QM - Quality Management

QPC - Qualified Provider Community

QUALIFIED PROVIDER COMMUNITY – The group of subcontractors subcontracted by a Contractor to provide supports and

services to persons for whom the Contractor authorizes care.

QUALITY MANAGEMENT (QM)- The framework for assessing and improving services and supports, operations, and financial

performance. Processes include: **QUALITY ASSURANCE**, and **QUALITY IMPROVEMENT**. **QUALITY IMPROVEMENT (QI)** is a

process to assure that services, administrative processes, and staff are constantly improving and learning new and better ways to provide services and conduct business. As distinct from QA, the purpose of QI, also referred to as continuous quality improvement (CQI), is to continuously improve the process and outcome (quality) of treatments, services, and

supports provided to consumers and administrative functions. *QUALITY ASSURANCE (QA)* involves periodic monitoring of compliance with standards.

RECOVERING STAFF - Counselors with and without educational degrees working in the substance abuse treatment fields who are in recovery.

RECOVERY – A personal process of overcoming the negative impact of a disability despite its continued presence. Like the victim of a serious accident who undergoes extensive physical therapy to minimize the impact of damaging injuries, people with active addictions as well as serious, disabling mental illnesses and developmental disabilities can also make substantial recovery through symptom management, psychosocial rehabilitation, other services and supports, and encouragement to take increasing responsibility for self.

REFERRAL - Establishing a link between a person and another service or support by providing authorized documentation of the person's needs and recommendations for treatment, services, and supports. It includes follow-up in a timely manner consistent with best practice guidelines.

REGISTER – The process of gathering initial data and entering an individual into the service system.

REVENUES – Money earned through reimbursements paid for covered services or other local sources, grants, etc.

SA - Substance Abuse

SAPT - Substance Abuse Prevention and Treatment

STATE-means the State of North Carolina.

STATE PLAN- Annual (each fiscal year) updated comprehensive MH/DD/SAS systems reform plan derived from the systems reform statute and titled "Blueprint for Change".

STATE PLAN (MEDICAID)- The written agreements between the State of NC and CMS which describe how the NC DMH/DD/SAS programs meet all CMS requirements for participation in the Medicaid program and the Children's Health Insurance Program.

SCREENING/TRIAGE – An abbreviated assessment or series of questions intended to determine whether the person needs referral to a provider for services based on eligibility criteria and acuity level. A screening may be done face-to-face or by telephone, by a clinician or paraprofessional who has been specially trained to conduct screenings. Screening is a core or basic service available to anyone who needs it whether or not they meet criteria for target or priority populations.

SEAMLESS - Treatment system without gaps or breaks in service, such that persons being served transition smoothly and with ease from one treatment component to another.

SELF-DETERMINATION – The right to and process of making decisions about one's own life.

SENTINEL EVENT – CRITICAL INCIDENT, UNUSUAL INCIDENT, ETC. A sentinel event may include any type of incident that is clinically undesirable and avoidable. Sentinel events signal episodes of reduced quality of care. Many organizations monitor medication errors, review of deaths, accidents, evacuation drill responses, rights violations, medical emergencies, use of restraint or seclusion, behavior management etc. The purpose of sentinel event monitoring is to discover root causes and implement a continuous improvement process to prevent further events.

SEVERELY EMOTIONALLY DISTURBED (SED) – A designation for people less than 18 years of age who, because of their diagnosis, the length of their disability and their level of functioning, are at the greatest risk for needing services.

SEVERELY MENTALLY ILL (SMI) – Refers to adults with a mental illness or disorder that is described in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, that impairs or impedes functioning in one or more major areas of living and is unlikely to improve without treatment, services and/or supports. People with serious mental illness are a target or priority population for the public mental health system for adults.

SERIOUSLY AND PERSISTENTLY MENTALLY ILL (SPMI) – Refers to people with a mental illness or disorder so severe and chronic that it prevents or erodes development of functional capacities in primary aspects of daily life such as personal hygiene and self care, decision-making, interpersonal relationships, social transactions, learning and recreational activities.

SERVICE MANAGEMENT – An administrative function that includes Utilization Management and Care Coordination under this Contract. The service is carried out by experienced professionals with broad knowledge of the services and programs supported by the public system, managing a set of services by advocating for access and linking the person to the services. At the system level, this means activities such as implementing and monitoring a set of standards for access to services, supports, treatment; making sure that people receive the appropriate level and intensity of services; management of state facilities' bed days, making sure that networks create consumer choice in service providers.

SPECIALIST REVIEW – A consultation or second opinion rendered by a member of the UM staff when an authorization request falls outside the defined criteria for service selection, amount or duration.

STANDARD OF CARE – A diagnostic and/or treatment consensus that a clinician should follow when providing care based upon the discipline's peer group organization, such as the APA or NASW.

STATE MENTAL HEALTH AUTHORITY – The single state agency designated by each state's governor to be responsible for the administration of publicly funded mental health programs in the state. In North Carolina that agency is the Department of Health and Human Services.

STATE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE

ABUSE SERVICES PLAN – Plan for Mental Health, Developmental Disabilities and Substance Abuse Services in North Carolina. This statewide plan forms the basis and framework for MH/DD/SA services provided across the state. **STATE OR LOCAL CONSUMER ADVOCATE** - The individual carrying out the duties of the state Local Consumer Advocacy Program Office

SUBSTANCE ABUSE – The DSM IV defines substance abuse as occurring if the person 1) uses drugs in a dangerous, self defeating, self destructive way and 2) has difficulty controlling his use even though it is sporadic, and 3) has impaired social and/or occupational functioning all within a one year period.

THE SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION OF THE FEDERAL GOVERNMENT

(SAMHSA) - SAMHSA is an agency of the U.S. Department of Health and Human Service. It is the federal umbrella agency of the Center for Substance Abuse Treatment, Center for Substance Abuse Prevention, and the Center for Mental Health Services.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SAPTBG) -A federal program to provide funds to states to enable them to provide substance abuse services.

SUBSTANCE DEPENDENCE - DSM IV defines substance dependence as requiring the presence of tolerance, withdrawal, and/or continuous, compulsive use over a 1year period.

SUBCONTRACT-means any contract between the Contractor (Contractor) and a third party for the performance of all or a specified part of this Contract. The *SUBCONTRACTOR* means any third party engaged by the Contractor, in a manner conforming to the se contract requirements for the provision of all or a specified part of covered services under this Contract.

SYNAR AMENDMENT – Section 1926 of the Public Health Service, is administered through the Substance Abuse Prevention and Treatment (SAPT) Block Grant and requires states to conduct specific activities to reduce youth access to tobacco products. The Secretary of the US Department of Health and Human Services is required by statute to withhold SAPT Block Grant funds (40% penalty) from states that fail to comply with the SYNAR Amendment.

TARGET POPULATIONS –Groups of people with disabilities with attributes considered most in need of the services available within the system; populations as identified in federal block grant language. *NON-TARGET POPULATION* are those individuals with

less severe disorders that can be adequately and most cost effectively treated by the private sector, primary physicians or by using generic community resources.

TRANSITION – The time in which an individual is moving from one life/development stage to another. Examples are the change from childhood to adolescence, adolescence to adulthood and adulthood to older adult.

UM - Utilization Management

UNIFORM PORTAL ACCESS - The standardized process and procedures used to ensure consumer access to, and exit from, public services in accordance with the State Plan.

UTILIZATION MANAGEMENT (UM)- is a process to regulate the provision of services in relation to the capacity of the system and needs of consumers. This process should guard against under-utilization as well as over-utilization of services to assure that the frequency and type of services fit the needs of consumers. The administration of services or supplies which meet the following tests: they are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; they are provided for the diagnosis or direct care and treatment of the medical condition; they meet the standards of good medical practice within the medical community in the service area; they are not primarily for the convenience of the plan member or a plan provider; and they are the most appropriate level or supply of service which can safely be provided. This function is carried out by professionals qualified in disciplines related to the care being authorized and requires their use of tools such as service definitions, level of care criteria, etc.

UTILIZATION-is the use of services. Utilization is commonly examined in terms of patterns or rates of use of a single service or type of service. Use is expressed in rates per unit of population at risk for a given period such as the number of admissions to the hospital per 1,000 persons per year, or the number of services provided per 1,000 persons by a system of care annually.

UTILIZATION REVIEW (UR)- is an analysis of services, through systematic case review, with the goal of reviewing the extent to which necessary care was provided and unnecessary care was avoided. The examination of documents and records to assure that services that were authorized were in fact provided in the right amount, duration and scope, within the time frames allotted; and that consumers benefited from the service. The review also examines whether the actual request for authorization was valid in its assessment of the consumer and the intensity of need. There are a variety of types of reviews that may occur concurrent with the care being provided, retrospectively or in some cases prospectively if there are questions about the authorization requested.

APPENDIX A

APPENDIX A

Family Support and Advocacy Groups in Orange, Person, and Chatham Counties

Roots and Wings--Person County

336-322-KIDS

The mission of roots & wings-person county, inc. is “Strengthening, supporting, and standing up with families in need”. Our motto is “helping families be families”.

Family Advocates seek to bridge communication and promote partnership between families and the community (which includes agencies such as Social Services, Mental Health, Juvenile Justice, and the school system). We also provide emotional and informational support (determining the need and resources available) tailored to each family’s unique needs, including educating the community and family to value the strengths, and partnering together to meet the needs of each family.

Family Advocacy Network-Orange County (part of Mental Health Association in Orange Co.)

919-942-8083

The Family Advocacy Network employs 3 Family Advocates to provide one-on-one family support, monthly peer support groups, and parent education seminars to parents/caregivers of children (5-18) who have emotional, behavioral, or other mental health issues. Family Advocates are available to meet with parents in the home or in the community at a time that is convenient for them. We can help families advocate for educational supports or other community resources to help reduce stress and isolation that they face in parenting high-needs children. We are aware that families sometimes have to wait for appointments or services. Please let them know that we can work with them in the interim to provide family support. Linda Canino is our Spanish-speaking advocate and can be reached by leaving a message at our office.

Chatham County Together Family Advocacy

919-663-2370

Chatham County Together Family Advocacy provides bi-lingual support, information and skill building to families/youth with mental health/behavioral/substance/learning related challenges. Individual and group support is available. Advocates are available to assist with families/youth in preparing for meetings with court, schools, DSS, mental health as well as to learn skills of working collaboratively with professionals, self-advocacy skills, stress management, building upon family strengths as well as developing natural supports in one’s community. For further information, please contact Elizabeth Vickrey/Nancy Oliva - Family Advocates at the number listed above.

APPENDIX B

Provider Agency: _____ Location: _____

Consumer: _____ MR#: _____

IPRS: Medicaid:

PCP plan Date: _____
M/D/YYYY

OPC PCP Quantitative/Qualitative Review		Met	Partially Met	Not Met	N/A
1. Is all demographic and contact information completed?	1.				
2. a) Are participants identified? b) How many individuals participated in the plan? 2b. <input type="text"/>	2a.				
INTERVIEWS					
3. Are the interview sections completed?	3.				
4. Is the Personal Interview written using the consumer's words?	4.				
5. Do all the interviews reflect issues related to the person's environment, culture, ethnicity and race as appropriate?	5.				
6. Does the Service/Support Providers Interview reflect what is important to the consumer?	6.				
SUMMARY OF ASSESSMENTS/OBSERVATIONS					
7. Was a diagnostic or other assessment completed? <i>There needs to be a comprehensive clinical assessment completed and documented on this consumer. The assessments and recommendations drive the PCP goals.</i>	7.				
8. Are all five DSM diagnostic Axes completed? <i>All 5 DSM axes need to be completed.</i>	8.				
9. Are there recommendations for services/support/treatment?	9.				
10. Are symptoms/observations of the individual listed?	10.				

OPC PCP Quantitative/Qualitative Review	Met	Partially Met	Not Met	N/A
ACTION PLAN				
11. Does the plan include a long range outcome?	11.			
<i>The long range outcome is driven by the consumer, not the provider so needs to be in their words. The short range outcomes are written by the provider.</i>				
12. Are short range goals measurable and achievable within a year and/or into the person's future?	12.			
<i>All goals must be measurable and specific to the symptoms/needs of the consumer.</i>				
13. Does the plan include target dates not exceeding 12 months?	13.			
14. Is all information related to goals complete?	14.			
15. Do the recommended Services/Support/Treatment relate to the diagnosis?	15.			
16. Are supports/interventions related to the goals?	16.			
17. Is the frequency of the service appropriate to the goals?	17.			
18. Are the supports/interventions adequate to reduce the need for services in the future?	18.			
19. Does it appear that paid supports are NOT taking the place of natural supports and community resources?	19.			
<i>Natural/community supports must be included in goal interventions and/or person responsible for goal sections.</i>				
20. If the consumer is a child over 16 years of age, does the plan include long range and short range goals that will assist the child in transitioning to adulthood?	20.			
21. If the consumer is a child over 16 years old, does it appear that the identified supports, interventions, assessments, & skill building are in place to assist the child in transitioning to adulthood?	21.			
22. Are natural and community resources identified as providing support?	22.			
<i>Natural/community supports must be included in goal interventions and/or person responsible for goal sections.</i>				
23. Was plan updated/revised on or before target dates?	23.			

OPC PCP Quantitative/Qualitative Review		Met	Partially Met	Not Met	N/A
CRISIS PLAN					
24. Does the crisis plan provide a detailed description of strategies to be implemented to help the person/family stabilize during a crisis? *	24.				
25. Does the crisis plan focus first on natural and community supports, starting with the least restrictive interventions? *	25				
26. Does the crisis plan provide specific detailed info on how to relate and/or respond to person/family at the point of contact? <i>* #24, 25, 26: Needs to be specific and detailed regarding both crisis triggers and also strategies to assist consumer if in crisis. Natural support resources need to be used first vs paid provider/inpatient resources</i>	26.				
27. If medication management is indicated as a service in the plan, are medications listed on the crisis plan?	27.				
28. Are sufficient contacts listed to make the crisis plan useful?	28				
SIGNATURES					
29. Does the plan contain the signature of the appropriate professional to order the services?	29.				
30. Was the plan signed by the consumer? <i>Plan must be signed by consumer or guardian or PCP is not valid.</i>	30.				
31. Was the plan signed by the legally responsible person? <i>Plan must be signed by consumer or guardian or PCP is not valid.</i>	31.				
32. Was the plan signed by the person responsible for the plan?	32.				
UPDATES/REVISIONS					
33. If the plan was reviewed, updated or revised, were new signatures obtained? <i>Whenever significant changes are made to plan (updates, new goals, etc), consumer or guardian signatures must be obtained or PCP is not valid.</i>	35.				
Initial Plan Date: <i>M/D/YYYY</i>	Revision Date: <i>M/D/YYYY</i>				
Notes:					
Reviewer:	Date Reviewed:				

Consumer: _____ MR#: _____

APPENDIX C

INSTRUCTIONS FOR REQUEST FOR OPC CARE COORDINATION

Date of Request: Please specify the date that the request has been sent to the LME.

Requestor/Supervisor, Requestor's Agency, Requestor's Phone # and Fax #: Please supply all of this information, as the expectation is that the response to the referral will be directed to the "Requestor/Supervisor" using the contact information provided. It is required that the request for OPC care coordination has been discussed in depth by the agency's involved Qualified Professional and his or her supervisor at the "Requestor's Agency", and that the supervisor has approved the request.

Best Time & Dates to Call: Please thoughtfully provide this information so that the OPC Care Coordinator (OPC/CC) responding to the request will have a strong likelihood of reaching the requestor by phone to follow up on the request.

Name of OPC Consumer Involved, Consumer's DOB: Please provide the first, middle initial, last name, and date of birth of the consumer.

Parent/Guardian: If the consumer is younger than 18 years old, or is an adult for whom guardianship has been assigned, please write in the parent/guardian's name (first, middle initial, and last). If the consumer is an adult who does not have guardianship assigned, please indicate this by writing "NA" on this line. Disability Area: Check all that apply.

Payer/Insurance: Please indicate the consumer's primary payer, and specify the other payer if checking "Other". If a consumer is currently Medicaid eligible, Medicaid is their primary payer.

Current MH/DD/SAS Services: Please specify the current MH/DD/SAS services, indicating frequency and duration. For example; "Medication Monitoring" (service), "1 X in 3 months" (frequency), "3 years" (duration). Please provide information on the most relevant 3 core services, if the consumer is receiving more than 3 services.

Reason For Referral: Please briefly describe the reason for referral for care coordination, with a concise statement specifying the hoped for, short-term outcome that care coordination could produce for this particular consumer.

Fax completed request to "Lead Care Coordinator or designee" at (919) 913-4009.

Upon receipt of the Request For OPC Care Coordination Form, OPC/CC will contact the Requestor/Supervisor using the contact information provided, and will likely ask some clarifying questions. OPC/CC will inform the requestor if the request for care coordination has been accepted as such, or will be considered as more appropriate for OPC/CC clinical consultation with the involved provider agency. Generally, requests for Care Coordination from an actively involved provider will be accepted as "clinical consultation" referrals.

- ✓ If request is accepted for Care Coordination, Request Form will be faxed back to Requestor with "Accepted for Care Coordination" box checked.
- ✓ If accepted for clinical consultation, arrangements will be made to best proceed with this service; by phone, face to face, with consumer, etc. Upon conclusion of an OPC clinical consultation, OPC/CC will fax back Request Form to Requestor with "Accepted for Clinical Consultation" box checked, and recommendations for the Requestor's Agency.

APPENDIX D