



## **The Durham Center Annual Quality Improvement Report, FY 2005-2006 July 20, 2006**

### **1. QI Plan Project**

Providers are required by contract to submit their quality improvement plans to the LME. Provider compliance with this requirement has been inconsistent; in FY 05, only 60 plans were received from 87 providers. Plans that were submitted were often found to be inadequate when reviewed by Quality Management staff. In keeping with Senate Bill 163, which requires a review of quality improvement processes, the LME Quality Management Department (QM) developed an initiative to improve QI plan submission rates and systematize the review and rating of plans. All providers who desired continued IPRS/local funding for FY 06-07 were expected to submit a QI Plan by June 30, 2006. The overall goal of the project is to ensure that contracted providers have a functioning QI system no later than FY 2008, to help assure that Durham Center consumers receive high quality services funded by state and local funds.

A Quality Improvement Template was created for providers. Providers were offered group training and individual consultations with QM staff to help with the completion of a comprehensive plan. The template contained 17 elements related to an agency's adherence to: its policies and procedures; its quality assurance functions; its quality improvement design and processes; and its framework for assessing service provision performance. The template was developed in accordance with current rules, regulations, best practice models and service definitions as set forth by the State of North Carolina, Division of Mental Health, and with standards required by National Accreditation Organizations which have been recognized by the State. While providers did not have to use the exact template, they were required to address all 17 sections of the template in their plan. Plans were rated by LME staff based on each plan's concordance with the template elements.

Out of approximately 100 providers who were currently receiving state and local funding from the Durham Center, 92% turned in a QI Plan for review and approval. Of this number, 61% received a fully approved rating and 39% received a provisionally approved rating. A fully approved rating meant the provider's plan addressed all required elements of the template and was considered complete, or needed an additional small piece of information to be sent within 30 days to be considered complete. A provisionally approved rating meant that one or more of the 17 required template sections was omitted or needed some kind of revision. Provisionally approved providers were given the opportunity to resubmit another QI Plan for review and approval between December 2006 and March 2007.

Provisionally approved plans usually needed revision in a several areas. The weakest area was outcome evaluation, where 78% of providers needed to revise this section or include it in their plan. 69% needed to specifically describe the structure and operation of their agency, and 61% needed to better explain their QI committee's processes and functions. Over 50% of the plans required revision related to the collection and management of data, staff orientation, and ongoing staff training. Components contained in a Person-Centered Plan were one of the areas that needed the least revision (14%).

Based on the rating results, the QM department has scheduled a series of trainings to be held between August 2006 and February 2007. Technical assistance will also be made available to those providers who were given a provisional rating and who attend the training sessions. The LME provides training and technical assistance to educate provisionally approved providers about quality improvement plans and processes. The providers must then show the Durham Center evidence that they will have a functioning QI system in place by FY 2008 in order to receive state and local funds for services. This is part of the LME's effort to ensure that high quality services are being delivered to Durham consumers.

## **2. NC-TOPPS DATA ANALYSIS**

The Quality Management Department analyzed data reports provided to LMEs on the NC-TOPPS website 1) to compare Durham's TOPPS submission rate to the rate expected based on population and 2) to profile the characteristics of Adult MH, Adult SA, and Adolescent TOPPS recipients. This analysis was based on a comparison of Durham consumers to all consumers state-wide who had Initial Assessments in the first half of FY 2006.

### **Submission rate**

The Durham Center exceeds the number of assessments submitted that would be expected based on population alone. Durham's population of adults is 2.8% of the state's, but Durham's adult assessments composed 6.6% of the statewide total. Durham's contribution of adolescent assessments to the statewide total was even greater. Ten percent (10%) of statewide adolescent assessments are from Durham, while Durham's proportion of 10-17 year-olds in the state population was 2.6%. In other words, while Durham compliance with NC TOPPS submission is lower than expected or than required, it is high when compared to submissions across the state.

### **Analysis of Initial Assessments from the first 6 months of FY 2006 NC TOPPS**

#### **ADOLESCENT MENTAL HEALTH**

Half of Durham adolescents are in the CMSED target population, compared to 37% statewide. Statewide, the most frequent diagnosis is Attention Deficit Disorder, while for Durham, Oppositional Defiant Disorder is most common (39%). However, Durham's adolescents are less likely than others to report "fair" or "poor" emotional well-being and family relationships (about 50% in Durham; the percentage is higher statewide.)

Durham adolescents appear poorer than others, according to the services they report needing. Over 30% need help with finding an appropriate living situation and with food; about 25% need help with jobs, housing and transportation. The most frequently reported need in Durham is for help with education (65%).

Other findings from the Initial NC-TOPPS are more similar for Durham and statewide adolescents.

- 75% live in a parent's or guardian's home
- 15% live in a therapeutic foster home or Level III group home.
- Half have moved residence in the past year.
- Over 30% have someone other than a parent as primary caregiver
- About 80% are involved in an academic program, most in regular schools
- 25% are involved with juvenile justice, and 21% have ever been arrested
- 10% are in DSS custody
- Over 20% experienced physical abuse in the last three months; 19% have had suicidal thoughts
- Over 30% have hit or physically hurt another person, and the same number have missed school due to out-of-school suspension, both in the last three months.
- 27% report using marijuana in the past year; 17% report alcohol, and 27% report tobacco use.
- 40% rate their mental health symptoms as moderate.
- Over 90% report they have family and friends supportive of recovery, and also have a positive adult role model.

#### ADULT MENTAL HEALTH

Half of Durham's MH adults are in the SPMI target population (AMSPM, 52%), compared to 40% statewide. Durham's diagnoses are consistent with this classification: 35% Schizophrenia and 33% Major Depression, compared to 25% and 44% for the same diagnoses statewide. One-quarter of Durham adults have a designated payee.

Consumers' ratings of services needed suggest higher poverty levels among Durham consumers. While the most frequent need expressed by both groups is services for emotional care (78%), Durham consumers report more basic needs:

- More than 60% need medical and housing services
- More than 50% need services for food, transportation, and "appropriate living situation"
- More than 40% need help with jobs, education, and crisis services.

Half of Durham consumers have never been married compared to 37% statewide. Thirty-five percent of both groups have children under age 18, but Durham consumers are more likely to have lost custody of all of their children (41%). More than half of Durham consumers in the labor force are unemployed (56%), and those working are more likely to be in supported employment (24%). Durham consumers are somewhat less stably housed: 48% have moved in the past year, compared to 39% statewide; 72% live in their own homes (81% statewide).

Other findings from the Initial NC-TOPPS are more similar for Durham and other MH adults:

- One-third receive SSI or SSDI
- One-third are uninsured; 56% have Medicaid and 20% have Medicare (for others, 48% have Medicaid)

- About 50% have had inpatient MH admissions in their lifetime
- 40% have ever been arrested (33% for others)
- In the past three months, about 10% have had inpatient admissions or face-to-face crisis contacts
- About 20% had emergency room admissions
- About 20% report having ever been sexually abused, and 10% report physical abuse in the last three months
- From 50 to 60% report their physical health, emotional well-being, and family relationships as “fair” or “poor”
- About 40% rate their mental health symptoms as moderate
- Alcohol was the most common substance used in the past year (29%) after tobacco (56%)
- 27% reported opiate, cocaine, or marijuana use in the past year (18% for others)
- 10% were homeless or lived in temporary housing
- 90% said they have family or friends supportive of recovery, and also have a positive adult role model

#### ADULT SUBSTANCE ABUSE

Target populations show that Durham SA consumers are quite different from others statewide. The most frequent target population in Durham is Communicable Disease Risk (ASCDR, 32%, assigned mainly to consumers receiving opiate treatment). Only 10% of the statewide group is ASCDR. High Management makes up 42% of statewide consumers but only 24% of Durham’s. SPMI is high among Durham’s substance users (29% AMSPM), compared to 13% of others, while the percentage reported for AMSMI is 20% (16% statewide). Combined, 49% of Durham consumers in the substance abuse state report have serious co-occurring disorders.

Cocaine and heroin/other opiates are most frequent primary substance abuse problem reported by Durham consumers (31% for each), compared to alcohol for non-Durham consumers (39%). Statewide percentages for cocaine and other opiates as primary problems are similar to Durham’s, but heroin alone is much lower statewide (4% vs 24% in Durham). Over 60% of both groups have diagnoses of drug dependence; alcohol dependence diagnosis is higher statewide. Schizophrenia is diagnosed in 18% of Durham consumers but only 6% of others. Substance users are also smokers: 81% of Durham consumers report smoking in the past month, compared to 71% of others. Fewer Durham consumers are under correctional supervision (12%) than others (29%). More Durham consumers receive SSI/SSDI (19%) than others (9%).

In terms of services needed, the highest need reported in both groups is for emotional care and jobs (over 50%). Durham consumers report higher needs than others for housing (50%), appropriate living situation (48%) and finances (44%). Over 40% of both groups report needing services for medical and transportation needs. Legal needs are higher statewide (33%) than in Durham (22%). Durham consumers in the labor force are more likely to be unemployed (61%), compared to 45% statewide.

Areas where Durham and other consumers are more similar:

- 52 to 71% rate their physical health, emotional well-being, and family relationships as “fair” or “poor”.

- 27% have had suicidal thoughts in the last three months; 12% have been physically abused
- 18% have ever been sexually abused
- 75% have ever been arrested; 22% arrested in the past 6 months; 39% have had felony arrests
- 43% have had previous outpatient SA treatment
- While 70% live in a private residence, housing is somewhat unstable: 61% moved in the past year.
- 56% have no insurance; 36% have Medicaid and 9% have Medicare.
- 47% have never been married; only 22% are married or living as married.
- While 47% have children under age 18, 50% of those have lost custody of all of their children.
- 26% have been admitted to an emergency room in the past three months; 9% have had a MH inpatient admission and 9%, detoxification.
- 15% have had a face-to-face crisis contact in the last three months; 12% have had a facility-based crisis admission (3% others).

## CONCLUSION

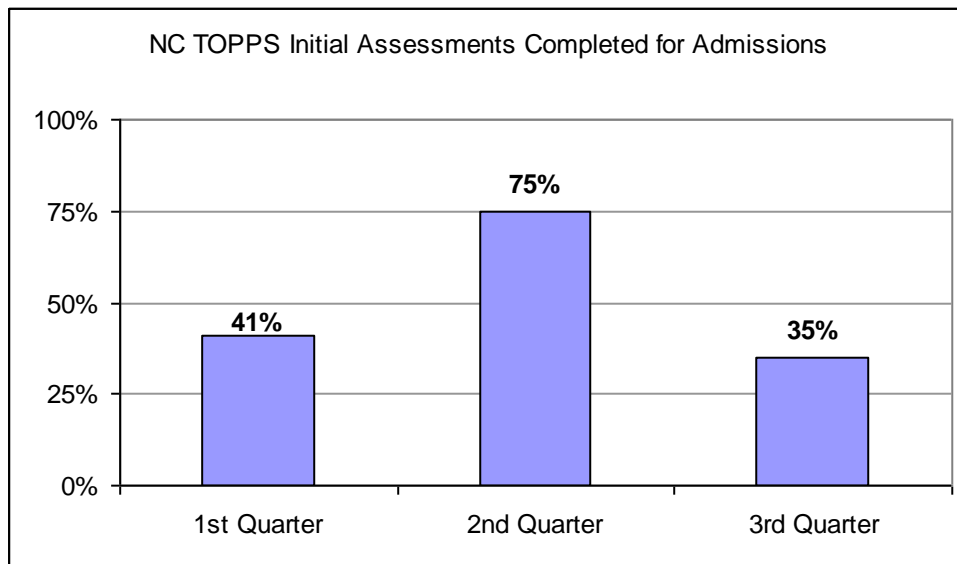
Overall, the data indicate that Durham consumers have more serious and complex disorders than consumers statewide in the NC-TOPPS samples. Durham consumers are more likely to express a need for services to address basic needs such as food, housing, transportation, and medical care. When compared to consumers statewide, Durham consumers appear to be drawn mainly from the city's disadvantaged African-American population. The Durham Center's system-of-care philosophy that takes into account strengths and needs in all life domains is especially appropriate in these circumstances.

### 3. MHST Grant

The Durham Center was asked by the Division to participate in the Mental Health Systems Transition Group developing an infrastructure and the tools necessary to implement evidence based practices. The expectation was that the tools developed will be shared with other areas and would inform the state in efforts to develop EBPs statewide. As a part of this initiative, the Durham Center QM Department led an evaluation workgroup and mini-grant funds were used to support independent fidelity assessments of the 2 ACT teams, IDDT and Illness Management and Recovery services along with pre-implementation assessments for Family Psychoeducation and Supported Employment. In addition, the beginnings of a cross agency program evaluation were completed by the four providers who are currently offering these services. Phase I of the evaluation included provider collaboration to identify the outcome and process indicators that are most significant to community stakeholders and to consumers as well as the methods and capability to collect information for each indicator. NC TOPPS will be a primary source for this evaluation data that will eventually result in a report to the community on EBPs in Durham.

### 4. Compliance with Outcome Measures

Durham Center Provider Compliance with NC TOPPS initial assessments in FY 06



In response to the low rate of compliance for Initial NC-TOPPS in the first quarter of FY 06, the Quality Management Department began quarterly Users Group meetings with providers to discuss NC TOPPS compliance, the benefits TOPPS provides for data usage, and issues providers have experienced in completing the assessments with consumers. We hoped to create NC-TOPPS champions in our provider agencies. There was initial excitement around the possibilities for data usage at the first meeting, with a resulting increase in second quarter compliance. However in the third quarter, providers experienced a significant decline in compliance, in part due to service definitions transitions, staff turnover, and consumer transfers. In the first quarter of FY 2007, the LME will require corrective action plans for compliance with NC-TOPPS Initial and Update assessment.

## 5. Customer Satisfaction

In addition to the state consumer satisfaction surveys, the Durham Center implements a call-back survey that is conducted within two weeks of an initial screening. 2142 individuals were called by our Customer Service staff to ask their impression of the service they received from Screening, if they were given choice of provider, if the appointment fit their schedule, if they attended the appointment. For consumers who were dissatisfied with their access to services or unable to attend their appointment, customer service staff assist in resolving concerns and rescheduling appointments.

529 consumers answered at least one of the questions, a response rate of 25%. Twenty-two percent (22%) answered most of the questions. Consumers were overwhelmingly positive about the courtesy of screeners, choice of providers, convenient time for their appointment, and the information they received from screeners. An average of 94% gave positive answers to those questions, 4% were neutral or unclear, and only 2% were negative. Seventy-five percent (75%) attended their appointment. Consumers were less likely to answer the question of whether they received the services they thought they needed (response rate was 19%), and they expressed less satisfaction than with the screening service. Eleven percent (11%) felt they did not get services they needed, 15% were neutral or unclear, and 73% were satisfied. Customer service staff worked to resolve the concerns of consumers who were less than satisfied with the services offered.

This project is ongoing. Screening, triage, and referral have been brought in-house during work hours in FY 2007. When call-backs find consumers who did not receive the services they thought they needed, and the consumers' concerns cannot be readily resolved, consumers can be immediately connected back to screening for discussion of consumers needs and collection of additional information to help resolve the situation.

## **6. Mystery Caller Project**

Complaints about calls for services to Durham County Access prompted the Durham Center to study the telephone screening responsiveness of our access provider. While call-back surveys were underway, it was unclear whether complaints indicated a systemic problem or scattered instances of inadequate service.

In the fall of 2005, the Quality Management Department initiated a volunteer mystery caller program to directly measure the quality of telephonic customer service at the access point. The information collected indicated that, in the majority of cases, information and direction given to individuals and families who called with concerns about themselves or loved ones, were provided in a timely manner by caring, knowledgeable call center personnel.

Sixty randomly timed calls were placed per month to the Durham County Access line, which offered 24- hour screening, triage, referral, and crisis stabilization. A mystery caller instrument was developed based upon specific criteria and contract performance guidelines related to timeliness of answering calls, responsiveness to the caller, and access to screeners. Information compiled over a 7 month period revealed that screeners identified themselves by name when answering calls 81% of the time. Calls were answered by a screener rather than an automated response 85.5% of the time and calls were answered in six rings or less 98.5% of the time. If a screener was not immediately available, the caller was referred to a screener in less than 10 minutes 91% of the time.

The LME gave copies of call records to our access provider monthly. The provider used the information to coach and counsel individual screeners, and to modify their training of new and on-call screeners. In

In FY 2007, the LME brought screening, triage and referral in-house during business hours. Information collected on individual screeners allowed the LME to select the most competent for LME employment. Results of the project also shaped how LME screeners are trained, monitored, and supervised.

The project provided invaluable information related to adequate customer service provision to the consumers of Durham County. The time and effort put forth by volunteers to ensure its success is deeply appreciated.

## **7. Provider Monitoring**

Provider monitoring visits by the Durham Center takes various forms and is carried out by various departments for various purposes. This paragraph summarizes overall results of monitoring in FY 2006. Approximately 138 providers received one or more monitoring visits from various departments of The Durham Center. Of this number, 75% were found to be in

compliance with state/federal regulations regarding expected standards of care or with The Durham Center's contract requirements. Significant findings occurred in 25% of all monitoring visits. A significant finding is noted based upon a range of issues, which can be related to quality management, personnel and staff competencies, client records, person centered plans, incident reporting, client's rights, medication compliance and billing requirements. Of the 25% of providers with significant findings, 41% of the monitoring visits occurred as a result of a reported complaint or incident. If a significant issue was found, providers were expected to complete a plan of correction within a given time frame. Technical assistance was also provided in order to educate agency staff and ensure that adequate care standards were met in the future.

## **8. Clinical Care Quality Reviews**

Clinical Quality Reviews began in FY 2005 with child mental health case management providers and then with adult mental health case management providers. Review instruments were developed incorporating items related to person centered planning, system of care principles and life domains. In FY 2006 these reviews were not considered by the LME to be a part of formal monitoring; their purpose was more to determine the kind of care being provided to high-risk consumers and to educate their providers about the standards of care expected by the LME. The review results were of great interest to the Durham Center's clinical team and resulted in a different approach for FY 2007.

The instruments contain the following Dimensions:

Child:

- Case Management (service linkage, timely services, child & family team process)
- Peer Support
- Treatment (Assessment including life domains, Interventions are individualized and strengths-based and provided in the context of the family, medication needs are addressed, least restrictive environments, co-occurring disorders are identified and addressed)
- Crisis Response Systems (plans are proactive, individualized and functional)
- Transition Services
- Family and Community Support

Adult:

- Case Management (service linkage, timely services, primary health care is addressed)
- Crisis Response Systems (plans are proactive, individualized and functional)
- Treatment (Assessment including life domains, Interventions are individualized, strengths-based and culturally appropriate, medication needs are addressed, case managers are trained, co-occurring disorders are identified and addressed, collaboration between agencies documented)
- Residential Stability
- Rehabilitative Services
- Budget/Financial Management
- Family and Community Support
- Vocational Services
- Peer Support

The instruments were tested and providers were informed of the review process and expectations. In FY 2006 these reviews continued with adult and child mental health case managers and later with community support providers. By the end of the 3<sup>rd</sup> quarter 16 Adult records had been reviewed and 12 child records from 4 case management/community support providers. Records were chosen for individual consumers who are high end users of the service system (multiple hospital admissions or crisis services, residential services, care review recommendations). Representation of providers was not given consideration, however providers were given technical assistance and participated in each review.

Overall the results for FY 2006 showed the strongest areas in the dimension of Case Management and in the identification of Co-occurring disorders. Weaknesses across the board consist in the areas of incorporating primary health, crisis response, treatment, budgeting, family support, rehabilitative services, and peer support. Data has been shared with all Community Support providers and trainings in FY 2007 will target the areas of weakness. In addition, during FY 2007, reviews will target provider organizations rather than individual consumers. Therefore a random sample of records will be reviewed from each community support provider and accountability standards will be developed. Finally, in FY 2006 a clinical review tool was developed for Developmental Disability Case Management services. The tool has been tested and reviews will begin in August 2006.

## **9. Corporate Compliance Committee**

This committee was formed in FY 2006 to bring together findings from the great variety of monitoring and reviewing activities throughout the LME. The role of the Compliance Committee is to advise the Compliance Officer and assist in the implementation of the compliance program in conjunction with the Quality Improvement and Provider Relations Departments.

The Compliance Committee is used to report findings of all completed reviews, which

- Allows for all members to note overlapping issues with providers
- Allows for the requesting of any area to complete a specific review based upon another area's findings
- Allows for initiation of a full compliance review if indicated
- Provides a place for the aggregate review of resolved customer complaint issues that may indicate provider system issues
- Provides a place for complaints to be brought that come in through other areas of agency for review and disposition

In addition, the committee roles include:

- Analyzing the organization's regulatory obligations;
- Assessing existing policies and procedures that address these areas
- Working with employees and providers to develop standards of conduct and policies and procedures that promote compliance;
- Recommending, developing and monitoring internal systems and controls to carry out The Durham Center standards, policies and procedures as part of The Durham Center's daily operations;

- Determining the appropriate strategy and approach to promote compliance and detection of potential risk areas through various reporting mechanisms;
- Assisting with the development of preventive and corrective action plans;
- Developing a system to solicit, evaluate and respond to complaints and problems; and
- Monitoring findings of internal and external reviewing bodies for the purpose of identifying risk areas or deficiencies requiring preventive and corrective action.

## **10. High Utilizer Analysis**

The Quality Management Department maintains data on individual consumer state hospitalizations and crisis service utilization. In FY 2005, data showed that adult consumers with 20 or more days of hospitalization were hard to serve in the community; they frequently dropped out of case management services, refused to take medication, and ended up back in the hospital or in crisis services. In FY 2006, QM aggregated lengths of stay in the hospital quarterly to provide updates to clinical team on which consumers had 20 or more hospital days. Data on jail stays began to be collected in FY 06 to augment hospital data. Individuals who frequented crisis stabilization services were also reported to clinical team. Utilization Management examined clinical data received with requests for authorization to determine which type of service would be most effective for these high-end consumers. Providers were encouraged to educate consumers about alternative services such as ACTT and IDDT, and presentations on these services were regularly made to appropriate hospitalized consumers. As a result, the IDDT program has grown, and two ACTT programs are near capacity.

QM also created reports showing another approach to high utilization. The dollar amount paid for claims was reported by service code and age/disability group, together with the unique number of individuals served for each category. LME disability specialists could drill down to find and review for appropriateness, quantity, and intensity, the services provided to especially high-cost individuals.

## **Information Management Projects for Consumer Choice and Continuity of Care**

### **11. Provider Choice in Transition to New Service Definitions:**

The Quality Management Department developed a database to track consumer response to letters regarding choice of services under the new service definitions. For example, when CBS and Case Management services were consolidated, the database held information on each consumers' current providers. As responses were received, consumer choices of a single provider were recorded. Current and new providers were notified of these choices, to ensure continuity of care for consumers in the transition to new service definitions.

### **12. Continuity of Care post-Hospitalization and/or Crisis Residential Services**

Two databases were developed by the Quality Management Department to assist in LME in assuring continuity of care for consumers discharged from state hospital or crisis stabilization services. The LME had a position dedicated as liaison to each of these services (2 positions total.) Customized databases were used by the liaisons to track and follow-up on consumers'

post-discharge services. If consumers missed their appointments, the liaisons prompted providers to follow-up with the consumer to reschedule, or to make a home visit.

The liaisons entered notes regarding issues that interfered with continuity of care. Database queries were created to show systems issues through aggregate data reports. Work within the LME is ongoing to resolve systems issues that are barriers to best post-discharge care. Due to budget cuts in FY 2007, the LME will have only one liaison position, which will be dedicated to state hospitals. In FY 2007 Quality Management is working with the hospital liaison and the LME Medical Director to more systematically determine data requirements and rebuild the database(s) accordingly.