Quality Management Plan

FY11

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INTRODUCTION

The Durham Center's Vision is to value people with disabilities as equal partners in the community. We believe that the entire community benefits when individuals with disabilities are given opportunities to reach their full potential.

The Durham Center's Mission is to pursue a community effort dedicated to supporting the lives of individuals affected by mental illness, developmental disabilities, and substance abuse by embracing a collaborative, accessible, responsive and efficient system of services and supports.

SCOPE

The Durham Center (TDC) through its Quality Management Program (QMP) promotes objective and systematic measurement, monitoring and evaluation of services and implements quality improvement activities based upon the findings. The purpose of quality management activities is to ensure the provision of quality services rendered by those providers who receive oversight by TDC and therefore applies to those governance, management, clinical, administrative, and support functions that affect desired consumer outcomes. While the Quality, Research & Development Department (QM) implements, maintains, and documents evidence of an ongoing QMP throughout the Durham County LME, quality management activity is a core function of all TDC departments and is a defined expectation per provider contracts and service agreements.

OBJECTIVES

The Durham Center develops, implements, and maintains a Quality Management Plan that:

1) Ensures compliance with state and federal law as well as regulatory requirements, and CARF and URAC accreditation standards;
2) Systematically measures consumer/family perceptions and clinical projects, monitors, evaluates and improves organizational performance to produce superior consumer outcomes and satisfaction through the efficient use of resources and effective oversight of the service provider network, and
3) Incorporates review and approval of agency projects related to quality improvement via the Quality Management Committee.

ACTIVITIES

The QM Department works closely with other departments and committees within The Durham Center, and with state and federal entities, providers and other community organizations and individuals to promote quality improvement. Some of the major functions of the QM Department as part of the overall Quality Management Program are as follows:

Internal LME Reporting

Prepare quarterly clients rights reports to include incidents and complaints data for review and analysis by Corporate Compliance Committee (CCC), Human Rights Committee (HRC), Continuous Quality Improvement Leadership Team (CQI), and Quality Management Committee (QMC)

Prepare quarterly compliance trends reports for review and evaluation by CCC, CQI, and QMC

Prepare monthly and quarterly reports to include Hospital Utilization trends, High Risk Consumer data, Authorizations data, etc to be reviewed and analyzed by UM/UR Committee, CQI, and QMC
Prepare disability specific trends reports quarterly for review and evaluation by Community Systems Improvement Committee (CSI), CQI, and QMC

Prepare monthly, quarterly and annual data reports for LME Area Board of Directors

Prepare special reports for other departments as requested

Reporting to the State (directly from the LME)
Quarterly access to services report – reviewed in UM/UR Committee, CQI, QMC
Quarterly complaints report – reviewed in CCC, HRC, CQI, QMC
Quarterly incidents report – reviewed in CCC, HRC, CQI, QMC
Annual Quality Improvement report – reviewed in CQI, QMC, Area Board
Quarterly Crisis Services report – reviewed in UM/UR Committee, CQI, QMC

Quality Improvement Projects
Conduct at least three QI Projects annually which will be submitted to the Continuous Quality Improvement Leadership Team (CQI), Quality Management Committee (QMC), Area Board of Directors, and other relevant parties. These projects are reviewed and approved by the Quality Management Committee. QI Projects are reviewed by TDC's Human Rights Committee as well.

Needs Assessment and Gap Analysis
Conduct an annual needs assessment to determine needs of consumers and families in Durham LME service area and facilitate development of services to respond effectively to needs

Strategic Planning
Data collection and analysis
Evaluation of data and planning
Prepare and present the final plan which includes goals, objectives, benchmarks and outcomes for a three year phase
Update annually

Program Development
Develop prevention and treatment services that reflect service needs and best practices
Technical assistance to providers regarding best practice
Development of new services in tandem with other TDC departments

Program Evaluation
Develop projected outcomes for both internal departments and providers
Collection of outcome data
Analysis of data
Develop research protocols as needed
Survey development
Technical assistance to contracted providers
Develop and monitor program budgets

Quality Improvement
Provide training and technical assistance regarding quality improvement

Staff various internal committees to ensure QI processes are streamlined and integrated

Consumer Satisfaction
Administer State Department of Health and Humans Services (DHHS) Consumer Perception of Care and State DHHS National Core Indicators Annual surveys
Develop, administer, and collect Quality of Life surveys
Review results data and implement QI activities based on findings

Provider Satisfaction
Develop, administer, and collect provider satisfaction surveys annually
Review results data and report to CCS, CQI for QI purposes

Provider QM Plans and Annual Report
Review provider QM plans prior to contracting for state and/or local funding
Provide technical assistance to providers in developing QM plans
Review and follow-up of Provider QI annual plans
Provide training and technical assistance to providers regarding quality improvement

Incident Reporting
Receive, review and follow-up on incident reports from providers
Receive, review and follow-up on quarterly incident reports from providers
Provide training and technical assistance to providers regarding incident reporting
Initiate Corrective Action Plans when indicated per TDC policies and procedures
Report to Compliance Committee when serious compliance and/or health and safety issues arise
Prepare and report incidents trends to CCC, CQI, and QMC

NC-TOPPS (North Carolina Treatment Outcomes and Program Performance System)
Review NC-TOPPS outcome evaluation data
Ensure submission compliance by providers
Provide feedback to providers to assist with quality improvement
Offer training and technical assistance to providers regarding NC-TOPPS

NC-SNAPS
Review NC-SNAPS outcome evaluation data
Ensure submission compliance by providers
Provide feedback to providers to assist with quality improvement
Offer training and technical assistance to providers regarding NC-SNAPS

Participation on LME and Community committees

STRUCTURE

The Quality Management Department (QM)

The QM team is responsible for the coordination of The Durham Center’s Quality Management Program. All staff persons are active participants and have key roles in the implementation of the various QM activities and they maintain, support, and document evidence of the ongoing QMP.

Functions of the Quality Management Team
Data throughout the LME is collected and analyzed by the QM team. The team becomes the "clearing house" of data to be analyzed and utilized for quality improvement strategies that are ultimately incorporated into the organizations on-going strategic planning.

The QM team acts as staff support to the various committees that make up an integral part of The Durham Center's Quality Management Program.

The QM team monitors service provider activities in the areas of outcome evaluation, quality assurance and quality improvement.

The QM team conducts needs assessment activities and provides technical assistance to other departments and community organizations in this area.

The QM team ensures that the strategic plan is thoroughly integrated into all aspects of the organization and is reflected in the business practices of its service providers.

The QM team is responsible for managing and reporting on all Division Performance Agreement required data.

Staff of the Quality Management Department
TDC leadership ensures adequate resources are available for implementation of the QMP. The staffing pattern is continuously evaluated based upon the evolving needs and currently consists of seven FTE's, headed by the QM Department Director.

Director of QM – Responsible for the overall operation of the QMP, serves on the QM Committee, Chairs the Continuous Quality Improvement Leadership Team, Management Team, Cultural Competency Committee, Corporate Compliance Committee, UM/UR Committee, Hospital Committee, Clinical Care Management Team, etc.

Human Services Planner/Evaluator – Main responsibilities include needs assessments, strategic planning, outcome evaluations, surveys, support staff to QM Committee and Community Systems Improvement Committee, internal reporting and reporting to the state, etc.

Quality Management Specialist – Main responsibilities include oversight of incident reporting, provider QM Plans, consumer and provider satisfaction surveys, monitoring of provider services, technical assistance, training, support staff to Corporate Compliance Committee, Human Rights Committee, Communication and Customer Service Committee, and Cultural Competency Committee, internal reporting and reporting to the state, etc.

Mental Health Specialist – Main responsibilities include oversight of NC-TOPPS, provider QI Annual Reports, development and monitoring of Mental Health services scopes of work, technical assistance, training, internal reporting, support staff to Hospital Committee and Health and Safety Committee, and participates on other internal and external committees as needed

Substance Abuse Specialist – Main responsibilities include provider QI Annual Reports, development and monitoring of Substance Abuse services scopes of work, technical assistance, training, internal reporting

and reporting to the state, support staff to Community Systems Improvement Committee, and others as assigned.

Developmental Disabilities Specialist – Main responsibilities include NC-SNAPS, provider QI Annual Reports, development and monitoring of Developmental Disabilities services scopes of work, technical assistance, training, internal reporting and reporting to the state, support staff to Community Systems Improvement Committee and others as assigned.

Processing Assistant – Main responsibilities include staff support to the QM Team regarding various QM activities such as recording minutes and processing data such as NC-SNAPS, incident reporting, satisfaction surveys, etc.

Quality Management Committee (QMC)

The Quality Management Committee is the standing committee that is granted authority for Quality Management by the Area Board. The Area Board's authority derives from General Statutes 122C-117 and reports to the County Commissioners. The Area Board Chairperson appoints the Quality Management Committee consisting of five voting members whereof three are Area Board members and two are members of the Child and Family Advisory Committee. Other non-voting members include at least one Area Authority employee and one provider representative. The Area Authority employees are the Director of Quality Management (QM) Department who has the responsibility for overall operation of the Quality Management Program and the Human Services Planner/Evaluator.

The QM Committee meets at least quarterly and provides ongoing reporting to the Area Board. The Committee approves annual Quality Improvement Projects, monitors progress in meeting Quality Improvement goals, and provides guidance to staff on QM priorities and projects. Further, the Committee evaluates the effectiveness of the QM Program and reviews and updates the QM Plan annually.

Committee member terms

One half of the initial positions will serve a one-year term. Thereafter, all terms will be for two years excluding LME staff assignments. Committee members are expected to show a knowledge and commitment to service quality, evaluation and incentive-based quality improvement. Committee members are expected to attend at least 80% of meetings and to actively engage in sub-committee involvement as needed.

Meeting Times and Minutes

The Committee meets at a regularly scheduled date and time at least quarterly. The Director of QM or designee will provide an agenda for each meeting to the Quality Management Committee Chairperson for review and dissemination to other members of the committee. Minutes will be taken at each meeting by a designated QM staff and sent to the chairperson for review. QMC agendas and minutes will be kept electronically on the QM Drive and hard copies will become part of the Area Board Packet.

Continuous Quality Improvement Leadership Team (CQI)

This committee is composed of the Area Director, Deputy Area Director, Medical Director, Director of Corporate Compliance, Director of Utilization Management, Director of Care Coordination, Director of Customer Service, Director of Contracts Management, Director of Finance, Director of IT, and Director of

Quality, Research & Development. The Director of QM staffs CQI meetings, prepares agendas and records the minutes. The CQI meets monthly to review TDC and provider network performance data. The CQI is responsible for the development, implementation and evaluation of TDC QMP, monitoring of quality improvement goals and activities and identifying opportunities for improvement within TDC and the provider network. This committee vets data and information for further distribution and action, both internally and externally.

Committees that come under the CQI Committee and which data flows from and to CQI are (see Attachment A):

Corporate Compliance Committee (CCC) - this committee reviews and evaluates organizational and network achievement on indicators designed to monitor compliance to applicable state and federal regulations. Committee membership includes representatives of Contracts Management, Customer Service, Quality, Research & Development, Care Management and Utilization Management Departments. It is chaired by the Corporate Compliance Officer and reports matters of significant non-compliance to the Continuous Quality Improvement Leadership Team. This committee meets twice per month.

Clinical Care Management Team (CCMT) – this committee meets twice per month to enhance lateral communication for all TDC clinical functions. Some of the responsibilities of the committee include the clinical oversight of UM/UR/Access center, assures that authorizations and clinical reviews are done properly, oversees problem cases of denials and appeals, identifies Best Practice to include in Clinical Guidelines, and monitors clinical data including high risk/high cost consumers. The committee also reviews cases of concern referred to TDC or elicited by TDC staff, conducts case conference for complex clinical cases, provides group clinical supervision for clinical department heads, encourages and ensures care coordination to improve quality of care and exercises clinical oversight of licensed supervisory staff within TDC. This committee is chaired by the Medical Director.

Utilization Management Committee (UMC) - this committee evaluates the utilization of services with the goal of ensuring that each consumer receives the correct services, in the right amount and in the most appropriate time frames to achieve the best outcomes. This is a collaborative, dynamic process by which over or under utilization of services can be detected, monitored and corrected. The committee serves as a vehicle to communicate and coordinate quality improvement efforts to and with the CQI. It is chaired by the Medical Director.

Community Systems Improvement Committee (CSI) - The primary charge of this committee is to review program related data, identify and address service gaps, explore trends and make policy recommendations based upon this information. In addition, the CSI Committee examines the clinical implications of ongoing state and federal funding reductions on the services that are provided within the community and makes recommendations on how to address these issues from a clinical perspective. All significant findings and recommendations are sent to CQI. The CSI Committee is chaired by the Director of UM/STR and meets once per month.

Communication and Customer Service Committee (CCS) – this committee reviews data related to access to services, STR, satisfaction (consumer, provider, and employee), stakeholder surveys, etc. Data is trended and analyzed in order to identify areas for improvement. Quality improvement recommendations are communicated to CQI. This committee meets quarterly and is chaired by the Deputy Area Director.

Cultural Competency Committee –this committee was formed to actively work to increase cultural awareness and competency by conducting community needs assessments of target ethnic/racial groups, developing a community engagement plan that includes community education forums and involvement of culturally diverse grassroots groups and consumers in decision-making, implementation and evaluation of programs, developing short- and long-range plans to increase ethnic/racial representation through the recruitment of a culturally diverse workforce, etc. This committee meets at least quarterly and is chaired by the Director of Quality Management.

Health and Safety Committee - the Health and Safety Committee is composed of staff representatives that identify concerns and make recommendations regarding the safe operation and security of the building, grounds and environment to the Continuous Quality Improvement Leadership Team. The committee is a forum to field and discuss employee safety, both on campus and in the field, as well as environmental issues, such as maintaining a healthy and comfortable workplace. This committee meets once per quarter and is chaired by the Director of Communications.

QUALITY MANAGEMENT ACTIVITIES FISCAL YEAR 2011-2013

Area Board Strategic Goals for FY11-FY13

TDC's Area Board has established the operational strategic goals listed below with input from the Management Team, community stakeholders, TDC staff, persons served and the provider network. These goals are synchronous with Durham County's Results Based Accountability (RBA) program and are therefore representative of Durham Center's role within the larger context of improvement initiatives in Durham County. Referencing these strategic goals, TDC shall maintain a long-range strategic plan with objectives to be achieved within a three year period. The CQI Leadership Team shall develop and evaluate strategies (see Attachment B, Strategic Plan FY11–13) for the completion of the following goals/outcomes:

1) The Durham Center will adopt exemplary practices in managing care for consumers as a comprehensive behavioral healthcare organization
2) The Durham Center will improve quality of life outcomes for consumers and their families/natural support systems.
3) The Durham Center will develop an array of high quality services and supports.

At any given point in time, the TDC maintains at least two quality improvement projects that address opportunities for performance improvement related to utilization management. The projects are based on an analysis of data that identifies opportunities for improvement. Measureable and quantifiable goals are established to improve performance, and interventions are carefully designed to ensure that there is a reasonable expectation that the issue will improve. At regular, pre-established intervals, (at least annually) re-measuring occurs. If expected improvements are not obtained, a barrier analysis is conducted and based on those findings, new interventions may be established.

Quality Improvement Goals for FY10 (see Attachment C)

TDC quality improvement projects that were approved by the CQI and QMC for FY10 are:

1) Quality of Life Survey
2) Screening, Triage and Referral Mystery Caller Project
3) Substance Abuse Case Study

Quality Improvement Goals for FY11

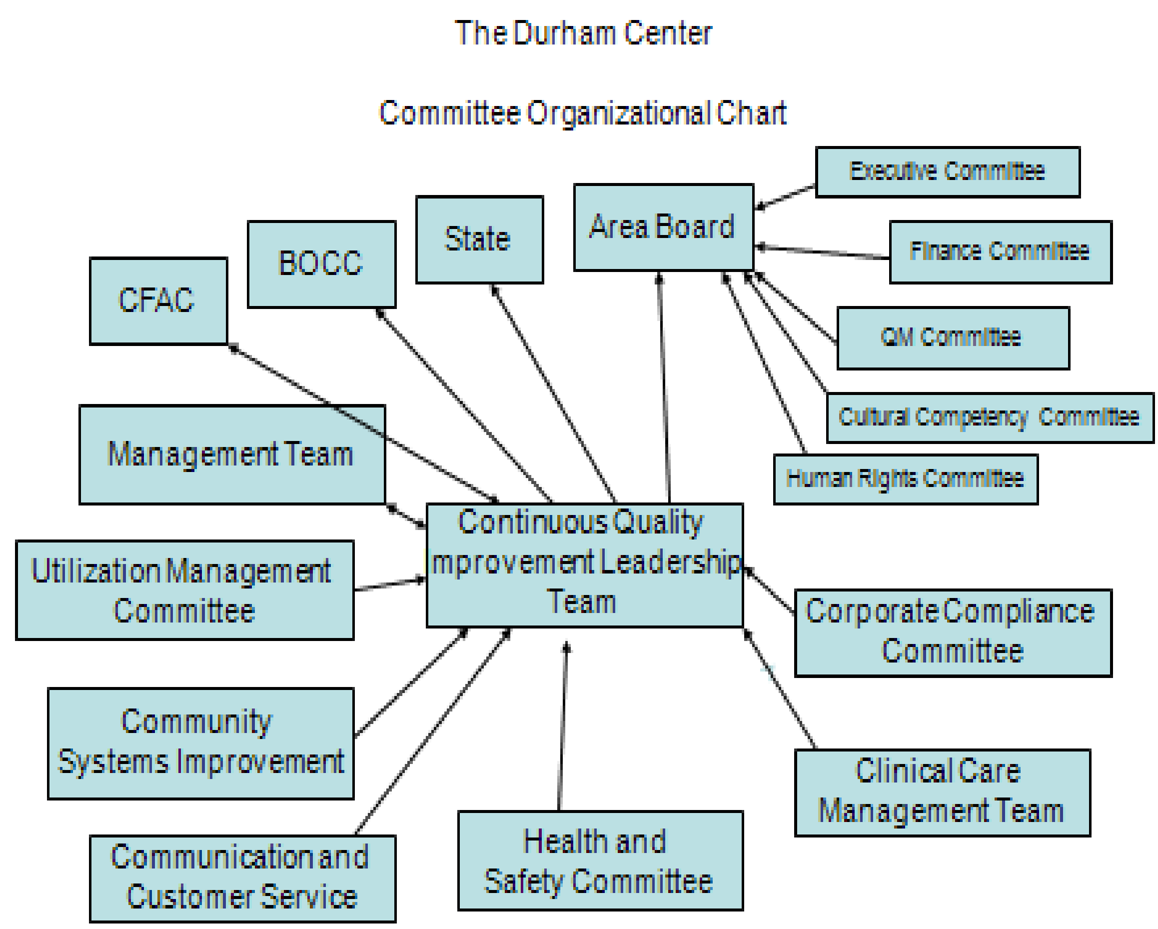
Each project shall be designed, developed and monitored by the QM Team, CQI, and QMC. Data collection, analysis and reporting shall be required in accordance with the project timeline. The status of each project shall be reported to the CQI quarterly.

TDC quality improvement projects identified for FY11 are:

1) High Risk Consumers Case Study
2) Substance Abuse Case Study
3) Quality of Life Survey

Attachments

A. Committee Structure Diagram



B. Strategic Plan, FY11-13

Reference Strategic Plan Document Located at S:/Strategic Plan/FY2011-2014

C. QI Projects FY10 & 11

1. Mystery Shopper (Still being Developed)
2. Substance Abuse Study
3. High Risk Study

2: Substance Abuse Study

QUALITY IMPROVEMENT PROJECT DESCRIPTION FORM, CORE VERSION 3.0

Implementation of all Quality Improvement Projects must occur prior to the URAC onsite review with at least one re-measurement post intervention

Name of Project: (Core 20 (g), Core 23 (b)
Substance Abuse Case Study (a case study of 50 individuals who currently have substance abuse diagnoses being served by The Durham Center's contracted agencies).
Description and Background [Core 19, 20, 21]
The purpose of this study is to gather baseline data on consumers receiving substance abuse services via The Durham Center's contracted provider agencies. The Durham Center is a Local Management Entity (LME) which oversees all private mental health agencies in Durham County. Individuals abusing substances in Durham County is at a high percentage, and approximately 75% of individuals admitted to TDC's Crisis Facility have a substance abuse diagnosis. Data will be obtained from consumer mental health records and from semi-structured interviews with consumers. A protocol for the chart reviews will be created by The Durham Center that will capture treatment outcomes per reports, assessments/evaluations conducted by provider staff, crisis and hospital events and other quantitative data. The Durham Center will develop the interview questionnaire with input from staff regarding the most pertinent questions to ask relating to substance abuse care services. Data from the chart reviews and transcripts from the interviews will be provided to Dr. Klumper for further analysis from that point. A final report will be provided to the students and UNC once the analysis has been completed by The Durham Center.
Describe the population affected by the Quality Improvement Project [Core 21(b)(i)(ii)(iii)(g)(h), Core 24(a),(b)]
Consumers and providers will be affected due to findings related to treatment that may or may not be effective per chart reviews and consumer reports. The plan is to provide the data from the findings to providers and to discuss treatment options that might work better in the future.
Selection Process [Core 19(b), Core 20(g), Core 21 (a)(b)(i),(ii),(iii)(c)(d)(e)(f) and Core 23(a)]
A large percentage of consumers served (with mental illness) in Durham county also have substance abuse or use as a primary or secondary diagnosis (approximately 65% overall). Engagement rates are low, however, with only about 12% staying in services. Consumers chosen for this project were those who volunteered to be interviewed and who gave permission to have their charts reviewed so that cross-tabulations could be made. The sample size is 50 consumers being served by state funded providers in Durham County.
Relation to Modules under Review [Core 21 (a)(b)(i),(ii),(iii), Core 24(a)(b)]

<table>
<tr><td colspan="2">This project relates to access as well as continued engagement in services for people with substance abuse issues. Baseline data will be obtained from this study and then a follow up study will occur in 6 months and 1 year post implementation of any new treatment options. STR, UM, QM, and Care Coordination staff will be included in the communication of results and any new or changed treatment modalities implemented. UM and STR will be involved in authorizing/approving any new or changed treatment modalities for individual consumers. This will include different authorization timelines as well as lengths of stay. Data from treatment received will be included in the follow up study. All results will be communicated to the CQI and QM Committees.</td></tr>
<tr><td>Date approved by the Quality Management Committee

[Core 20(g)]</td><td>Date of meeting minutes reflecting approval by Quality Management Committee [Core 20(d)]</td></tr>
<tr><td>August 19, 2010</td><td>August 19, 2010</td></tr>
<tr><td colspan="2">Time Frames [Core 23(c)]</td></tr>
<tr><td colspan="2">Research began May 2010. Final report and analysis will be available in the end of September 2010.</td></tr>
<tr><td>Focus of Project [Core 24(a)(b)]</td><td>Name of Senior Clinical Staff Person Involved [Core 24 (b)]</td></tr>
<tr><td>Clinical.</td><td>The principle investigator is Lena Klumper, Ph.D., Director of Quality, Research & Development. Two students from UNC-Chapel Hill from the School of Public Health are investigators as well.</td></tr>
<tr><td colspan="2">Baseline Measurement [Core 21(d)]</td></tr>
<tr><td colspan="2">This will be provided after the collection of data phase, approximately the end of August, 2010. Current baseline data are from Durham Center Access referrals that indicate an approximate 75% rate of admissions of individuals with substance abuse co-morbidity.</td></tr>
<tr><td colspan="2">Data Collection [Core 21(a),(b),(c) and Core 23(a)]</td></tr>
<tr><td colspan="2">Data collected are from consumer report via structured interviews and their mental health and/or medical charts. Both quantitative data and qualitative data will be cross-tabulated to determine if what the consumer perceives as working in treatment is evidenced in provider charts and practices.</td></tr>
<tr><td colspan="2">Measurable Goal(s) toward improvement [Core 23(a)]</td></tr>
<tr><td colspan="2">1. Reduce rate of admissions of individuals in this study with SA diagnoses to the Durham Center Access crisis facility by at least 25% from baseline.</td></tr>
</table>

2. Reduce recidivism rates of crisis events among the population in this study with SA diagnoses by a minimum of 25% from baseline.

Projected Timeframe to Achieve Goals [Core 23(c)]

1. October 2010 will be when any changes in models or levels of care being offered are conducted.
2. The follow up study will occur in December 2010 or January of 2011 and June/July 2011.

Initial Interventions/Action Plans [Core 23 (b)(e)(f)]

Barriers Identified and Intervention/Action Taken	Date Implemented
Intervention during study period is to inform TDC's UM department about treatment modality changes, authorization timeline differences/changes, and lengths of stay in treatment	Expected date: Dec 2010
Information disseminated to all TDC departments to implement changes as needed, such as new or changed treatment modalities for authorizations, closer follow up with providers re: outcomes.	Expected date: March 2011
List the 3rd interventions/actions taken to improve performance	Date intervention/action implemented
List the 4th interventions/actions taken to improve performance	Date intervention/action implemented
List the 5th interventions/actions taken to improve performance	Date intervention/action implemented

Periodic Measurements at least annually [Core 23(d)] and re-measurement for changes or improvements to baseline [Core 23(e)]

Date of Measurement	Result of Measurement	Date Reported to QM Committee
Date of 1st Measurement (Not the baseline measurement)	Summarize the results acheived utilizing statistical methodologies If an initial project improvement measurement has not occurred, then when will it be	Date results submitted to QMC

	conducted?	
QMC comments based on results of 1st measurement [Core 20(f) (h)]	Interventions/Actions implemented based on results of 1st measurement [Core 23(b)]	
Date of 2nd measurement	Summarize the results acheived utilizing statistical methodologies	Date results submitted to QMC
QMC comments based on results of 2nd measurement [Core 20(f) (h)	Interventions/Actions implemented based on results of 2nd measurement [Core 23(b)]	
Date of 3rd Measurement	Summarize the results acheived utilizing statistical methodologies	Date results submitted to QMC
QMC comments based on results of 3rd measurement[Core 20(f) (h)	Interventions/Actions implemented based on results of 3rd measurement [Core 23(b)]	
Date of 4th Measurement	Summarize the results acheived utilizing statistical methodologies	Date results submitted to QMC
QMC comments based on results of 4th measurement [Core 20(f) (h)]	Interventions/Actions implemented based on results of 4th measurement [Core 23(b)]	

Conducts an analysis if performance goals are not met [Core 23(f)]

Barriers Identified and Actions Taken

3: High Risk Study

QUALITY IMPROVEMENT PROJECT DESCRIPTION FORM, CORE VERSION 3.0

Implementation of all Quality Improvement Projects must occur prior to the URAC onsite review with at least one re-measurement post intervention

Name of Project: (Core 20 (g), Core 23 (b)
High Risk Consumer Case Study (individuals determined to be high risk as defined below).
Description and Background [Core 19, 20, 21]
The purpose of this study is to gather baseline and follow up data on individuals identified as "high risk." The definition indicates that consumers with 3 or more emergency events (including hospitalization) within a 12 month period are considered high risk. The definition also includes an admission to a psychiatric hospital, Durham Center Access (crisis facility), Duke's ER, Durham County EMS, police department and/or Durham County Jail. There are approximately 200 individuals identified in TDC's system of care that meet these criteria, but for the purposes of this study, a sample of 50 people have been selected to conduct an in depth case study over the next 12 months. A quality of life survey will be used to collect baseline data in August 2010. The survey is a standardized survey that has been augmented slightly to meet the criteria for this study. A follow-up survey post treatment/services/supports changes will be conducted at 6 months and 12 months post baseline. In addition, a protocol for chart reviews will be created by The Durham Center that will capture treatment outcomes per reports, assessments/evaluations conducted by provider staff, crisis and hospital events and other quantitative data. The Durham Center will develop the interview questionnaire with input from staff regarding the most pertinent questions to ask relating to treatment models utilized, service provision, lengths of stay in treatment and crisis events. Data from the chart reviews will be analyzed and cross-tabulated with survey data to corroborate findings. A 6 month and 12 month report of findings will be provided to TDC staff, including the UM Department and other interested parties.
Describe the Population affected by the Quality Improvement Project [Core 21 (b)(i)(ii)(iii)(g)(h), Core 24(a),(b)]
Consumers and providers will be affected due to findings related to treatment that may or may not be effective per chart reviews and consumer reports. The plan is to provide the data from the findings to providers and to discuss treatment options that might work better in the future. Ultimately, the intent is for the data to inform practices, to prevent crisis events and recidivism for emergency services.
Selection Process [Core 19(b), Core 20(g), Core 21 (a)(b)(i),(ii),(iii)(c)(d)(e)(f) and Core 23(a)]
A large percentage of consumers served (with mental illness) in Durham county also have substance abuse or use as a primary or secondary diagnosis (approximately 65% overall). Many of these consumers meet the high risk criteria. Some of the individuals in the sample have developmental disabilities in addition to mental illness. The sample of 50 consumers was chosen due to having the

highest number of admissions to emergency services or inpatient care over the past 12 months.

Relation to Modules under Review [Core 21 (a)(b)(i),(ii),(iii), Core 24(a)(b)]

This project relates to access as well as continued engagement in services for people with mental illness, substance abuse issues and developmental disabilities—many of these have co morbidity. Baseline data will be obtained from this study and then a follow up study will occur in 6 months and 1 year post implementation of any new treatment options. STR, UM, QM, and Care Coordination staff will be included in the communication of results and any new or changed treatment modalities implemented. UM and STR will be involved in authorizing/approving any new or changed treatment modalities for individual consumers. This may include different authorization timelines as well as lengths of stay. Data from treatment received will be included in the follow up study. All results will be communicated to the CQI and QM Committees, as well as providers of care.

Date approved by the Quality Management Committee [Core 20(g)]	Date of meeting minutes reflecting approval by Quality Management Committee [Core 20(d)]
August 1, 2010	August 1, 2010

Time Frames [Core 23(c)]

Research to begin August 1, 2010. Final report and analysis will be available in the end of August 2011.

Focus of Project [Core 24(a)(b)]	Name of Senior Clinical Staff Person Involved [Core 24 (b)]
Clinical.	The principle investigator is Lena Klumper, Ph.D., Director of Quality, Research & Development. QM staff and Care Coordination staff are co-investigators.

Baseline Measurement [Core 21(d)]

This will be provided after the collection of data phase, approximately the end of August, 2010. Current baseline data are from hospital admissions, ER admissions, EMS/police involvement, and crisis facility/mobile crisis involvement.

Data Collection [Core 21(a),(b),(c) and Core 23(a)]

Data collected are from consumer report via quality of life surveys, structured interviews and their mental health and/or medical charts. Both quantitative data and qualitative data will be cross-tabulated to determine if what the consumer perceives as occurring in treatment is evidenced in provider charts and practices.

Measurable Goal(s) toward improvement [Core 23(a)]
1) Reduce rate of emergent admissions of individuals by at least 25% from baseline of the individuals in the study. 2) Reduce recidivism rates of crisis events among the population by a minimum of 25% from baseline of the individuals in the study.
Projected Timeframe to Achieve Goals [Core 23(c)]
September 2010 will be when any changes in models or levels of care being offered are conducted. The follow up study will occur in January 2011 or July/August 2011.
Initial Interventions/Action Plans [Core 23 (b)(e)(f)]

Barriers Identified and Intervention/Action Taken	Date Implemented
Intervention during study period is to inform TDC's UM department about treatment modality changes, authorization timeline differences/changes, and lengths of stay in treatment.	Expected date: Dec 2010
Information disseminated to all TDC departments to implement changes as needed, such as new or changed treatment modalities for authorizations, closer follow up with providers re: outcomes.	Expected date: March 2011
Providers of care will be informed of better practices to improve outcomes of consumers.	Expected date: December 2010 and continuing.
List the 4th interventions/actions taken to improve performance	Date intervention/action implemented
List the 5th interventions/actions taken to improve performance	Date intervention/action implemented

Periodic Measurements at least annually [Core 23(d)] and re-measurement for changes or improvements to baseline [Core 23(e)]

Date of Measurement	Result of Measurement	Date Reported to QM Committee
Date of 1st Measurement (Not the baseline	Summarize the results acheived utilizing statistical methodologies	Date results submitted to QMC

<table>
<tr><td>measurement)</td><td colspan="2">If an initial project improvement measurement has not occurred, then when will it be conducted?</td><td></td></tr>
<tr><td colspan="2">QMC comments based on results of 1st measurement [Core 20(f) (h)]</td><td colspan="2">Interventions/Actions implemented based on results of 1st measurement [Core 23(b)]</td></tr>
<tr><td>Date of 2nd measurement</td><td colspan="2">Summarize the results acheived utilizing statistical methodologies</td><td>Date results submitted to QMC</td></tr>
<tr><td colspan="2">QMC comments based on results of 2nd measurement [Core 20(f) (h)</td><td colspan="2">Interventions/Actions implemented based on results of 2nd measurement [Core 23(b)]</td></tr>
<tr><td>Date of 3rd Measurement</td><td colspan="2">Summarize the results acheived utilizing statistical methodologies</td><td>Date results submitted to QMC</td></tr>
<tr><td colspan="2">QMC comments based on results of 3rd measurement[Core 20(f) (h)</td><td colspan="2">Interventions/Actions implemented based on results of 3rd measurement [Core 23(b)]</td></tr>
<tr><td>Date of 4th Measurement</td><td colspan="2">Summarize the results acheived utilizing statistical methodologies</td><td>Date results submitted to QMC</td></tr>
<tr><td colspan="2">QMC comments based on results of 4th measurement [Core 20(f) (h)]</td><td colspan="2">Interventions/Actions implemented based on results of 4th measurement [Core 23(b)]</td></tr>
<tr><td colspan="4">Conducts an analysis if performance goals are not met [Core 23(f)]</td></tr>
</table>

Barriers Identified and Actions Taken