



Local Managing Entity

The Local Business Plan 2007—2010

Wake County Local Managing Entity
Local Business Plan 2007 -- 2010
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EXECUTIVE SUMMARY

The Wake County Human Services (WCHS) Local Managing Entity is responsible for the coordination and quality assurance of Mental Health, Developmental Disability and Substance Abuse (MH/DD/SA) services for the residents of Wake County. The Local Managing Entity (LME) works with an extensive provider network of about 460 agencies and is involved in a variety of wide-scale collaborative community processes.

WCHS successfully implemented its 2003-2006 Local Business Plan after extensive planning involvement from the community-at-large, consumers and families, advocacy groups, WCHS staff, and provider agencies. That plan included provider capacity development schedules as well as descriptions of the proposed LME structures and functions within the unique design of Wake County's consolidated Human Services agency – the culmination of seven years of work to develop an integrated Human Services agency, blending public health, social service, and MH/DD/SA strategies.

The LME Division of WCHS was created in January 2004 and has assumed direct responsibility, management and staffing for the Screening, Triage and Referral, Quality Management, Provider Relations and Development, Utilization Review/Management, and Care Coordination functions. Tasks associated with LME functions such as Business Management and Human Resources, Contracting, Consumer Affairs, Claims Adjudication and Information Technology are shared with and supported by the WCHS Operations Division and/or the County offices.

In planning for this new Local Business Plan, the LME was once again able to rely upon the traditional strengths of the broad agency—integration and communication, and wide stakeholder involvement. Two processes in particular were helpful to this work. First, in approaching its tenth anniversary, WCHS sought to examine and revise the agency's mission and to think about not only the next three years, but the next ten. A yearlong series of discussions within the agency—from leadership to front-line staff—and across the community at multiple focus groups and open forums led to the development of the Agency's Ten Year Strategic Plan. Secondly, the Agency has just completed its Community Assessment as required every four years through our Public Health division. Again, stakeholders from across the community participated in a variety of surveys, forums, and prioritization processes.

In addition, the Wake LME conducted a variety of opportunities for input from stakeholders particularly interested in the business of the LME. Along with LME staff and members of the WCHS Board, the Consumer and Family Advisory Committee (CFAC) and the Community Provider Advisory Committee (CPAC) have been especially strong partners in the development of this plan.

The Wake LME has experienced a variety of successes in the past two years. This Local Business Plan 2007 – 2010 outlines an ambitious set of strategic objectives to build on those successes and further strengthen the services and supports available for consumers and families. The Plan is written to support the Priority Strategic Objectives of the NC Division of MH/DD/SAS as well as to meet the local needs of Wake County.

The most pressing challenge for the Continuum of Care in Wake County remains the lack of local psychiatric bed capacity and the impending closure of Dorothea Dix Hospital. The Wake County Board of Commissioners recently signed an agreement with Holly Hill Hospital to work together in a partial solution towards the community's critical need for local beds. The LME will play an important role in the implementation of this agreement as well as in the processes to develop the rest of the acute care/crisis continuum.

This Plan contains 45 individual objectives to be implemented over the next three years. Although these are distributed throughout the seven chapters in order to define lead responsibility for functional teams of the Wake LME, all are easily categorized into the following six focus areas.

1. Further development of the acute/crisis continuum of care. Key objectives relate to the implementation of the Holly Hill Hospital agreement and ongoing planning for other facility-based care for persons with mental health and addictions crisis needs. (Much more detail about the rest of the crisis continuum is also addressed in the Crisis Planning document submitted to the NC Division of MH/DD/SAS on March 1, 2007.)
2. "Right-sizing" of the provider network through the use of outcome driven data to assure timely quality service delivery and adequate capacity across the continuum of care. Key objectives focus on quality assurance mechanisms, training, and engagement of providers in the planning and development of needed capacity in areas such as housing.
3. Ongoing implementation of evidence-based practices (EBP) throughout the network. Key objectives focus on planning, development, support, review, and fidelity monitoring with providers, and refinement of LME business practices—all in a systemic effort to create a network that values and promotes the recovery philosophy inherent in evidence-based practice models.
4. Enhancements to LME performance. Key objectives center on obtaining new automation systems that will support improved performance in consumer and provider data collection efforts, survey processes, and benefits management.
5. Building community-wide partnerships. Key objectives include social marketing and educational strategies along with the use of traditional and non-traditional partners to enhance support, access, and choice for consumers and families.
6. Focusing on peer support initiatives and consumer concerns. Key objectives include several to be undertaken with active CFAC partnership such as the development of CFAC educational curricula and the development of consumer friendly printed and web-based educational materials. In addition, a plan focusing on support for consumer-run businesses and the use of peer support specialists will be highlighted.

This Local Business Plan outlines how the Wake LME will meet the continuing challenges of system transformation and ensure that a thriving continuum of care is available for Wake County consumers during the next three years.

Chapter 1

GOVERNANCE AND ADMINISTRATION

Mission: The Wake County Local Managing Entity (LME), as a Division of Wake County Human Services (WCHS), strives to uphold the values, principles, and mission of the agency as related to the needs of consumers and families with mental health, developmental disability, and substance abuse (MH/DD/SA) concerns.

“Wake County Human Services, in partnership with the community, will anticipate and respond to the public health, behavioral health and the economic and social needs of Wake County residents. We will coordinate and sustain efforts that assure safety, equity, access and well-being for all.”

Purchaser Standards: The Wake County LME follows all applicable local, State and federal rules, laws and mandates, including those found in the Performance Agreement and in Communication Bulletins.

Current Operations:

The first Local Business Plan required by the 2001 Mental Health Reform legislation was created by a WCHS steering committee and approved in April 2003. At that time, seven years of work to develop an integrated Human Services agency, blending public health, social service, and MH/DD/SA strategies had occurred. The agency and community were heavily invested in maintaining a broad view and committed to ongoing work to serve consumers with holistic outcome-oriented methodologies. A discrete MH/DD/SAS agency had not existed for a number of years. Staff providing MH/DD/SA services were integrated into all divisions of the agency. The agency already had extensive experience in contracting for a variety of services, good existing business practices, and strengths in involving community stakeholders in planning processes.

The April 2003 plan focused heavily on the use of existing agency-wide processes and structures to support the transition from being a primary provider of MH/DD/SAS services to being a primary assessor of those services. In some cases that strategy has been quite successful. Tasks associated with LME functions such as business management and human resources, contracting, consumer affairs, claims adjudication and information technology are still processed by the WCHS Operations Division and/or the County offices. For other functions, it became apparent early on that cross-agency committees without specific dedicated staff were going to be less than effective at managing the rapid pace of MH Reform and the specific new tasks of LME's. The LME Division of WCHS was created in January 2004 and has assumed direct responsibility, management and staffing for the screening/triage/referral, quality management, provider relations and development, utilization review/management, and care coordination functions. An LME operations manager/liaison position has been created to assure interdepartmental communication for those functions not directly managed by the LME.

In fact, it has rarely been an *easy* task to develop an LME structure that is nested in a consolidated and integrated county Human Services agency. Policy guidance from the State often requires local interpretation that is more complex here than in traditional MH/DD/SA programs. Providers have legitimate concerns about a model of doing business that is sometimes out-of-sync with their experiences with other LME's. Consumers and family members

sometimes require extra attention in navigating the systems of care that support them. LME staff must stay particularly alert to issues of “firewalls” and “level playing fields” where consumers continue to receive some of their MH/DD/SA services in integrated programs operated by other Divisions of the WCHS agency.

Nevertheless, the underlying values and infrastructure of Wake County Human Services have been a strong foundation for the system transformation process during the tremendous amount of change over the last few years. Wake County consumers have experienced far less serious disruption of care than in some parts of the State. The provider network has expanded in both capacity and competencies at a steady rate. And the LME Division itself is now properly staffed and well positioned to lead the ongoing work associated with managing the network of MH/DD/SA services for the residents of Wake County.

In planning for this new Local Business Plan, the LME was once again able to rely upon the traditional strengths of the agency and to use two processes in particular to inform this work. First, in approaching its tenth anniversary WCHS sought to examine and revise the agency’s mission and to think about not only the next three years, but about the next ten. A yearlong series of discussions within the agency—from leadership to front-line staff—and across the community at multiple focus groups and open forums led to the development of the agency’s Ten Year Strategic Plan. Concerns for the MH/DD/SA system are readily apparent in the plan’s four goals. (See Appendix 1.) Secondly, the Agency has just completed its Community Assessment as required every four years through our Public Health division. Again, stakeholders from across the community participated in a variety of surveys, forums, and prioritization processes. The Behavioral and Social Health chapter reflects the entire community’s concern with one of the most prominent issues facing Wake County—the impact of the closure of Dorothea Dix Hospital. In fact, at the final prioritization meeting of the Community Assessment, several hundred community leaders chose this concern as one of the top four that must be addressed in the Community Assessment Action Plan for the upcoming years. Another of the top four concerns addresses youth safety and prevention of gang violence—an issue closely tied to adolescent substance abuse concerns and one that LME staff are closely involved with already. (View full report at <http://www.wakegov.com/humanservices/assessment.htm>.) The LME will provide staff resources and leadership to some action steps in that plan, as they are congruent with some of the strategic objectives outlined below.

In addition, the Wake LME conducted a variety of stakeholder input opportunities for those most interested in the business of the LME. Along with LME staff and members of the Board, the Consumer and Family Advisory Committee (CFAC) and the Community Provider Advisory Committee (CPAC) have been especially strong partners in the development of this plan. In a particularly energizing process, a “Joint Stakeholders’ Committee” has developed the early draft of a “Wake Coalition” work plan that will re-design the way work is accomplished. All stakeholder groups have agreed to more frequent and open discussion amongst all parties, respect for positions of other groups, participatory decision-making, including compromise as needed, and assigned accountability for tasks. This shift from advisors to contributors should only serve to further strengthen the inclusiveness we strive for in our growth.

Wake County Human Services’ unique status as a consolidated human services agency offers unique challenges as well. The agency was consolidated in an effort to improve outcomes for consumers with multiple needs by integrating services across traditional agency lines. A ten-

year history of demonstrated success must be acknowledged. The agency intends to continue to be a service provider in arenas where engaging traditional public health or social services consumers with MH/DD/SA strategies leads to improved outcomes. DHHS is promoting integrated behavioral and physical health strategies. Across the state, other local DSS or PH departments are hiring mental health and substance abuse clinicians. WCHS believes that consumers here should be able to experience the same benefits and that full divestiture is not in the best interests of consumers. For example, WCHS has placed Mental Health clinicians in the HIV/AIDS clinic for years, with demonstrated improvement in the ability to engage and treat these consumers. Divestiture of those clinical staff is simply not wise. The CFAC and other local stakeholders have supported this limited service provision.

On the other hand, WCHS is significantly transforming itself from a primary provider of care to a primary assessor of care and intends to continue to do so. WCHS has separated its duties into distinct functional divisions. The LME manages and oversees services (assessor). With the exception of crisis services all other integrated services and remaining traditional services are delivered by other WCHS divisions (providers). The agency will complete divestiture of most enhanced benefits services by July 2007. Recognizing the growth in the provider community's depth and breadth, a deliberate and thoughtful plan to divest non-integrated, traditional MH/SA services by December 2008 has begun. In addition, the agency recognizes the need to re-align some of its administrative and business practices in order to provide full transparency to the community about the extent of internal service provision and to safeguard consumer choice and portability of benefits.

The most pressing challenge for the LME remains one noted above and in the 2003 Local Business Plan. Despite concerted negotiation efforts and additional approved funding for both capital and operating costs, the community still lacks local psychiatric bed capacity. This results in continued high numbers of admissions to Dorothea Dix Hospital and an impending community crisis when Dix closes. The local ED's and the Wake County Public Safety Center are particularly concerned about increased volume. The Wake County Board of Commissioners recently signed an agreement with Holly Hill Hospital to work together in a partial solution to the community's critical need for local beds. Strategic objectives will appear in several spots throughout this document around this major initiative. In addition, the LME will participate in ongoing planning processes around the design and costing of the acute continuum of care to include facility-based crisis and secure detox beds and a single acute crisis entrance point service. (Please also reference the Wake LME Crisis Plan document submitted to the NC DMH/DD/SAS on March 1, 2007.)

Governance Structure: Wake County Human Services operates as a consolidated human services agency under G.S. 153A-77. As such the Agency is a department of the County and the Wake County Board of County Commissioners is the governing body. The Human Services Director carries the powers and duties of the Area Director. The Human Services-Environmental Services Board serves as an advocacy, advisory, and policy board and this board's committee named the "MH/DD/SAS Continuum of Care" offers particular attention, support and direction to the LME. The agency's full-time Board Executive Assistant provides administrative support.

The Wake County LME Director and the LME Division are designated to provide leadership and management for the development, implementation, and oversight of the array of community-based services and supports for persons with MH/DD/SA needs. The LME also remains the

primary provider of walk-in crisis services for the community and offers some time limited but essential direct service to consumers as part of its care coordination function.

The administrative team consists of the LME Director, the Chief of Psychiatry, the Operations Manager, and an executive assistant. In addition, five senior clinical staff—known as the Provider and Community Development Team (PCDT)—function as age/disability specialist clinical directors for approximately 25% of their duties. The agency’s director, medical director, and deputy director offer support as needed.

County Government Relations: The LME Director and Chief of Psychiatry are members of the WCHS Leadership Team and also are charged with regular communication and reporting on LME activities to the County Manager’s office. The LME Director also has frequent interaction with other County departments. A variety of functions (as noted above and throughout this plan) are partially or fully supported by the Operations Division of WCHS or other County Departments.

Legal Services: The Wake County Attorney’s office provides any legal counsel needed to the LME. The Attorney’s office is routinely involved in clinical or financial risk management matters, non-standard contracting questions, and human resources situations.

Policy Development: All new policies and many new procedures are products of collaborative committee work with routine involvement of stakeholders, including CFAC members and provider representation. Policies require Board approval.

Strategic Planning: Broad community processes, as described above, guide the overall planning process for the LME and assist to align the LME’s work with the larger mission of the agency and our partners. The LME administrative team conducts shorter term and more specific planning processes using a variety of methods. For instance, surveys and monthly topic-specific forums are used to assess provider capacity around network gaps. Annual work plans focus resource needs and requests for the budgeting process. CQI projects are undertaken to enhance our ability to become increasingly data driven in our planning processes.

Compliance: Each member of the LME administrative team and each program manager for the other LME teams is responsible for informing the entire LME Management of compliance requirements within their areas of expertise. Recommendations for compliance strategies for new regulations are reviewed with the full team and educational strategies for staff are developed. The Quality Management team is currently taking the lead in researching options for the LME’s future accreditation.

Strategic Objectives:

- Refine the mission and structure of the WCHS Board Continuum of Care Committee to become the home for the “Wake Joint Stakeholders’ Coalition”. Develop the participatory work plan for the coalition.
 - Lead Responsibility: WCHS Board Chair, Continuum of Care Committee Chair, CFAC co-chairs, CPAC chair, LME Director
 - Stakeholder Group: Same
 - Target Dates: Begin April 2007 and assess quarterly

- Continue successful development of Evidence-Based Practices (EBP) throughout the Wake network. Focus efforts by hiring a new position—EBP coordinator—which will assist providers in development, successful implementation and fidelity monitoring, and will lead consumer and family EBP education and outreach efforts, and will inform the work of the rest of the LME’s strategies to support proper fund management and data collection around EBP’s.
 - Lead Responsibility: LME Director, Provider and Community Development Team and Chief of Psychiatry
 - Stakeholder Group: Consumers, families, providers, all LME staff.
 - Target Dates: Wake currently participates in the CMS grant funded Mental Health Systems Transformation project and desires to broaden and focus lessons learned from this venue. Hire Coordinator by July 1, 2001

- Continue the facility planning processes to meet the acute crisis continuum needs of Wake County.
 - Lead Responsibility: Currently led by County Facilities Design and Construction and Budget Departments. Participation by LME Director and Chief of Psychiatry. Will involve other LME staff soon.
 - Stakeholder Group: DHHS leadership, Board of Commissioners, CFAC and broad community-wide input once early design concept is established.
 - Target Dates: In process and ongoing

- Establish mutually agreed upon procedures between Wake County, Wake LME, and Holly Hill Hospital for successful implementation of an MOA to enhance local inpatient psychiatric capacity for indigent care.
 - Lead Responsibility: Currently at County Manager’s office with routine LME Administrative involvement. As task list is built, more LME staff will be designated.
 - Stakeholder Group: Wake County, all LME teams, Holly Hill, consumers, other providers throughout the network, other local hospitals.
 - Target Dates: In process and ongoing

- Complete the divestiture of Behavioral Health Outpatient services for adults with mental illness and substance abuse needs.
 - Lead Responsibility: LME Director, Chief of Psychiatry, Provider and Community Development Team specialists
 - Stakeholder Group: LME, Internal Services staff, CFAC, CPAC.
 - Target Dates: Begin transition team and project management task list immediately. Divestiture is to be completed by December 31, 2008, with quarterly benchmarks and quarterly reviews of progress toward divestiture goals by the WCHS Board Continuum of Care Committee, CFAC, and other stakeholders

- Re-align budgeting mechanisms to support transparency for all stakeholders to understand the use of federal, state, and local funding and to assure portability of benefits/consumer choice. Establish MOA’s across WCHS Divisions as related to internal “purchase of service” arrangements for integrated services, monitoring and quality assurance measures, and expected outcomes.

- Lead Responsibility: LME Director, LME Operations Manager, WC/WCHS budget and contracts offices.
 - Stakeholder Group: Internal Services staff, CPAC, CFAC.
 - Target Dates: Utilize new mechanisms for FY0708
- Evaluate the extent of racial disparities in consumer outcomes across the provider network. Educate LME staff and provider network on the causes of racial and ethnic disparities in outcomes. Redesign practices, using CQI processes, to achieve equitable outcomes.
- Lead Responsibility: QM team leader and newly created EBP coordinator.
 - Stakeholder Group: All LME staff, provider network staff, consumers and families.
 - Target Dates: Begin training opportunities and data collection FY0708
- The Wake LME is concerned about the numbers in the recent Division report “Community Systems Progress Indicators” suggesting a lower than average percentage of persons using our system for care. We will undertake an evaluation of this and propose solutions for improvement.
- Lead Responsibility: LME Operations Manager.
 - Stakeholder Group: Technical assistance from DHHS, County finance and budget offices.
 - Target Dates: Begin evaluation FY0708 using past year’s performance indicators and fiscal analysis. Propose solutions by December 2007

Resource Allocation:

Specific resource allocations are identified below for this chapter and in each following chapter. This first chart shows the overall LME total FTE’s, cost model allocation and variance. It also illustrates an explanation for the variance that is pertinent to several functions. The cost model is based on the assumption that Wake County will manage approximately 50 contracts. In fact, the actual number of contracts to be managed is 130; meaning additional staff positions are required and at this point are funded by county contributions. Also, in addition to managing the Medicaid and State functions as required in the model, Wake County has contributed approximately \$14 million to consumer care. The LME needs more employees to manage this additional service dollar contribution.

And, finally the LME was fortunate enough to retain many staff with long-term County employment history and hence some salaries and benefits are a bit more expensive than the model funds.

Total for All LME Functions

	Cost Model FTEs	Cost Model Expenses	Wake Actual FTES	FTE Variance from Model	Wake Total Expense	Expenditure Variance from Model
Model, as is (assumes 50 contracts):	108.31	\$ 7,726,107	153.89	42%	\$14,053,683	85%
Model w/actual # of contracts (130):	151.30	\$10,718,893	153.89	2%	\$14,053,683	31%

Variance and figures for Governance and Administration exceed the cost model allocation. Wake County has a variety of buildings requiring a bit more administrative support than allocated for in the model. Board support and senior executive staffing costs are somewhat higher due to our agency structure.

General Administration & Governance

Cost Model FTEs	Cost Model Expenses	Wake Actual FTES	FTE Variance from Model	Wake Total Expense	Expenditure Variance from Model
6.56	\$605,317	8.41	28%	\$ 1,054,557	74%

Business Rules:

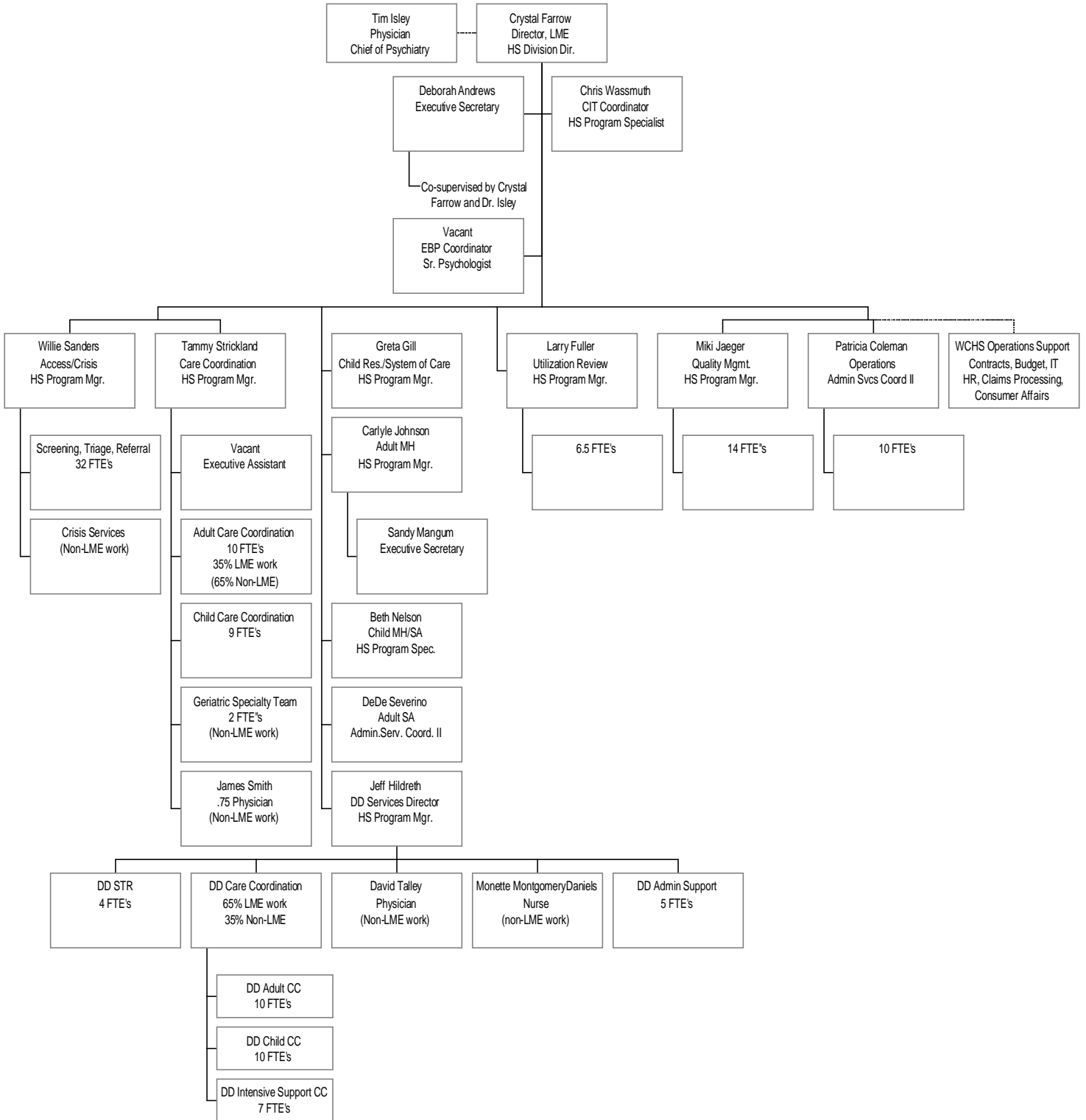
The following business rules **enhance** the Wake LME’s efficiency and effectiveness:

1. Wake LME has developed strong partnerships with stakeholder groups throughout the community. At the backbone the CFAC and our CPAC are routinely and regularly involved. In addition, the Wake LME participates in a variety of broad community-based partnerships that enhance education, outreach, and access to treatment for consumers throughout the community.
2. Despite the occasional difficulties associated with our unique structure as a consolidated Human Services agency, the agency provides benefits to consumer care, as well as to the efficiency of the operations of the LME.

The following business rules **inhibit** the Wake LME’s efficiency and effectiveness:

1. Rules that inhibit the development of facilities beyond a maximum of 16 beds for which Medicaid will reimburse are in sharp contrast to the numbers of beds needed to adequately serve Wake’s growing population. The IMD rules and service definition rules for “Professional Treatment Services in Facility Based Crisis Programs” and “Non-Hospital Medical Detoxification” limit economies of scale in both capital and operating expenses.
2. Historical allocations of state funding to Wake County have always lagged behind the dramatic population growth here. Now new allocations of state dollars based upon an ‘equalization’ formula versus per capita allocation limit the LME’s ability to provide services at the demanded levels. Service dollar allocations based on a percentage of the population’s poverty limit the LME’s ability to expand treatment resources to a greater number of citizens and contribute to waiting lists for services.
3. The local crisis precipitated by the closure of Dorothea Dix Hospital before local solutions are in place has been of great concern to the entire community and particularly to consumer and family advocates. The ongoing tension about this decision of the State creates a climate of uncertainty that necessitates constant attention—sometimes at the risk of neglecting other important topics in the continuum of care.

WCHS LME



Chapter 2

BUSINESS MANAGEMENT, HUMAN RESOURCES, CLAIMS ADJUDICATION AND INFORMATION TECHNOLOGY

Mission: The operations and business management divisions of the LME strive to ensure that operational decisions are informed by the best data analysis possible, that decision making is driven by the MH/DD/SA needs of the citizens, and that procedures are consistent with State and local rules and regulations.

Purchaser standards: The Wake County LME follows all applicable local, State and federal rules, laws and mandates, including those found in the Performance Agreement and in Communications Bulletins.

Current operations: As identified in the Cost Model (11.21.06), this function includes several business management functions that are housed within the LME, within Wake County Human Services Operations Division, or within Wake County administration.

Wake County LME authorizes all contract IPRS and county funded services, calling this combination of funds "Non-Medicaid." There is a contract signed annually with each non-Medicaid provider. The contract designates for which non-Medicaid services the provider is allowed to bill. Standard reimbursement rates are set up in the UniCare Managed Care Module for each provider's contracted services only. When clinical, financial and budgetary criteria are met, authorizations are issued for the specific provider/service/client combination. The authorization specifies the effective dates and maximum units. Before payment, claims are adjudicated against authorizations. Non-Medicaid payments are made prior to IPRS revenues being received from the State. IPRS denials are worked to ensure budgeted revenues are earned.

The Provider and Community Development Team (PCDT) is responsible for the overall management of service funds. The PCDT Service Managers manage purchase of service budgets by developing and adhering to guidelines for state-funded services. With the support of LME Operations staff, the PCDT analyzes and reviews IPRS earnings, expenditures and projections. Changes to budgets and authorization practices are made when necessary, based on this analysis.

Wake County LME has been putting considerable effort into ensuring compliance with NC General Statute 122C-146: "The area authority and its contractual agencies shall prepare fee schedules for services and shall make every reasonable effort to collect appropriate reimbursement for costs in providing these services from individuals or entities able to pay..." In an effort to ensure that limited State and local service dollars are reserved for those who most need assistance, and to ensure that providers and consumers are treated equitably, a network-wide consumer co-pay schedule has been developed and will be implemented in July 2007. A key aspect of this fee policy is verifying the consumer's income, and thus their ability to pay. LME Operations Support staff started verifying the consumer's financial eligibility for publicly funded services in December 2006.

Claims Processing: The administrative processing and entry of consumer information, consumer eligibility (IPRS and financial), and service authorization is performed by LME Operations Support staff. Claims entry is conducted within the WCHS Operations Division, Billing Department. Claims adjudication and provider payment is done within the LME Claims

Processing department, and the check writing/disbursement is handled by County administration. This separation of authorization entry, claims entry, and claims payment functions helps ensure maximum accounting controls are in place.

Wake County LME ensures the accuracy of payments by a reconciliation process that balances payments to providers with the non-Medicaid claims files and with Medicaid claim payments reported on the Medicaid Remittance Advice (835). Prompt payment of providers is carefully monitored. In FY2005-06 over 95% of the dollars paid to contract providers met the 45-day prompt payment standard.

Information Management: Telecommunications, computer operations and system administration functions are performed by Wake County Information Services department, including server maintenance, software maintenance, security, internal communication and basic software support, PC purchasing and support, administrative support, and the help desk. Other functions are performed by staff housed within the WCHS Operations Division, including data retrieval, database administration, report writing, data analysis, analysis of 835 denials, and administrative support on LME/billing software.

CDW: The CDW reporting and error correction function is in the process of being transferred from WCHS Operations to the LME Operations Support department, with support from Wake County Information Services.

IPRS: The 837 submission is done as a part of claims processing, in the WCHS Operations Division/Billing Department. Target Population entry, CNDS, 834 file submission, working 835 denials, and rebilling are the responsibility of the LME Operations Support staff.

Human Resources: Human Resources policies and recruitment are handled by County administration. The WCHS Operations Division has staff who handle administrative processing of new hires, terms, payroll, timekeeping, salary administration, and position management. Payroll check writing/disbursement is handled within County administration.

Finance: County administration maintains the general ledger and accounting software and finance policies. Accounting, including non-provider payments, supplies and administrative purchases, staff travel reimbursement, etc., is performed by the WCHS Operations Division. The WCHS Operations Division also maintains budgets by cost center.

Strategic objectives:

➤ **Improve Information Processing and Analysis Capacity:** WCHS has recently published an RFP for new LME System Administration software. The LME has been utilizing outdated and inadequate software initially implemented in the early 1990s. This software does an inefficient or inadequate job of meeting the following requirements:

- Client Data Warehouse (CDW) reporting requirements
- Screening, Triage and Referral tracking
- Person Centered Plan Admission Form and related data
- The reporting of access to services

New software will be implemented with the objective of rectifying these inadequacies, and:

- Improving the efficiency with which consumer information is entered and processed;

- Allowing providers to track their Wake County authorizations, claims and units used online;
- Allowing providers and Crisis Services to maintain and access current consumer information, including crisis plans, online;
- Providing tight accounting controls throughout the stages of authorization, claims processing and payment; and
- Providing timely and accurate data for systems level analysis of populations served, patterns of service usage and expenditures.

The process of choosing, acquiring, and fully utilizing new software will likely take three years, taking into consideration the requirements to implement these new business practices.

Lead Responsibility: LME Operations Support, Wake County Information Services, specific WCHS Operations staff

Stakeholder Group: LME, WCHS, Community providers, CFAC

Target Dates: Choose vendor and negotiate contract by July 1, 2007; install, convert current consumer data, develop new business rules, and begin implementation essential elements of software during FY07-08; broaden implementation during FY08-09 and FY09-10.

Resource allocation:

Insignificant variance is found when the business management functions are consolidated into relationships that best match Wake’s organizational structure.

	Cost Model FTEs	Cost Model Expenses	Wake Actual FTES	FTE Variance from Model	Wake Total Expense	Expenditure Variance from Model
Business Management	8.00	\$ 480,562	9.68		\$ 799,632	
Claims Processing	12.04	\$ 574,905	7.75		\$ 480,037	
Information Management	6.67	\$ 488,917	4.30		\$ 404,822	
Subtotal	26.71	\$1,544,385	21.73	-19%	\$ 1,684,491	9%

Business rules:

The following business rule **enhances** the Wake LME’s efficiency and effectiveness:

The Wake County LME has clear documentation of business rules for contract providers in the WCHS Provider Manual. Internal LME business rules are documented in the LME Administrative Manual.

The following business rules **inhibit** the Wake LME’s efficiency and effectiveness:

1. There are business rules within the LME that are inefficient for the LME and providers. Many of the restrictive business practices within the LME’s control are necessitated by the software currently in use, and will be corrected when new software is implemented. These inefficiencies include current opening paperwork requirements, and the LME’s inability to accept online or file transfer of claims and consumer information.
2. There are State requirements that are burdensome to the management of the LME. Frequently, new funding comes late in the fiscal year and requires significant administrative changes in order to earn it. The use of Target Populations that are only good for three days

for earning Crisis funds utilizes significant administrative resources for very little return in the way of information or funding. The IPRS funding hierarchy also results in LMEs being unable to draw down specific funding. Requiring a separate IPRS rate for each MD who provides psychiatric support services is another example. Other administrative rules aren't funding-based but show a lack of thorough planning – e.g., the statewide PCP Admission Form is not user friendly, conflicts with 834 requirements, relies on faxes and paper, and increases data entry time and errors for LME's such as ours with inflexible data entry screens. It is essential that funding be allocated with well-developed administrative rules that streamline, or are at least consistent with current practices. The rulemaking process should strictly adhere to procedures that promote input and comments from stakeholders, and give sufficient lead-time for implementation.

Chapter 3

PROVIDER RELATIONS AND DEVELOPMENT

Mission: To recruit, develop, and maintain a community of quality providers whose services are evidence-based and of high quality through support, monitoring, and consistent involvement of consumers, families and the LME.

Purchaser Standards: The Wake County LME follows all applicable local, State and federal rules, laws and mandates, including those found in the Performance Agreement and in Communications Bulletins.

Current Operations: As identified in the Cost Model (11.21.06), this function not only recruits and develops a community of Providers but also assures the quality of those providers through endorsement and monitoring and provides training and technical assistance.

The Provider Relations and Development functions are performed by multiple LME teams working in collaboration with each other and with community partners, including the Wake Consumer and Family Advisory Committee (CFAC), the Wake Community Provider Advisory Committee (CPAC), the provider community and all interested Wake County citizens.

Endorsement:

Following the procedures outlined in *Communication Bulletins #44, #47 and #55*, the Quality Management Team (QMT) is responsible for provider endorsement from application review through the related site and service reviews, both initial and recurring. Since many of the endorsement criteria are also part of SB 163 monitoring, the QMT can often coordinate regular monitoring activities with endorsement activities to increase efficiency for both the provider and the QMT.

The Provider and Community Development Team (PCDT) uses its knowledge of service gaps to post Requests for Interest (RFI's) and Requests for Proposal (RFP's) seeking providers for endorsed services. Responses are reviewed by members of the PCDT, as well as other stakeholders, and providers are selected to fill identified gaps. The PCDT also provides technical assistance and support as needed for providers to successfully begin and sustain services in Wake County.

A current list and service array distribution of endorsed and enrolled providers is kept updated on the LME website.

Monitoring:

The QMT monitors Category A and B providers for compliance with the law per SB 163 as well as other quality measures such as crisis planning. In conjunction with Care Coordination Teams, QM reviews person-centered plans (PCP's) for appropriate components of the plan. Providers' progress on achieving national accreditation is also reviewed during monitoring and endorsement review.

Provider monitoring is completed following a predetermined schedule (based on the LME's assessment of provider competency and stability) or in response to a complaint or incident or at the request of another LME.

Routine monitoring and endorsement events are scheduled in 3-month blocks. The entire LME is kept informed of both monitoring and endorsement. The QMT representative to CFAC brings a copy of the quarterly schedule to the CFAC meetings and also makes it available electronically.

In order to avoid any duplication of efforts with the NC Division of Facility Services (DFS), the QMT has worked to build a partnership with this agency and has made the monitoring schedule available to DFS to assure that there will be no overlap, particularly in the case of DFS annual surveys and LME endorsement reviews. Coordination with other LMEs through increased communication has greatly decreased duplication of effort.

Monitoring of “First Responder” capability is currently identified during reviews and audits. The QMT may randomly call the “First Responder” telephone number listed on a consumer’s Person Centered Plan to assure the viability and ease of connecting with the “First Responder”.

The Child Care Coordination Team has been trained in facilitation of child and family teams using the “System of Care” model for service delivery. This is the foundation for review of quality for service delivery for children and adolescents. Developmental Disability Services staff review all PCPs upon initial and annual authorization review. Plans are reviewed for quality and appropriateness.

The PCDT and QMT monitor provider use of evidence-based practices through routine monitoring as well as focused review of model fidelity.

Training and Technical Assistance:

Trainings are held regularly for the provider community and other stakeholders to assist in understanding and following the processes and policies not only from the LME but also from the NC Department of Health and Human Services and other regulatory agencies. Targeted technical assistance is provided by the QMT and other LME teams to those who request it or as a result of monitoring and complaint reviews.

Regularly scheduled training is offered to providers, covering such topics as endorsement, NC-TOPPS, incident reporting, and hiring practices. The training needs of the provider community are determined by evaluations after trainings and feedback from the Provider Forum (co-hosted quarterly by the LME and Wake CPAC), as well as from the aggregate data collected from monitoring events regarding compliance and outcome data.

The PCDT offers various opportunities to community providers and interested stakeholders for training. For example, “special topic” trainings are offered each month. Recently offered topics include *Development of Services for the Latino Population*, *SAPT Block Grant Reporting Requirements* and *Intensive In-Home Services Enhancement*. Additionally, quarterly training is available through Child MH/SA Continuous Quality Improvement (CQI) and Adult MH/SA CQI meetings.

The PCDT assists providers with better understanding of evidence-based practice models and fidelity to the models through training. Examples include: the annual System of Care training series to assist providers with integrating key concepts in daily work practice; monthly meetings with the Integrated Dual Disorders Treatment team; monthly meetings with DD targeted case

management and developmental therapy providers; and a gang intervention best practice training series.

All providers seeking a Letter of Support for the initiation of child residential treatment services are offered orientation and training to assist them in preparing to provide quality services that can serve consumers without interruption. The letter of support process includes submission of additional information related to the manner in which a prospective agency will recruit and train its staff for the provision of qualitative residential services utilizing a System of Care treatment approach.

Community Development Plan:

The Provider and Community Development Team is responsible for developing a plan for the community, based on an assessment of local needs, priorities and service gaps. PCDT Service Directors, in collaboration with other LME staff, provide leadership in the ongoing recruitment and maintenance of the provider network.

PCDT Service Directors have primary responsibility to:

- ♦ Conduct annual gaps analysis to identify service deficits and underserved populations
- ♦ Collaborate with providers and other stakeholders to increase service capacity
- ♦ Recruit providers through RFIs and RFPs based on service capacity needs
- ♦ Provide supports necessary to implement and sustain services
- ♦ Provide guidance, education and technical expertise to support implementation of evidence-based practices
- ♦ Provide technical consultation to ensure adequate community provider crisis response capacity

Effective provider relations and development requires collaboration and positive relationships with stakeholders and the community. The PCDT initiates collaborative projects and competitive bids to ensure development of community based services for all age/disability groups, as well as other specialty populations.

Provider Operations Manual:

A current Provider Operations manual is maintained on the LME website and training is provided when new procedures are implemented to assure understanding and compliance. Communications regarding new updates to the manual are also sent via email whenever needed to the Provider community.

Contract Administration:

Contract administration is handled by members of the WCHS Contracts Management Team and follows Attachment II 2.2 of Statewide requirements. The LME includes a requirement in its contracts that "...all activities carried out by contract providers conform..." to all applicable provisions of Attachment II, as well as federal and State laws, regulations and policies.

Providers who are currently enrolled with the NC Division of Medical Assistance (DMA) for enhanced service provision may submit an application to the PCDT to be contracted for IPRS funds, if there is a demonstrable need for additional providers in that area.

Sub-recipient monitoring

If it is determined under the definitions found in the Federal Office of Management and Budget's Circular A-133 and/or N.C.G.S. Sec. 143-6.1 that an agreement is a sub-recipient agreement or if an agreement is modified at any time during the term to become a sub-recipient agreement, the sub-recipients agree to provide Wake LME with copies of appropriate financial statements in the format required by Circular A-133 and/or N.C.G.S. Sec. 143-6.1.

As the pass-through entity, the LME reserves the right to engage an independent auditor to conduct limited scope audits. Sub-recipients agree to make accounting records available for the purpose of audits. Audits are conducted to monitor the sub-recipient's compliance with one or more of the following types of compliance requirements: activities allowed or un-allowed; allowable costs/cost principles; eligibility; matching, level of effort, earmarking; and reporting. The sub-recipient's award may be charged for the cost of such limited scope audit. Additional on-site monitoring by contracts management staff with the purpose of ascertaining sub-recipient's compliance with various requirements may also be completed as needed.

Providing Arbitration and Resolutions of Provider Complaints and Grievances:

Provider complaints and grievances are handled following the procedure found in Section I.1 of the Wake County Provider Operations Manual. Any complaints and grievances that are not resolved between the LME and the provider are then referred to the procedures outlined in GS 122C-151.4. Further, if providers wish to appeal the findings from any monitoring, audits, or investigations, the policies found in Section VI.10 are followed, again with providers able to appeal following the procedures outlined in 122C-151.4.

Strategic Objectives:

- Right-sizing of the provider community. In order to recruit, develop and maintain a quality provider system, LME staff will conduct/review needs assessments, utilize RFI/RFP processes and identify effective providers through the analysis of identified measures.
 - Lead Responsibility: PCDT, QMT
 - Stakeholder Group: Providers, consumers, community partners
 - Target Dates: July 1, 2007 – June 30, 2008

- Development of a Consumer Choice website to assure informed consent. For consumers to make informed choices about providers, there must be a simple yet inclusive system with which a consumer can review multiple dimensions of any service provider as well as information related to quality performance. The information should allow for consumers to supply input about their experience with a provider, as well as allow providers to post information about their services and capabilities.
 - Lead Responsibility: QMT
 - Stakeholder Group: Providers, consumers, community partners
 - Target Dates: April 1, 2007 – December 31, 2007

- Development and implementation of a "Provider Management" database, which will integrate multiple information sources to create complete profiles of providers. The creation of a database that captures information in one place related to contracting, monitoring, endorsement, QI reporting, incidents, complaints, outcome data and service capacity will increase the accuracy and efficiency of the LME overall.
 - Lead Responsibility: QMT, IT, Operations, Contracts Management, PCDT

- Stakeholder Group: Consumers, LME staff, Providers, community partners
- Target Dates: July 1, 2007 – June 30, 2008
- Implementation of a CQI project to better inform the LME of providers' capacity and skill in providing and maintaining "First Responder" capability. Information gathered from incident reports as well as requests to provide training on "First Responder" requirements indicates that providers are not well schooled in how to be a quality "First Responder". The project will include data collection from consumers who present for crisis services, training for providers on this issue and data collection to inform the LME of the effect of training.
 - Lead Responsibility: QMT manager, Screening, Triage, Referral manager, PCDT
 - Stakeholder Group: Consumers, community stakeholders, providers
 - Target Dates: May 1, 2007 – ongoing
- Increased pool of facilitators for System Of Care (SOC) workshops.
 - Lead Responsibility: SOC Coordinator
 - Stakeholder Group: Providers, QMT
 - Target Dates: April 1, 2007 – June 30, 2008
- Conduct ongoing assessment of community needs, capacity and gaps in housing for MH/DD/SA consumers, establish a housing development plan and identify resources for improving access to housing.
 - Lead Responsibility: PCDT, LME Director
 - Stakeholder Group: WCHS Economic Self-Sufficiency staff, local housing/homeless services providers, stakeholders, WCHS Housing and Community Revitalization team
 - Target Dates: April 1, 2007 - ongoing
- Develop a written plan and procedures for implementation and support of evidence-based practices. This plan will include supports and procedures necessary to sustain EBPs, including plans for referral, authorization, and funding of services through Medicaid enhanced benefit services and non-Medicaid funding sources.
 - Lead Responsibility: New EBP Coordinator, PCDT
 - Stakeholder Group: Providers, LME staff
 - Target Dates: April 1, 2007 – ongoing

Resource Allocation:

Provider Relations and Support costs vary significantly from the cost model allocation primarily because this group includes most of the higher salary costs associated with senior clinical director staff for each age/disability group—positions which have been essential to the management of the large network and to provide specific focus to our successful evidence-based practice implementation.

Provider Relations & Support

Cost Model FTEs	Cost Model Expenses	Wake Actual FTES	FTE Variance from Model	Wake Total Expense	Expenditure Variance from Model
8.40	\$ 662,409	8.85	5%	\$ 1,132,408	71%

Business Rules:

The following business rules **enhance** the operation of the Provider Relations and Development function:

1. Implementation of 10A NCAC 27G rules for .1700 level residential providers. With the implementation of these rules, providers have been required to provide more supervision and structure, which in turn will produce not only safer facilities for children and adolescents but also more professional treatment focus with the addition of mandated licensed professionals.
2. Standardized criteria for endorsement. Because the endorsement process relies on standardized and objective criteria, providers are better able to complete the endorsement process across multiple LME's. Providers seek standardization of processes and this has met that need.

The following business rules **inhibit** the operation of the Provider Relations and Development function:

1. Requirement to endorse all willing and qualified providers. Although the majority of providers can qualify for endorsement, they are not necessarily able to provide quality services over time. These endorsed providers require extra time and staff focus through complaints and monitoring and provision of technical assistance. LME's should be able to recruit rather than accept any willing and qualified Provider if a specific service has adequate capacity to serve a population. With more rigorous standards and more in depth review of those providers who have never provided a comparable service, the potential for a "quality" provider community is enhanced. Endorsing a provider takes much time, especially those who require a great deal of technical assistance and those are the providers who ultimately are less able to provide quality services. There would be a reduction in incidents and complaints.
2. Letter of Support: This process should be based on local need rather than arbitrarily giving a Letter of Support to all requesting providers. Any new provider will have a steep learning curve and should be reviewed closely upfront as to their overall understanding of the concepts of providing treatment to the population they wish to serve.
3. Inability to meaningfully stop endorsed providers from accepting new referrals if service provision is not meeting service definition standards. LME's who are expected to monitor for compliance with service definitions have no capacity or authority to stop providers who are exhibiting seriously out-of-compliance issues from accepting new referrals until the provider has implemented an appropriate plan of correction. To allow consumers to seek services from less than competent providers seems antithetical to good consumer care.

Chapter 4

CUSTOMER SERVICE AND CONSUMER AFFAIRS

Mission: Wake County is committed to the highest level of customer satisfaction and service responsiveness.

Purchaser Standards: The Wake County LME follows all applicable local, State and federal rules, laws and mandates, including those found in the Performance Agreement and in Communication Bulletins.

Current Operations: Customer Service is considered to be one of the core values at WCHS. LME staff, like all WCHS staff, have received training in customer service principles as outlined in the staff guide, Wake County Human Services Customer Service Standards And Principles “Promoting Excellence in Human Services.” Staff are also evaluated on customer service at annual performance reviews. Hence, this is the backbone for the LME’s work in customer service.

Customer service and consumer affairs duties are primarily carried out by the LME Quality Management team and the WCHS Consumer Affairs staff.

The Wake County Consumer and Family Advisory Committee (CFAC) was established in 2002 as a committee of the WCHS board. CFAC has been a valued partner in every step of Reform and in the LME’s work. The Wake CFAC recently completed a review of the new statutory changes and developed a new Relational Agreement to meet the requirements of the statute and to re-define its relationship with the LME, the WCHS Board, and the Wake County Board of Commissioners.

Support to Committees: The Consumer Affairs Director meets with the CFAC co-chairs in advance of regularly scheduled meetings to assist with agenda development. Consumer Affairs staff also lend sub-committee support upon request of the CFAC and administrative assistant time to the tasks of taking minutes and meeting preparation. The LME Director and a member of the LME Quality Management Team are regular guests to the CFAC meetings and provide support, data, and information routinely and upon request. Other members of the LME staff are also available to CFAC, consumers and other stakeholders for presentations and consultation regarding evidence-based practices (EBP’s) and clinical practice standards (see marketing plan under Strategic Objectives in Service Management section), access to care, and other requested topics of interest.

The CFAC contributes an independent section to the LME’s quarterly report to the State as well as review/approval of the entire report. CFAC members are routinely included in committee-based work related to changes in policies and procedures. A CFAC member serves on the Mental Health System Transformation EBP grant project, which is developing an educational training curriculum on EBP’s that will be presented to CFAC. Another member contributes to the police Crisis Intervention Team (CIT) training by arranging program site visits for the officers in training. New initiatives such as the start-up of an Integrated Dual Disorders Team or the ongoing conversations about WCHS provided services are presented to CFAC for comment. CFAC weighs in on the County budget process each year. And, the LME Quality Management team uses a consumer survey designed by the CFAC as part of its provider monitoring.

The Wake CFAC has been particularly committed to advocacy throughout the course of Reform. They have published papers, written letters to the LME, County, and State offices, and to the local newspapers. They have found partners in other local advocates—particularly NAMI-Wake. Subjects have ranged from appropriate funding of care to outcomes and performance measures.

The CFAC has expressed interest in revisiting the travel stipends, as well as meeting times. Although extremely well informed and effective, the CFAC has had difficulty recruiting new membership.

Appeals and Grievances, Complaints follow-up: The Quality Management Team is responsible for fulfilling this function and has identified staff that receive, review and investigate complaints. Any and all complaints regarding the provision of public services can be made to this team, with efforts made first to assure that the provider and the consumer have made good faith attempts to informally solve the complaint. The LME Provider Operations Manual explains to providers how complaints are handled and additional information is provided to consumers who enter the system through the LME crisis/triage points. Procedures are in place to protect the identity of the complainant.

The Quality Management Team received complaint investigation training from the Division of MH/DD/SAS Accountability Team to assure that complaint, complaint follow-up, and rights investigations were handled appropriately to ensure health and safety. This team also maintains information and appropriate data concerning all complaints, and reports per Communication Bulletin #056. Further, the Quality Management Team presents data related to complaints, incidents and appeals regularly to the Human Rights Committee. This information, along with the information from incident reporting, informs the LME as to training and quality improvement needs in the community.

The Provider and Community Development Team service directors have disability specific service management expertise. Periodically, they provide technical assistance and a trouble shooting function for other LME teams, providers and families who call with specific concerns related to service access and customer satisfaction. They often respond to callers connected through the Client Rights telephone line.

Consumers who wish to appeal the findings of a complaint investigation may appeal to the Human Rights Committee (HRC) following Communications Bulletin #038 processes. The Human Rights Committee of the Wake County Human Services Board of Directors is comprised of Board members and community members who receive services, or are family members of recipients. The HRC reviews complaints and grievances, and/or conducts its own formal hearings of client grievances. The HRC is staffed by the Consumer Affairs Office

The LME recently implemented a non-Medicaid appeals process, consistent with Communication Bulletin #063. These appeals are handled within the LME UR team by a Clinical Reconsideration Review process.

System navigation and consumer outreach: The LME staff would like to offer a more comprehensive curriculum to the CFAC around Evidence-Based Practices. From there, the

CFAC and LME have committed to working together to develop a “map” of the very complex system which could help other consumers and families access care more easily.

Customer Services/Rights Education and Outreach: Wake County publishes a Your Rights brochure for clients which has been made available in hard copy, or printed from the County’s website, for nearly a decade. The Consumer Affairs Office also publishes and distributes a consumer rights poster in English and Spanish with consumer complaint and concern information. Wake County maintains a consumer rights page on its website with helpful links for consumers, and specific instructions for making complaints.
(<http://www.wakegov.com/humanservices/about/consumer/default.htm>)

Consumer Satisfaction: The Quality Management Team interviews consumers during monitoring events or complaint investigations to assess the quality of services that they are receiving. Currently there is no regular consumer satisfaction study other than the mandated annual State Consumer Survey.

Strategic objectives:

- Field a consumer satisfaction study to assess consumer satisfaction with the **LME** processes.
 - Lead Responsibility: LME Management Team
 - Stakeholder Group: CFAC, LME
 - Target Dates: Develop annual survey for use beginning January 2008
- Review stipend and conference reimbursement, meeting times, other recruitment strategies.
 - Lead Responsibility: Consumer Affairs Director, LME Director and CFAC co-chairs
 - Stakeholder Group: CFAC, other local advocacy groups, governing boards
 - Target Date: July 2007
- Develop and offer a comprehensive curriculum for CFAC members on topics of interest including EB, funding and authorization mechanisms, access to care, etc.
 - Lead Responsibility: LME Management Team
 - Stakeholder Group: CFAC and Consumer Affairs staff
 - Target Dates: Beginning September 2007
- Work with CFAC to develop a visual “map(s)” of the system describing various levels and types of treatment available.
 - Lead Responsibility: LME Director, Consumer Affairs Director, designated CFAC member
 - Stakeholder Group: CFAC, IS staff, Quality Management team, provider community
 - Target date: Complete draft by June 2008
- Develop a Mystery Shopper program. Working with FAC co-chairs to develop a partnership with other advocacy groups such as the MH Consumer’s Organization or Governor’s Advocacy Council for Persons with Disabilities in order to expand the anonymous pool of consumers needed for this project.
 - Lead Responsibility: Consumer Affairs Director and LME Director
 - Stakeholder Group: CFAC, LME team, Providers

- Target Date: Pilot plan by late 2007
- Focus more attention on development of peer support initiatives and recovery-oriented consumer run supports.
 - Lead Responsibility: Provider and Community Development team
 - Stakeholder Group: Participants from current initiatives, CFAC, NAMI-Wake, The ARC of Wake County.
 - Target Dates: Develop plan including resource identification by July 2008
- Develop consumer information packet for all new consumers and create opportunities for public information display (library partnerships, etc.).
 - Lead Responsibility: LME Management Team
 - Stakeholder Group: Current consumers, provider network representation
 - Target Date: July 2008
- PCDT will provide educational presentations and consultation to CFAC, consumers and other stakeholders regarding evidence based practices and clinical practice standards (see marketing plan under Strategic Objectives in Service Management section).

Resource Allocation:

Upon first review, the Consumer Affairs/Customer Services function appears to be under-resourced. In fact, the Quality Management Team performs many of the Customer Service functions as noted above. Some of the resources that might appear to be missing here will show up in the Quality Management chapter.

Consumer Affairs & Customer Services

Cost Model FTEs	Cost Model Expenses	Wake Actual FTES	FTE Variance from Model	Wake Total Expense	Expenditure Variance from Model
4.91	\$ 344,852	1.99	-59%	\$ 132,665	-65%

Business Rules:

The following business rule **enhances** the Wake LME’s efficiency and effectiveness.

Standardization of data collection for complaints. The procedures outlined in Communication Bulletin #058 go a long way toward identifying issues in a consistent and measured way. Having this information for all LME’s will assist in the creation of a provider grading/report card system.

The following business rules **inhibit** the Wake LME’s efficiency and effectiveness.

1. Lack of current information on complaints handled by the NC Division of Facility Services or the NC Division of MH/DD/SAS. Complaints about providers and provision of service are still made regularly to DFS and to the Division. The LME may not be made aware of that complaint until a report is forwarded to the LME with the results from the investigation or perhaps not at all. Both of these systems inhibit the LME from having a complete picture of a provider. Who investigates the complaint is not of concern here, but how information flows to keep DFS, DMH and the LME’s aware of the current

complaints under investigation and the outcome of those investigations is paramount to assuring a community of quality providers.

2. The CFAC has consistently requested data that has been unavailable due to the antiquated systems addressed elsewhere in this document. Lack of data has inhibited the knowledge of providers needed for system mapping.

Chapter 5

SERVICE MANAGEMENT

Mission: The Wake County LME shall conduct various Service Management functions including Care Coordination, Community Collaboration, Utilization Review and all other aspects of Service Management that are both financially feasible and defined in the Performance Contract.

Purchaser Standards: The Wake County LME follows all applicable local, State and federal rules, laws and mandates, including those found in the Performance Agreement and in Communications Bulletins.

Current Operations:

Care Coordination: Care Coordination Teams (child MH/SA, adult MH/SA, and child and adult DD) function within the LME to monitor the effectiveness of person-centered plans, including participation in person-centered plan (PCP) development or modification for high risk and high cost consumers, with the goal of achieving better outcomes or equivalent outcomes that are more cost-effective. Care Coordination team members work directly with providers and consumers, and review PCP's, charts and other client outcome data supplied by service providers for the purpose of monitoring care and filling service gaps when necessary. (Quality Management team staff support the service monitoring effort through site reviews and service record audits.)

Care Coordinators for all age/disability groups ensure effective communication and information exchange within and between organizations, including health care providers, social services providers, and state and county government agencies, resulting in high quality coordinated care and support for individuals with complex needs. Care Coordinators develop and research new resources and provide education to consumers, families, providers, and other professionals. Care Coordination is also responsible for authorizing the utilization of State psychiatric hospital bed days and ADATC resources, assisting with transitions from ICF facilities and state Mental Retardation Centers and is actively involved in discharge planning from these facilities, and management of the CAP-MR/DD waiver waiting list.

Particularly for adult MH and SA consumers, the provider network capacity for rapid response is still limited. The Adult Care Coordination Team currently provides clinical services to clients in need of a service provider, including those clients discharged from the state and private hospitals in need of contact within five working days. Clients in the local jail in need of services are also referred to this team at release for screening/triage/referral, coordination, and interim service provision.

The Geriatric-Adult Specialty Team (funded separately) identifies needs and provides training and technical support to caregivers of clients over the age of 60 and clients under the age of 60 in residential facility settings. The goal is to keep the client in the least restrictive and most desired residential setting.

Utilization Review: The primary focus of Utilization Review (UR) is to ensure that consumers receive authorizations for medically necessary clinical services in a professional, timely, and cost effective manner. The UR Team is committed to connecting consumers with the most effective, medically necessary services available which promote recovery and integrate the consumer's

needs, wants and desires. Utilization Review Care Managers, guided by protocols, promote the concepts of consumer freedom of choice and person-centered planning to community-based service providers.

- A. Services are authorized based on individual need and standardized procedures.
- B. Pre-authorization, concurrent and retrospective reviews, clinical targeted reviews, and research and trend analysis processes are followed to maximize utilization of the most effective, medically necessary services while offering consumer choice.
- C. Utilization Review Care Managers participate in the agency wide effort to educate providers on clinical protocols, best practice guidelines, and standards of care through orientation, ongoing technical assistance and updated provider manuals.

The Wake County Human Services LME Utilization Review team is currently staffed with eight Clinical Care Managers, a Program Director, and psychiatrist time as needed. The UR team receives data support services from the LME Operations team. All UR team members are Master's level clinicians; five of the Care Manager staff are Licensed Clinical Social Workers, and one is State-certified as a Infant, Toddler and Family Specialist. The UR team has elevated its academic requirements over the past year to be more consistent with Medicaid UR standards. By maintaining these higher standards, the LME will be in the position to assume responsibility for Medicaid UR functions in the event that opportunity becomes an available option in the future.

The Utilization Review Team of the Wake County LME is responsible for developing and implementing processes that promote efficacious, cost-effective, and well-coordinated services for each consumer. The core functions of the Utilization Review Department are to:

- Utilize designated criteria for making service authorization decisions for state and county funded services in a time-efficient manner (15-20 minutes for routine services; 30 minutes for specialized services).
- Conduct clinical case reviews to monitor provider clinical performance and adherence to clinical practice guidelines and evidence-based practice standards.
- Provide technical assistance to service providers to ensure the most appropriate level of service utilization.
- Notify Quality Management and/or Care Coordination staff, as necessary, to report inappropriate, inadequate services or unmet service needs.
- Conduct ongoing utilization review activities to monitor overall usage of services and IPRS funds across all covered age and disability populations, while ensuring compliance to the non-Medicaid appeal process as outlined in the Provider Operations Manual.
- Review 100% of PCP's submitted for non-Medicaid funded services, as part of the authorization process, measuring: evidence of person centeredness, quality of plan development, use of evidence-based practices, adequacy of crisis plan, and use of natural and community supports. Deficiencies are documented in UR notes, and reported to QM and/or Care Coordination and the PCDT service director as necessary.

Community Collaboration: The Provider and Community Development Team (PCDT) is responsible for developing and implementing strategies that promote community collaboration within the Wake County Continuum of Care. The Continuum of Care includes consumers, service providers, local & state governmental officials, informal supports, and other key agencies (schools, juvenile & adult justice systems, law enforcement, etc.). PCDT Service Directors, in

collaboration with other key LME staff, provide leadership and active participation in local collaborative efforts that bring together community partners to coordinate and improve services and supports in Wake County.

Key collaborative groups/efforts include:

- A. Child Development Community Policing (CDCP)
- B. Creating Hope and Opportunities In Communities Everywhere (CHOICE)
- C. Crisis Intervention Training (CIT)
- D. Continuous Quality Improvement Provider Meetings (Adult MH/SA CQI, Child MH/SA CQI, DD Directors)
- E. Drug Treatment Court Steering Committees (Adult and Juvenile)
- F. Gang Prevention Partnership (GPP)
- G. Juvenile Crime Prevention Partnership (JCPC)
- H. Mental Health System Transformation (MHST)
- I. Multisystemic Therapy (MST) Workgroup
- J. Treatment Accountability for Safer Communities (TASC)
- K. Wake Community Collaborative for Children and Families (WCCCF)
- L. Wake Community Provider Advisory Committee (CPAC)
- M. Wake Consumers and Family Advisory Committee (CFAC)

Through these collaborations and community initiatives, annual strengths and needs assessments are completed. PCDT Service Directors utilize this information to identify service gaps and needs. Strategic objectives in this section outline plans to better coordinate and develop this strengths and needs assessment process across the Continuum of Care.

Strategic Objectives:

- Develop and implement a marketing plan to increase community awareness of, interest in and contribution to the implementation of evidence-based practices. Plan will include an educational and training curriculum, presentation materials, list of stakeholders, routine training schedule, and identification of resources needed to educate stakeholders initially and to sustain their involvement over time. Provide information to consumers to promote awareness of EBPs when choosing a provider.
 - Lead Responsibility: PCDT
 - Stakeholder Group: Providers, consumers, LME staff
 - Target Dates: April 1, 2007 - ongoing

- Coordinate and develop strengths and needs assessment process across the Continuum of Care in order to assess for gaps and identify recruitment needs.
 - Lead Responsibility: PCDT
 - Stakeholder Group: Consumers, providers, LME staff
 - Target Dates: January 1, 2008 - ongoing

- Develop “benefits packages” that utilize evidence-based and best practice strategies.
 - Lead Responsibility: UR manager, PCDT
 - Stakeholder Group: Consumers, providers, LME staff
 - Target Dates: January 1, 2008 - ongoing

- Use of System of Care (SOC) Quality Improvement forms for child and family team observation and case file review forms related to qualitative review of child and family team process and person centered plans.
 - Lead Responsibility: Child CC team leader, QM manager, SOC Coordinator
 - Stakeholder Group: Providers and Families
 - Target Dates: On-going after May 1, 2007

- Develop and implement marketing strategies for the Wake Community Collaborative for Children and Families to better inform the community of its existence and activities to develop the continuum of services and system of care within Wake County.
 - Lead Responsibility: SOC Coordinator
 - Stakeholder Group: WCCCF, Providers, Families, Community at Large
 - Target Dates: July 1, 2007 – June 30, 2008

- Continue the LME’s successful efforts in working with local law enforcement and the criminal justice partners to establish a Criminal Justice-Mental Health Steering Committee. Map the community’s intersections of the system to identify gaps and needs using the GAINS Center “Sequential Intercept” model.
 - Lead Responsibility: CIT coordinator, LME Director, Wake County Jail MH Liaison
 - Stakeholder Group: DMH Justice Systems team, LME, Wake County Jail, Criminal Justice Planning, Re-Entry services, CIT partnership, DJJDP, DDH forensics, court system
 - Target Date: Begin April 2007.

- Develop Utilization Review criteria for admission, continuing stay and discharge criteria related to the Holly Hill inpatient agreement.
 - Lead Responsibility: UR manager, Chief of Psychiatry
 - Stakeholder Group: CFAC, Care Coordination, Holly Hill, County Board of Commissioners
 - Target Date: 2008

- Develop a more consistent plan of PCP review wherein 10% of Medicaid and 25% of non-Medicaid funded services are reviewed for appropriate components of quality including evidence of person-centeredness and consumer/family involvement, inclusion of natural and community supports, and adequacy of crisis planning.
 - Lead Responsibility: Care Coordination manager, UR manager
 - Stakeholder Group: Consumers, providers, LME staff
 - Target Date: Begin 7/31/07

- Develop a more consistent procedure, either through PCP review or other means, to review high risk/high cost consumer care to ensure the appropriateness of services and supports and to affect changes to the PCP to ensure the use of EBP and cost effective treatment alternatives.
 - Lead Responsibility: Care Coordination manager, UR manager
 - Stakeholder Group: Consumers and families, providers, LME staff
 - Target Dates: Ongoing

- Develop a tracking/notification procedure in order to follow up in 15% of consumers for whom no PCP is received in 45 days following a referral to an enhanced benefits provider in order to assure good referral and communication procedures are in place.
 - Lead Responsibility: Information Technology staff, STR manager, Care Coordination manager
 - Stakeholder Group: Consumers and families, providers, STR team
 - Target Date: December 2007

- Strengthen partnerships with primary care physicians around integrated behavioral health/physical health care for consumers.
 - Lead Responsibility: Chief of Psychiatry, WCHS Medical Director, LME director
 - Stakeholder Group: Local physicians, PCDT, consumers and families
 - Target date: July 2008

Resource Allocation:

There is insignificant variance from the cost model allocation for the Utilization Review portion of Service Management.

UR for State Funded Services

Cost Model FTEs	Cost Model Expenses	Wake Actual FTES	FTE Variance from Model	Wake Total Expense	Expenditure Variance from Model
10.13	\$ 749,498	9.50	-6%	\$ 816,208	9%

In Care Coordination and Community Collaboration, the Wake LME has the most variance from the State’s model. Wake County has invested significantly in the Care Coordination function with a belief that Care Coordinators are the most flexible resource an LME has to provide a variety of safety-net functions. Wake’s share of clients new to the system is very high, related to the tremendous overall population growth of the County. This means that the model’s assumptions do not work for time allotted to plan reviews, discharge planning functions, and ensuring the direct care needed for consumers entering the system who have not yet selected providers. As noted above, Community Collaboration efforts have been high on Wake LME’s success list. However, this has required some dedicated staffing in order to achieve true partnerships and active participation in very wide-based community initiatives.

Service Management

Cost Model FTEs	Cost Model Expenses	Wake Actual FTES	FTE Variance from Model	Wake Total Expense	Expenditure Variance from Model
14.51	\$1,126,842	38.38	165%	\$ 3,878,461	244%

Business Rules:

The following business rule enhances the Wake LME’s efficiency and effectiveness:

Allowing the LME to conduct utilization review of state and county funded services will continue to enhance the effectiveness of the LME because of the LME’s familiarity with the

consumer population and services available in the community, as well as the availability of funding.

The following business rules **inhibit** the Wake LME's efficiency and effectiveness:

1. The absence of Medicaid data makes it extremely difficult to track consumers, particularly those receiving services from multiple providers. Accurate and timely Medicaid data is needed to enable the LME to better coordinate care for consumers.
2. The two-hour limitation on Community Support Services for consumers in many Medicaid funded enhanced services, as stated in the DHHS service definitions approved by CMS, can interfere with the coordination and effectiveness of treatment.

Chapter 6
QUALITY MANAGEMENT

Mission: To ensure continually improving, effective, and high quality best-practice based services through an on-going process that defines outcomes and accountability.

Purchaser Standards: The Wake County LME follows all applicable local, State and federal rules, laws and mandates, including those found in the Performance Agreement and in Communications Bulletins.

Current Operations: The responsibility of using Continuous Quality Improvement processes to regularly evaluate and plan is shared among all of the Wake LME teams. The information within the multiple external and internal reports, service patterns and community information must be reviewed to assure that the same information and data is disseminated and used by all in a focused manner that reflects the mission and values of the LME. The Provider and Community Development Team (PCDT) is responsible for the overall evaluation of the provider community and ultimately the consumer outcomes for the broader Continuum of Care. PCDT Service Directors identify performance measures and desired outcomes and provide technical assistance regarding the use of evidence- based practices and outcomes.

Ultimately, all data, whether from quality improvement or quality assurance processes, can be used to provide a comprehensive picture of the Wake provider community. This, in turn, will present consumers with the necessary information to make informed choices about services.

Data Analysis and Reports:

DMHDDSAS Compliance Reports:

Data from the following groups and /or reports are collected, analyzed and utilized to evaluate quality of services, outcomes, trends in service delivery, fidelity to EBP models, penetration rates and review of processes: NC-TOPPS, DD COI, Service Utilization Patterns (IPRS, Hospital Utilization data including SOS BDU Reports, Crisis Utilization), NCTOPPS (specific to Evidence Based Practices), Adult MH/SA CQI Quarterly Meetings, Child MH/SA CQI Quarterly Meetings, DD Directors Meetings, MH/DD/SA Community Systems Progress Indicators.

Trend Analysis:

Information regarding provider performance, which includes not only complaint and performance data but also incident reporting, is used to inform the LME on contracting with providers and will in the future be used to provide consumers with more information to assist them in choosing the appropriate providers.

Consumer complaints, client rights and outcomes:

The Quality Management Team is responsible for collecting, analyzing and reviewing information related to all complaints surrounding MH/DD/SA Services as well as complaints pertaining to the LME. Following Communication Bulletin #56, the Quality Management Team collects complaint information and reports quarterly per requirements. Complaint information is also presented quarterly to the Human Rights Committee of the Board, which also responds to appeals by consumers concerning disputes related to complaint resolution. Complaint information is used as part of the

provider data in order to assess a provider's level of performance. Trends and patterns related to complaints are carefully reviewed and decisions regarding responses are made; for instance, risk-monitoring events may come out of complaint data.

Provider audits, performance and satisfaction:

The Quality Management team maintains statistical data from provider monitoring and audits in order to assess training needs for the provider community as well as to provide benchmarks for Provider competency. This information is also used to determine frequency and focus of monitoring events. The LME meets the State's requirement for participation in the annual Consumer Satisfaction Survey. Consumer satisfaction is also collected during monitoring events and merged with other data to assist baseline database development for informed consumer choice.

Evidence-Based/Promising Practices:

The PCDT is responsible for expanding availability of evidence-based practices and evaluating current capacity and accessibility of these services. The PCDT and QM Teams monitor quality of care, outcomes data, and model fidelity and ensure that this information is used to improve quality of care.

Internal LME Operations:

The LME Management Team, comprised of leadership from all LME areas, is responsible for review of internal LME Operations, resources and trends, including management of state funds, state facility use, continuity of care from state-operated facilities, LME care management effectiveness of high-risk consumers, and adherence to Access/STR standards. The management team meets weekly to review and respond to trends, data and other information in these areas. Additional details about management of state funds are included in the "Business Management, Claims Processing and Information Management" section.

Quality Improvement:

Quality Improvement as well as quality assurance is a process that ensures the provision of quality services and safeguard health, safety and rights.

The LME QI process provides a broad and consistent framework for:

- Monitoring, improvement and innovation activities
- Alignment of strategies with the mission and principles
- Communicating our policy on quality to all stakeholders

The following activities are a part of the LME QI process:

Developing surveys and studies including EBP and Promising Practices:

The PCDT works closely with providers, consumers and stakeholders to assess community needs, service gaps, capacity and awareness with respect to EBPs. PCDT service directors, in collaboration with CPAC, convene quarterly CQI meetings, during which survey and outcomes data for EBPs can be reviewed.

QI studies of LME Operations and Functions: Throughout the year opportunities for QI activities abound. However, the strategic objectives of the LME lend themselves best to directing QI studies. In the past, using gap analysis to identify provider capacity and to

ensure the expansion of EBP led the LME to two meaningful QI studies surrounding Multi-Systemic Therapy and Integrated Dual Disorder Treatment programs. The Quality Management Team provides QI “coaches” to all projects in order to provide a structure and expertise to those fielding a QI project.

Community Provider Network QI Studies: Before review occurs, providers receive training from the LME on the QI process and have the opportunity to attend quarterly QI meetings hosted by the Provider Community Development Team. The LME encourages collaboration among providers on QI projects that can inform and enhance the entire provider network.

LME Process Improvements: Internal LME process improvements are developed and evaluated in weekly LME Management meetings as well as bi-monthly LME All-Staff meetings. LME staff also solicit feedback both internally and from stakeholders through surveys, focus group discussions, and shared meetings such as CPAC and quarterly CQI meetings.

Risk Management assessment: using trend analysis data to assess indicators that serve as a potential risk to LME:

Risk management assessment of the provider community through review of not only insurance and financial data but also data from incident reporting complaints and monitoring allows the LME to see a composite picture of a provider. Information from DFS and other LME’s is also used when available. Per procedures in our Provider Operations manual, Section VI.9, if a provider poses a serious risk to the health, safety, welfare or continuity of care to consumers, an email recommending the suspension of referrals will be sent to all LME’s statewide, the Wake provider community, CFAC, Value Options, DFS, DMH, Social Services, the Wake County Manager’s office, among others, to reduce the risk of new consumers being introduced into a potentially unstable setting. If the LME deems the risk to be imminent, the Care Coordination team will contact the parent/guardian or individuals currently affected to alert them to the situation and to allow them an opportunity to exercise their right to choose another provider. The LME will also assure that the appropriate regulatory and oversight agencies have been given the information regarding the risk as the LME has no authority to stop a provider from continuing to serve consumers.

Quality Assurance:

The following Quality Assurance data is collected and analyzed primarily by the Quality Management Team.

Audit coordination and compliance of 122-C Licensed Providers and endorsed service Providers:

As noted in section #3, the Quality Management Team monitors Category A and B providers for compliance with the 122-C licensure rules as well as auditing endorsed providers for compliance with service definitions. Information on the endorsement process and quality monitoring can be found in Chapter #3 of the Provider Relations and Development Chapter.

In order to create the least disruption to services, the Quality Management team completes compliance auditing, quality monitoring and endorsement review at one time

whenever possible. All providers are reviewed for compliance with State and Federal laws including, but not limited to, HIPAA practices and confidentiality rules such as 42 CFR, part 2. Further, service analysts provide audits to assure billing standards such as whether a service note is consistent with the billed service.

Incident Reviews and Reporting:

The Quality Management team receives, reviews, analyzes, responds to and reports on Incidents. Under the supervision of the Chief of Psychiatry, a monthly meeting occurs for review and an expanded group meets quarterly to review the quarterly report sent to the State as well as an extensive narrative report prepared for the committee. From these meetings come recommendations for provider training possibilities to reduce incidents. The Quarterly report to the State is also reviewed and discussed quarterly in the Human Rights Committee. More formal structures are in place for Level III incidents to assure that Providers are reviewing these incidents appropriately.

Provider compliance to incident reporting is tracked - provider response to incidents is an important part of provider performance. The Quality Management team provides training on how to report incidents and technical assistance on how to reduce incidents.

Review Complaints on provision of services:

The Quality Management Team is responsible for collecting, analyzing and reviewing information related to all complaints surrounding MH/DD/SAS services, as well as complaints pertaining to the LME. Following Communication Bulletin #56, the Quality Management Team collects complaint information and reports quarterly per requirements. This information is also shared with the Human Rights Committee, which is available to hear consumer appeals to service provision complaint resolution. Service providers may appeal decisions to the LME Director and ultimately to the NC Division of MH/DD/SAS.

Technical Assistance on Quality issues including implementation of EBPs:

The PCDT provides technical assistance to providers to assist in the implementation, maintenance, and continuous improvement of EBPs. The PCDT and QM teams also collaborate on the use of monitoring, fidelity review, and outcomes data in assuring and improving the quality of EBPs.

Strategic Objectives:

- Development of a fully functioning CQI Advisory Committee. This committee will utilize a comprehensive approach to assess satisfactory outcomes in services and business practices from the external and internal customers. At a quarterly meeting members will review and analyze data to continuously inform and improve the service delivery system.
 - Lead Responsibility: LME Director, QM manager
 - Stakeholder Group: LME, CPAC, CFAC, Community Partners
 - Target Dates: July 1, 2007 and ongoing

- Development and implementation of a Provider Satisfaction Survey. It is imperative to assess the needs of current providers in order to enhance service delivery. There are many avenues to assess consumer satisfaction but very few related to providers. Since most interaction between providers and an LME is based on rules, regulations and statutes, it is

important to discover from the provider’s point of view how they relate to the LME. A semi annual survey will be fielded with results being reviewed by the aforementioned QI Advisory Committee.

- Lead Responsibility: QI Advisory committee
 - Stakeholder Group: Providers, CPAC, all LME teams
 - Target Dates: July 1, 2007 – ongoing
- Implement a monitoring plan for evidence-based practices, including monitoring of capacity, access, outcomes and fidelity.
 - Lead Responsibility: New EBP coordinator
 - Stakeholder Group: Providers, LME staff
 - Target Dates: April 1, 2007 – ongoing
 - Develop and implement routine review of outcomes data through a CQI process.
 - Lead Responsibility: PCDT, QM manager
 - Stakeholder Group: Providers, consumers, LME staff, IT staff
 - Target Dates: April 1, 2007 - ongoing
 - Monthly report of residential treatment utilization within Wake County.
 - Lead Responsibility: QMT staff, PCDT, IT staff
 - Stakeholder Group: Providers
 - Target Dates: July 1, 2007 – June 30, 2008
 - Increase the submission of NC TOPPS initial assessments and updates to provide an adequate sample for review of data.
 - Lead Responsibility: QMT staff, PCDT
 - Stakeholder Group: Providers, consumers
 - Target Dates: April 1, 2007 – June 30, 2008
 - Develop quality assurance mechanisms to assure quality of care at Holly Hill Hospital as related to new indigent care MOA.
 - Lead Responsibility: LME Director, Chief of Psychiatry, WCHS Board Chair
 - Stakeholder Group: CFAC, WCHS Board, Holly Hill Hospital
 - Target Dates: Begin April 2007

Resource Allocation:

The Quality Management Team is approximately 3 times the size the State funds via the cost model. As noted in Chapter 1 Wake also has approximately 3 times the number of contracted providers than the model assumes. As noted in Chapter 4, The Quality Management Team also picks up some of the Customer Services function.

Quality Improvement & Outcomes

Cost Model FTEs	Cost Model Expenses	Wake Actual FTES	FTE Variance from Model	Wake Total Expense	Expenditure Variance from Model
4.50	\$ 316,630	12.00	167%	\$ 1,032,595	226%

Business Rules:

The following business rule **enhances** the Wake LME's efficiency and effectiveness:

Current focus on standardizing processes such as complaint and incident reporting. Consumers, LME's and providers will benefit from the focus on collecting and reporting standardized information. The current method LME's use to report QI projects translates well to the provider community. Increased focus on standardized outcome measures will assist in the creation of a meaningful Provider Profile and grading system.

The following business rules **inhibit** the Wake LME's efficiency and effectiveness:

1. The LME is held accountable for data reporting and other compliance activities by providers. Currently, several LME performance measures are dependent on provider compliance, which includes the submission on NC-TOPPS outcome data. Two factors work in opposition to an LME meeting this requirement. The information gap between Value Options and an LME inhibit tracking consumers whose services need no authorization by the LME and have entered the system through a provider "door." This inhibits the LME's ability to identify and intervene with non-reporting providers. Even if an LME could identify the non-reporting providers, there is little leverage to effect a change. LME's need the information about where their consumers are being served, particularly for consumers receiving multiple services, otherwise the LME is unable to assess for consumer outcomes using trends.
2. The State Consumer Satisfaction Study is not available in a timely manner to LME's. Information from this study (another instance in which the LME is held responsible for provider compliance) is not easily or readily available to the LME or to providers, which makes the importance of this process suspect. If LME's and providers are to complete these surveys under a very specific time schedule then it would behoove the State to follow suit.
3. Lack of a standardized provider rating system. Given the enormous amount of data available, it is imperative that there be standardized measures statewide to best grade providers. The information that is available does not assist consumers in choosing providers and does not assist providers in assessing their performance and their need to make improvements.

Chapter 7

ACCESS, SCREENING, TRIAGE AND REFERRAL

Mission: The goal of this service is to serve as the gateway for all MH/DD/SA consumers to enter into services within the Wake County catchment area in a manner that offers prompt access, informed choice, and coordination of services and benefits.

Purchaser Standards: The Wake County LME follows all applicable local, State and federal rules, laws and mandates, including those found in the Performance Agreement and in Communication Bulletins.

Current Operations:

The Access, Screening, Triage, and Referral (STR) LME functions are integrated with a 24/7/365 outpatient walk-in crisis service for all age/disability groups, Crisis and Assessment Services (CAS), that also provides emergent assessments including involuntary commitment evaluation, urgent appointments for new consumers, and routine assessments plus initial authorization and eligibility determination for non-Medicaid eligible consumers. In addition, urgent short-term treatment services to prevent hospitalization and support community stabilization are offered, including psychiatric evaluation and medication management for both mental health and substance abuse consumers. CAS also serves as the hub of response for community disaster events and has extensive experience in providing lead staffing to disaster events as well as coordinating with other disaster response volunteer agencies. Developmental Disability (DD) consumers may also access services through the DD single portal system.

Services above and beyond the STR functions are financed with local funding and small collections of Medicaid BHO revenues.

STR: CAS has been in operation since 1992, providing STR services 24/7/365. Brief telephone and face-to-face screening, triage and referral functions are provided. Consumers are given the opportunity to make an informed choice of service provider(s) based on the initial determination of need. CAS also provides technical assistance to those service providers who offer direct entry to services in order to maintain the uniformity of the process of accessing care within Wake County.

Trained mental health professionals answer the telephone within the designated time frames established by the State. The current telephone system is set up with a rollover feature where after three rings the call automatically goes to an 8 line system.

CAS maintains a 24/7/365 Access line with trained, competent staff available at all hours. The Access line is toll-free for all persons in the Wake LME catchment area and is published in several places throughout the phone book including under the emergency section inside the front cover. It is also posted on the Wake County LME website, published in brochures and in other essential places.

TTY language interpretation is offered as per Title VI guidelines. Standard Practices for Interpreting in Mental Health Settings established by the Registry Of Interpreters For The Deaf, Inc., is posted in our policy and procedural manual as well as clear procedures for when deaf or hard-of- hearing consumers present to CAS.

Consumers in need of urgent care have immediate access to services at CAS, or they are given an appointment option to have face-to-face service within 48 hours of requested care. Individuals in need of urgent care may choose to receive a referral to a private provider or agency of their choice. Individuals who are determined eligible for services are referred to the provider network. Providers are expected to make further determination of the individual's need for services as published in the LME Provider Operations Manual. Acceptance of a referral by an agency is an indicator the consumer meets admission criteria and the provider has capacity to initiate treatment. Should a consumer be denied service, specific reasons for denial must be given and other consumer choice options explored.

Access to services includes the provision of a consumer choice list of enrolled Medicaid and IPRS funded providers to all consumers seeking services. Service type and age group served identifies providers on the list. Quality of access to care can vary from provider to provider based on appointment availability as determined by the provider and population served.

Because of the co-location of STR with 24/7 Crisis Services, consumers in need of emergent care have immediate access to services at CAS. Triage clinicians have access to professionals of all types, including psychiatry for 14 hours/day and psychology 24 hours/day, to assist with evaluation and disposition.

Registration Management: The Data Support Team supervised by the LME Operations Manager is currently doing registration management for all providers.

CDW form completion: CDW completion has been a challenge due to technology issues described elsewhere, but is done.

Follow-up on providers' delivery of PCP compliance: See Strategic Objective in Service Management chapter.

The current information technology system, as noted earlier in this Plan, has been limiting the LME's capability to perform several critical STR functions well including follow-up on referrals to providers as well as to other community resources, full Client Data Warehouse (CDW) reporting requirements, accurate STR tracking/reporting, and access/management of crisis plans. Manual processes and awkward database interfaces are time consuming and inefficient. With a volume of more than 8000 face-to-face client visits per year and a phone volume of many more events, new technology is critical.

Crisis Plans/ "First Responder":

Currently, providers prepare "hot sheets," consumer crisis plans which serve as information for emergencies. These plans are stored in the CAS triage area for ready access when a consumer calls or visits.

The "First Responder" duties of enhanced benefits providers are of concern. CAS works with all referring providers on appropriate roles. Nevertheless, systemic training on the "First Responder" role is needed. (Please also refer to March 1, 2007 Wake LME Crisis Plan document for extended discussion, plan, and objectives related to this need.)

Recommendations for modifications to crisis plans: CAS staff contacts providers directly with appropriate feedback or recommendations concerning the crisis plan should the consumer phone or visit CAS for services in crisis. The information is also communicated to Care Coordination should a closer look at the consumer's services appear necessary. (Please reference Strategic Objective in Service Management chapter.) In cases where a trend with a particular provider's referrals for crisis services exceeds expectations, the CAS manager notifies the Quality Management Team and the appropriate service director on the Provider and Community Development Team (PCDT) so technical assistance may be arranged with the provider.

Care Coordination follow-up for new consumers. CAS routinely links new consumers to Care Coordination for monitoring and linking to the provider system.

Strategic Objectives:

- See Automation Strategic Objectives in Chapter 2 and Chapter 3.
- Refer to previously submitted Wake LME Crisis Plan.
- Provide quarterly report of providers who send consumers to CAS without their "First Responder" requirement upon the creation of a sufficient database to monitor "First Responder" requirements. Provide broad training soon, more focused training after reporting mechanism is in place.
 - Lead Responsibility: CAS Management Team
 - Stakeholder Group: CAS, Quality Management Team, PCDT
 - Target Dates: June 2008
- Improve timely access to care for routine entrance to services. Work with provider network on capacity issues, barriers to care that prevent timely admission, overuse of CAS treatment services, and extended use of Care Coordination for new consumers.
 - Lead responsibility: CAS manager plus PCDT service directors.
 - Stakeholder Group: CPAC, provider focus groups
 - Target Dates: Ongoing
- Improve the participation of the provider network in disaster response events by offering training and coordination in preparation activities. Assure behavioral health disaster response is well linked to the Human Services Disaster Response planning process.
 - Lead responsibility: LME Director, CAS and Care Coordination managers.
 - Stakeholder Group: Provider network, other local responder groups, DHHS disaster response network and DMH coordinator, WCHS and County Emergency Management offices.
 - Begin work July 1, 2007

Resource Allocation:

There is insignificant variance from the cost model in the ASTR function.

Access, Screening, Triage, & Referral

Cost Model FTEs	Cost Model Expenses	Wake Actual FTES	FTE Variance from Model	Wake Total Expense	Expenditure Variance from Model
32.60	\$2,376,171	31.30	-4%	\$ 2,637,807	11%

Business Rules:

The following business rule **enhances** the Wake LME’s efficiency and effectiveness:

CAS maintains effective daily/weekly personal communication with providers and the rest of the LME Management Team in order to have current information about decisions to no longer accept referrals, the type of services provided, waiting lists, availability of appointments and any rule changes surrounding access to care.

The following business rule **inhibits** the Wake LME’s efficiency and effectiveness:

Business rules previously addressed regarding lack of Medicaid and other consumer data availability also affect STR functions.

Wake County Human Services
 Ten-Year Strategic Plan

Goal 1

WCHS will ensure that every individual, family and community will have the opportunity to meet their basic needs and to thrive

Engage community partners to increase the supply of safe, affordable and stable housing

Realign resources with priorities identified by the community and provide services required by federal and state laws.

Collaborate with partners to assure Wake County's physical health, mental health, substance abuse and developmental disabilities services meet the community's needs

Promote family safety and decrease the occurrence of violence

Promote youth safety and decrease the occurrence of youth violence

Prepare for and respond to natural and man-made disasters

Goal 3

WCHS and community partners will anticipate and respond to threats to public health and safety

Goal 2

WCHS will eliminate differences based on race and ethnicity in public health, behavioral health, economic and social outcomes

Increase public and staff awareness of the causes of racial and ethnic disparities in outcomes

Redesign business practices and service delivery to achieve equitable outcomes

Engage private industry, government, community and faith-based partners to create initiatives and realign policies to eliminate racial and ethnic disparities in outcomes

Equip staff and community partners to effectively collect, analyze and use data

Work with community partners to identify the needs of the community and gaps in services that provide basic needs

Shift resources to community partners who effectively use evidence-based strategies

Goal 4

WCHS will make decisions for improved outcomes based on the effective use of data

KEY

Goals

Strategies

Wake LME Local Business Plan 2007 - 2010

LME function	Per Cost Model Organizational Structure	Per LME Structure	Page # of Wake LBP
CEO	General Governance	LME Mgmt. Team	6
Board support and expense	General Governance	WCHS	6
Policy analysis	General Governance	LME Mgmt/WCHS Bd.	7
Human Resources	Business Management	WCHS Ops & WC HR	13
Accounting/Budget/Payroll	Business Management	LME & WCHS & WC	12-13
Financial Reporting	Business Management	WCHS Ops & WC	13
Claims processing, billing, payment	Claims Processing	LME & WCHS Ops	12-13
CDW and IPRS reporting	IT	LME & WCHS Ops	13
Provider Endorsement and Monitoring	Provider Relations	LME QM	16
Provider recruiting and contracting	Provider Relations	LME QM, PCDT, & WCHS Ops	18-19
Provider technical assistance	Provider Relations	LME QM, PCDT	17-18
Handling Provider complaints	Provider Relations	LME QM	19
24/7/365 Access, STR	STR	LME STR	39-40
Consumer registration	STR	LME Ops	40
Person Centered plan reviews	Service Management	LME UR & CC	27-28
State funded service authorization	Service Management	LME UR	27-28
Maintenance of waiting list for CAP- MR/DD Waiver	Service Management	LME CC	27
Care Coordination	Service Management	LME CC	27
Community Collaboration	Service Management	LME PCDT	28-29
System of Care and other interagency coordination and collaboration	Service Management	LME PCDT	28-29
Education to general public and activities to address stigma	Service Management	LME Mgmt. Team	28-30
Consumer appeals and grievances	Customer Service	LME QM & WCHS Consumer Rights	23, 33
CFAC staff and expenses	Customer Service	LME director & WCHS Consumer Rights	22-23
Consumer education and outreach	Customer Service	LME PCDT, QM, WCHS Cons Rights	23-24
Internal data analysis and reporting	Quality Management	LME QM, Ops, WC IT	33
Critical Incident reporting	Quality Management	LME QM	36
Quality Improvement studies	Quality Management	LME QM, PCDT	34-35

