

VANCE, GRANVILLE, FRANKLIN, WARREN

LOCAL MANAGEMENT ENTITY

LOCAL BUSINESS PLAN

EXECUTIVE SUMMARY

March 6, 2003

Excellence by Choice

INTRODUCTION

The 2000 North Carolina General Assembly created the **Joint Legislative Oversight Committee** consisting of eight (8) members of the House and eight (8) members of the Senate. This Committee was directed to develop a Plan for Mental Health system reform with the intent that the Plan be fully implemented by January 1, 2005. This directive resulted in the reform of North Carolina General Statutes Chapter 122c “Mental Health, Developmental Disabilities and Substance Abuse Act of 1985”. The new statutes were approved by both chambers of the General Assembly and were enacted into law by Governor Easley in October of 2001 with an effective date of July 1, 2002.

Chapter 122c directs the Department of Health and Human Services to develop and implement a State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services with the Secretary responsible for overseeing the development of such a plan. The outcome was the State Plan 2001: Blueprint for Change that has now undergone an annual revision resulting in the **State Plan 2002: Blueprint for Change**. This document may be viewed by visiting the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SA) web site.

The reform plan is based on citizens receiving treatment appropriate to their needs that are accessible and timely, consumer-driven, outcome oriented, cost effective and reflective of best practices. Emphasis is placed on community-based services, less reliance on state institutions, separation between the service delivery function and the management function and reduction in administrative costs that would be redistributed to the service system. Specifically, the local mental health center that the community has known for over thirty years (30) as a provider of mental health, developmental disability and substance abuse services will become the manager of the public system and the public dollar. Direct services will be provided by other for profit or not for profit entities under a contract. By January 1, 2007 there will be a reduction in the number of community mental health centers from the current number of thirty-eight (38) to no more than twenty (20) organizations called **local management entities** (LME). The plan requires each LME to have a set of **core services** available to all citizens of the geographic area. These include screening, assessment, consultation, education, universal prevention, emergency triage, care coordination and service coordination.

As required by Chapter 122c-115.2, “every county, through an Area Authority or county program, shall provide for the development, review and approval of a **business plan** for the management and delivery of mental health, developmental disabilities and substance abuse services”. This section further requires that business plans provide a specific description of how the core administrative functions of planning, service management, financial management, service monitoring and oversight, evaluation, collaboration and access will be carried out. Additionally the local business plan must be in congruence with the mission, vision and guiding principles of the Division of MH/DD/SA Services. The majority of the plan is due to the Secretary by January 1, 2003 with the remainder due to the Secretary April 1, 2003.

VGFW, its Board of Directors, county managers and county commissioners made the

decision to move forward with reform and to become a participant in phase one of the transition to a local management entity. As part of this decision each set of county commissioners passed resolutions determining that the existing four counties would make-up the new entity and that the existing area authority would be responsible for the new management functions. Area Authority management was given the task of developing the local business plan for the four county area. The Area Authority initially developed eight (8) project teams, one for each of the specific areas required in the plan. After it became apparent that there was much overlap across several of these project teams the number was reduced to six (6). Each team initially consisted only of VGFW staff but later consumers, family members of consumers and representatives of various community agencies were added to each team. Approximately twenty-five consumers, family members and agency representatives have subsequently been added to these teams. Each team had the assignment of developing the specific information for our area that would be in compliance with Chapter 122c and the State Plan 2002: Blueprint for Change.

The following is a summary of each of the areas required in the **local business plan** (LBP). The LBP may be viewed in its entirety at any of the four VGFW Clinic sites, at each of the four County Managers office or at the VGFW web page. Comments may be provided to the Area Authority through an e-mail, fax, letter or personal telephone call to Valerie Keraga. The phone number is 252-430-1330, fax is 252-430-0909 and e-mail address is vkeraga@vgfw.ncmh.org.

I. PLANNING

Planning started with VGFW meeting with the four county managers and the four county commissioners who serve on the Area Board to discuss strategy and make decisions regarding the development of the local business plan. From those meetings the group made specific decisions regarding the counties involvement in the plan and formulated recommendations regarding those issues on which each county must make its own decisions. This group continues to meet on a regular basis to review local business plan status and to discuss any further issues that have surfaced.

As part of the planning process, VGFW also developed a **Consumer & Family Advisory Committee** (CFAC) whose purpose is to review and provide advice regarding the local business plan, to provide recommendations regarding service eligibility and service array, to monitor the implementation of the local business plan, to educate local officials and advocate for funding, to review and provide advice regarding outcome data collection and tracking, to monitor quality improvement activities and to ensure consumer and family participation in quality improvement projects. VGFW initially gathered participants for this group from recommendations from staff, from local newspaper articles and from invitations to those persons who attended community forums. A total of approximately thirty individuals volunteered to participate and the group has now had two meetings where they were given information regarding the State Plan for Change and the purpose of the Committee. The group has now elected officers, has reviewed the local business plan and has provided a report on the planning and collaboration process. The long-term projection is for this group to be represented on a

broader community collaborative group that would coordinate the various disability specific collaboratives.

VGFW developed a **Planning Committee** consisting of VGFW staff, consumers, family members and community agency representatives. The group conducted a review of the strengths and weaknesses of the current system, developed a policy regarding the establishment of a Consumer & Family Advisory Committee and defined the mission, vision and values of the local management entity (LME). In conjunction with VGFW management, the planning committee has conducted a needs assessment to determine currently existing service gaps in the community and to formulate a three (3) year strategic plan describing how VGFW will move from its present role to the role of being a local management entity.

VGFW conducted a series of forums with the intent of educating staff, community agencies and the general public regarding mental health reform. We first provided in-service training to staff to explain the new system and to provide clarification and procedural answers.

Following these efforts VGFW held four community agency forums, one in each county. These forums were intended to reach staff from other agencies, independent practitioners and family physicians. Flyers were sent out to various agencies and individuals requesting their attendance.

Step three was a series of community forums held in each county for the general public. A public announcement was placed in one newspaper in each county, flyers were placed in strategic locations, and announcements were made on local radio stations to encourage attendance. At each of the forums we provided education about the reform plan, asked for volunteers to participate on the Consumer and Family Advisory Committee and gained information relative to the needs assessment.

VGFW staff has also made an effort to further educate others by providing an overview of the State Plan to civic groups, to local juvenile justice partnership boards and any other group that express a desire to gain information about the reform.

The Consumer & Family Advisory Committee developed a separate report regarding the local business plan and the process.

II. GOVERNANCE, MANAGEMENT AND ADMINISTRATION

Each of the counties participating in the LME passed resolutions deciding the governance structure would be an Area Authority model and the geographic area to be covered would be the counties of Vance, Granville, Franklin and Warren. The governing Board of Directors of the LME will be an advisory body and members will be chosen per the requirements contained in Chapter 122c-118.1.

Chapter 122c-115.1 requires local management entities to have a targeted minimum population of 200,000 or a targeted minimum number of five counties served by the

program. If the existing structure does not meet these requirements, it must demonstrate efforts at consolidating with other counties/programs and/or of sharing resources with the effect of reducing administrative costs. VGFW has contacted the following programs to determine their interest in consolidation: Halifax, Edgecombe-Nash, Roanoke-Chowan, Durham and Orange-Person-Chatham. At this point in time none of these entities have expressed an interest in consolidation with VGFW.

VGFW has also contacted several programs regarding their interest in sharing administrative costs. VGFW, O-P-C, Alamance-Caswell and Rockingham have subsequently formed the North Central Consortium to study the feasibility of sharing resources and costs across multiple programs.

VGFW has developed a new organizational structure for the local management entity based on the functional areas of quality management, finance, administrative support and planning, care management, case management, core services and information management.

III. QUALIFIED PROVIDER NETWORK

The VGFW Local Management Entity (LME) will be responsible for the management and coordination of an array of services that will be provided by private providers on a contractual basis.

Potential providers, who want to provide a specific service, will submit an application with additional information regarding their credentials, experience, treatment models, etc., to the LME as part of the recruitment process. The LME, accompanied by consumer and community partner representatives, will review all applicants through a standard selection process, which will include an on-site review of providers' facilities as applicable. All qualified providers will be selected to join the LME's network of service providers. The **provider network** will be developed to assure that the service array is sufficient to meet the needs of consumers and to allow for choice of the service provider. Network providers will receive orientation and training from the LME on network policies and procedures, as well as applicable State and Federal regulations and rules.

The VGFW LME will monitor providers through several methods. One method will be to set performance standards; such as, the expectation that best clinical practices shall be utilized to promote quality of care or that consumer satisfaction rates shall be 90% or greater. As follow up monitoring, the LME will conduct monthly reviews of providers to ensure the set performance standards are being met. Upon each visit, case managers will perform quality of care monitoring reviews with consumers. LME staff will conduct annual monitoring reviews to assess continued best practice usage and compliance with performance standards. Other monitoring measures will include summarizing each provider's monthly performance standards and issuing the results in quarterly provider report cards. If report cards show that a provider's performance standards are not being met, the provider will be required to submit a plan of corrective action outlining goals for improvement. If a pattern of unacceptable performance

continues to be noted, the provider's contract with the VGFW LME will be cancelled. Providers may utilize the Provider Dispute Resolution Policy and Procedure in appealing any decision by the LME in which the provider is not in agreement.

IV. SERVICE MANAGEMENT

The LME must ensure that **core service functions** are available to all citizens of the four counties and are delivered in a timely and responsive manner. The core service areas are screening, assessment, emergency/crisis, education, and consultation and universal prevention.

When a consumer needs help for a mental health, developmental disability, or substance abuse problem, they may seek help through one of our many informational "**points of referral**", such as, Department of Public Instruction, Juvenile Justice, Department of Social Services, or Health Department. These "points of referral" will assist the individual in accessing the mental health system. The LME also can be accessed directly via its toll free number at 1-877-619-3761. This information is available from a variety of different sources and locations, for example: newspapers, yellow pages, churches, medical facilities, as well as other non-governmental offices. The number will connect the consumer to a professional counselor, any day of the week, 24 hours a day. If the consumer prefers, he/she can come to a designated LME site, in any of the four counties for a face-to-face contact.

Whether the contact with the LME is by phone or face to face, the process typically will begin with a screening. A **screening** will allow the counselor to do a brief assessment of the consumer's needs. The screening will result in either a more thorough and comprehensive assessment or a referral to other community resources, such as, community support groups, faith-based initiatives, senior citizens center, or Department of Social Services.

The **assessment** will determine whether the individual is in need of MH/DD/SA treatment. A person-centered planning process will begin whereby the individual determines the service array and the service provider. The individual will be given a brief description about each provider to assist in making an informed decision. The fact that all contract providers are licensed and are actively monitored by the LME to ensure that best practice standards are applied will be included in the description. The LME shall develop an adequate network of providers to ensure the capacity is available to meet the demand for services.

The LME shall have a system for **authorization of services** in order to accurately determine that specified services are needed and to evaluate the consumer's progress in meeting the goals set forth in the person-centered planning process. Treatment will continue to be examined at specific intervals to assess movement within the person-centered plan. The process of looking at clinical quality and outcomes is critical in order to make sure that the consumer's needs are being appropriately addressed.

Case management will be extremely valuable for the consumer when multiple care providers are involved and when the consumer needs assistance in planning and coordinating day-to-day functions. With the current emphasis on treating and responding to the most severely disturbed individuals, the LME expects to see more consumers who could be assisted through case management.

In some instances, consumers may call-in or present as being in acute distress and there is concern of imminent dangerousness to self or others. In these situations, the consumer will be immediately referred to the LME's emergency triage service team, comprised of private contractors and LME employees, within the consumer's respective county. This team will be comprised of highly skilled clinicians who have the clinical training, judgment, and experience to be able to quickly, thoughtfully, and purposely respond to any kind of emergency situation, ranging from natural disasters, dangerousness to self, or threatening to harm others. If the individual's mental and/or physical condition precludes him/her from being able to access our emergency/triage services, law enforcement and/or local rescue teams will be immediately notified.

Although the LME has a responsibility for managing and ensuring that the necessary MH/DD/SA services are readily available to our communities, it also has an active role as a consultant and educator to other agencies and provider systems. Through this role, the LME will teach people about mental illness and how it can be more responsive to the needs of these individuals. The LME will work with communities to identify gaps in the human service field and how to more effectively plan, develop, and implement services for individuals who suffer from mental illness. The utilization of natural supports, in conjunction with the promotion of healthy living standards will be stressed by the LME.

The LME shall also develop a community education plan geared at informing the general public about MH/DD/SA issues. Universal prevention activities will be developed which will have the goal of improving the mental health of the community at large and of preventing more serious mental health issues in the future.

V. ACCESS TO CARE

The LME's **uniform portal system** shall ensure that consumers and families will have the ability to access MH/DD/SA services through a standardized process. There will be multiple points of entry into the LME system for consumers throughout the service area. This may be accomplished through a contact with either a point of referral or directly with the LME's point of screening. A **point of referral** is defined as a community agency/resource that will have knowledge of the process a consumer follows in order to access a screening with the LME (that is, a point of screening), in an effort to obtain MH/DD/SA services. The points of referral will provide this information to a consumer, or if appropriate, provide guidance to the consumer, and assist the individual in contacting a point of screening. A **point of screening** is defined as the service accessed by a consumer to receive a brief screening, whereby a single standardized screening tool is used. The purpose of the screening will be to determine the seriousness of a consumer's needs and whether the person should be referred for a more extensive, face-to-face assessment. This process will facilitate the redesigned system to provide services to

individuals with the most severe disabilities within a structured process for prioritizing services and/or managing wait lists.

No less than seventy-five (75) points of referral exist presently throughout Vance, Granville, Franklin and Warren Counties. Examples of points of referral include public agencies such as the Department of Social Services, all public and private schools in each county, juvenile court counselors and probation officers in each county, private providers (such as therapists, and local physicians), law enforcement (sheriff departments and local city and town police departments), homeless shelters, senior centers, rest homes, nursing homes, attorneys, and judges. In addition to the present points of referrals non-state as well as state hospitals will be points of referral for consumers being released from public institutions to the community. These points of referrals will assist the consumers in contacting the points of screening from the facility of the point of referral, or the consumer may directly initiate contact with the LME for a screening and to obtain information regarding services. The LME will provide information and training to points of referral, so that they will develop an understanding of the responsibilities of the LME, and then be able to communicate this to consumers as well as the process involved in accessing the LME's point of screening. The points of referral will have information to help consumers locate the points of screening, so the consumer can independently initiate this contact, or the point of referral can more actively assist the consumer by allowing the consumer to contact the LME for a telephonic screening while they are together.

The primary avenue of initiating contact with the LME for a screening is through the LME's toll free telephone phone number (as well as a TTY number for the hearing impaired). **Telephonic screenings** help insure mandated services are accessible on an area wide basis. Utilizing a standardized screening tool, the LME offers consumers the opportunity to explore their MH/DD/SA needs, and provides them with information about resources that may be appropriate to meet those identified needs, based on medical necessity, funding sources, geographic location, etc. The screening process identifies urgency of need, and this uniform portal system follows established criteria to assure the consumer is offered services within appropriate time frames. For emergent situations, a consumer will secure immediate assistance from an emergency triage clinician with the LME. For urgent situations, routine, consumers will be offered a face-to-face appointment for a more in-depth assessment within two days. For consumers being discharged from an in-patient state or non-state psychiatric facility, they will be offered an appointment for a face-to-face assessment within 72 hours of discharge from the facility. For routine contacts, appointments are offered within seven days. Emergency services will be available without interruption, 24 hours each day, seven days each week, including holidays, so that situations involving dangerousness are immediately addressed regardless of time/day of contact. In this manner, emergencies can be addressed without delay, to dispatch appropriate resources and initiate emergency evaluations in an effort to keep consumers and the community safe.

If the screening reveals that alternative community resources, supports, self-help groups, or faith-based initiatives might appropriately meet the consumers' needs, or if

the LME clinician assesses that the consumer does not meet criteria for a target population, referral information shall be fully shared with consumer. The LME will utilize the community resource manual to assure consumer choice when providing information about providers and supports in the community. To effectively implement this process, the LME will demonstrate on-going efforts to expand the qualified provider network, as well as maintain a current database to keep the information current. Consumers who meet criteria for target populations for MH/DD/SA services will be offered an opportunity to be scheduled for a face-to-face assessment within seven days of the initial contact with the LME. If a screening suggests referral is appropriate, but the consumer disagrees with the recommendation and is not interested in considering alternative options presented, the consumer will be given an opportunity for a face-to-face assessment. If however, the face-to-face assessment confirms the disposition concluded by the initial screening, the consumer may follow the procedure governing the consumer's right to grievance and appeals. At the face-to-face assessment, all consumers will receive written explanation of their rights as well as an explanation of the grievance and appeals process, so they will have the information needed to initiate an appeal.

A fundamental objective for the LME will be to develop crisis stabilization services for specific populations, whereby crisis bed placements or residential placements that have provisions for managing certain crisis scenarios will be available. In addition, case managers will be assigned quickly to assist consumers in resolving more emergent types of situations, such as a consumer suddenly becoming homeless. A primary goal of the LME will be to reduce the need for in-patient psychiatric hospitalizations, by having the capability to triage and manage situations, utilizing community-based care.

Throughout the assessment process, the LME will strive to demonstrate cultural sensitivity to consumers, so that consumer needs may be appropriately met. Similarly, the LME shall have a network of providers that include bilingual clinicians or interpreters for the Latino/Hispanic population, and have written materials available in Spanish, as well as English. For the hearing impaired, the LME will ensure that providers have interpreters to sign. In addition, LME sites and sites with whom the LME contracts, will be required (and it shall be stipulated directly in the contracts) to be accessible for the handicapped, both in the buildings and in parking areas.

Those consumers who meet established criteria for one or more of the **target populations** shall receive priority over those consumers not in a target population. The LME shall assist those "non-target" consumers as well, as long as the serving of these other consumers does not create any wait time for those in a target population. If the LME is unable to access needed services immediately, numerous interim services and supports outside of the boundaries of a single network will be implemented, while others are in the process of being developed. The LME will continue these efforts on an on-going basis, to ensure consumers will have access to interim services until more appropriate services become available. Identification and utilization of natural supports will be encouraged. To ensure the consumers' needs are always central, the LME will be committed to focusing on a person-centered planning process. From the time a consumer initiates an interest in accessing a MH/DD/SA service, the driving force of

service provision will be how the consumer defines these needs. To assess the effectiveness and efficiency of the LME's uniform portal system, the LME will conduct outcome studies, and will incorporate changes in response to those outcomes.

VI. Service Monitoring and Oversight: Quality Management

The LMEs' **Continuous Quality Improvement Plan** (CQI) will include a process that strives to ensure that quality services are provided to consumers and families and that these services meet Federal & State regulations and outcomes.

The LME **care management** functions and **quality management** functions will monitor all risk management, health and safety issues in the LME and its qualified provider network. The monitoring process will include formal review of incident reports; review, approval and monitoring of behavioral management, behavioral intervention and restrictive intervention plans etc. All qualified providers in the Qualified Provider Network and all LME staff providing core functions will be monitored for compliance with privileging/credentialing and staff core competencies. A client outcome system will be developed that will ensure that a system of effective internal utilization management and qualified provider profiling is developed and implemented. Some of the outcomes that will be measured will include: access standards, denial of admission rates, Length of Stay (LOS) data, complaint/incident reporting, evidence of use of best practices, client outcome data, & satisfaction survey data. The results of these outcomes will be documented in the Provider Report Card and shared with providers, CFAC, consumers and the QM Committee. A case management function will include performing on-site quality of care reviews on each visit with consumers. In addition, other LME staff will conduct on-site initial and annual compliance verification reviews of each provider. Consumer and provider satisfaction measures will be established on an individual and program level for qualified providers and LME staff.

The LME will implement an effective client rights program that protects the rights, health, safety and welfare of consumers and that is in compliance with State rules and regulations. This will include, but is not limited to, monitoring the adherence to: Client Rights Policies & Procedures/ Client Rights Directives; Incident Reporting Policy and Procedures; DFS Healthcare Personnel Registry 24 Hour and 5 Day Reporting Forms' procedures; reporting procedures of local Department of Social Services' Child and Adult Protective Services. Complaints about the LME and/or qualified providers will be identified, reported and investigated as outlined in the Client Complaint Resolution Policy and Procedure.

A system of effective internal **utilization management**, which will include access standards, denial of admission rates and length of stay (LOS) data, will assist in continuously improving qualified provider profiling. Such a system will ensure positive client outcomes in the most efficient delivery of services. Some of the outcomes that will be measured will include: access standards, denial of admission rates, LOS data, complaint/incident reporting, evidence of use of best practices and clinical pathways, client outcome data, and satisfaction survey data.

Care management and quality management units will generate reports compiling the data from the different monitoring tools. As part of the Continuous Quality Improvement (CQI) process, a Quality Management Committee (QM Committee) will review the data to determine trends, needs, and oversight. The QM Committee will be composed of consumers and family members, representatives of CFAC (Consumer and Family Advisory Committee), community partners, qualified providers, and LME staff. The QM Committee will review overall quality indicators of system performance, evaluate consumer and stakeholder feedback regarding system performance and need, develop and implement corrective action plans (training in best practices, etc.), and monitor/oversee implementation of corrective action plans by qualified providers. The QM Committee will perform the administrative processes associated with the quality management process of collaboration in planning, determination of effectiveness of system quality improvement processes & activities, and identification of training needs.

The QM Committee will review and approve the Requests for Proposals (RFP) and Requests for Applications (RFA) that are submitted to the LME by potential providers. The QM Committee may periodically appoint smaller ad hoc committees to assist in the CQI process. Consumers, qualified providers, and community partners will participate in the CQI process. As per the State Plan, the LME CQI Plan will rely on the CFAC representatives to bring to the QM Committee reports from their independent monitoring of the LME. It is anticipated that the LME QM Committee will develop the LME CQI Plan by July 1, 2004.

The LME's **Management Information** System's capacity to collect and analyze data to be utilized for planning and decision support will be an integral component to the LME's continuous quality improvement process. The LME will continue to use the Area Authority's existing computer system with some enhancements. VGFW will be IPRS compliant by October 31, 2002 and the LME will take over those capabilities. The Outcomes and Managed Care Modules will be in place and ready to produce data reports by June 2003. Additional MIS personnel resources have been added in the project management and data analysis area and staff are scheduled for more training to further develop report-writing capabilities.

The Outcomes module will give the LME capability to have an on-line version of various assessment and outcome tools, as well as the client satisfaction survey. This will be integrated with client data and provider data so that various cross-tabulations can be examined. With notice, the system can make changes or add additional instruments as best practices are defined. Providers will submit instruments by hard copy. We are investigating phone and web-based interface for the second year plan. The Unicare system can link provider, client and utilization data to produce reports in various combinations that can be used for information management and provider profiling. Satisfaction and outcome data can also be linked to these reports when the Outcomes Module is operational.

MIS staff will analyze reports and share analysis as appropriate with all stakeholders, including regular reporting to the board and consumer groups. The Quality Management Committee will receive reports that will be designed according to their specifications.

These reports will be used to determine trends, needs and oversight. Problems will be identified, plan of action will address functions and processes, solutions will be implemented, and progress will be monitored, all as a means to ensure the continual striving to improve all areas of the LME, as well as to move the MH/DD/SA system towards emerging best practices.

VII. Evaluation

In the Area Authority's strong commitment to deliver the highest quality of services to its consumers and family members, VGFW achieved **national accreditation** through the Council of Accreditation (COA) on December 31, 2001. The LME will maintain this accreditation through December 31, 2005 and will pursue further accreditation as directed by the Division.

In order to maintain this commitment to high quality of service delivery, the LME will structure the organization to include Quality Management and Care Management Units whose functions will provide a systematic means of reviewing and analyzing various performance indicators data in order to effectively evaluate the organization's performance. Several areas of performance review will include Access systems to determine the number of individuals served within the four county area as compared with the number of individuals with MH/DD/SA disabilities in the catchment area to assess penetration rate; to track the length of time before an individual was seen for treatment based on results of screening as compared with the Divisions required timeframes; to determine if there are sufficient qualified providers in the LME's network to meet the consumers needs, as well as provide consumers with a choice. The Quality of Care systems will track no show rates, consistency in treatment, length of treatment, etc. Service provision will be evaluated for use of clinical pathways and best practices. Person centered planning will be tracked and monitored to ensure that plans are completed in a timely manner, that services are comprehensive and are of a quality to ensure positive real life changes for the consumer and that the plans identify the educational needs desired by the consumer and family members. Administrative processes will be evaluated through on-going consumers, community partners and qualified providers' satisfaction surveys and assessments of service needs. These satisfaction surveys and needs assessments will assist in determining the effectiveness of the LME's collaboration in planning, as well as the effectiveness of the CQI process and trainings. The ultimate measure of outcomes is related to real life changes for people with disabilities and the system's performance relative to those outcomes. The Core Indicators Project and the Client Outcomes Inventory will be two tools used to measure Consumer outcomes. Additional outcome measures will be implemented as directed by the Division, as well as the outcomes developed internally by the LME.

The LME will use a continuous quality improvement process that will involve consumers, community partners, qualified providers and LME employees in the review of the various performance indicators data to determine trends, needs and oversight. The LME's management information system (MIS) capacity to collect and analyze data to be utilized for planning and decision support will be an integral component to the LME's continuous quality improvement process. As previously addressed in Section VI, plans are

underway to modify and upgrade the Area Program's existing MIS system in order to comply with the requirement of the Local Business Plan.

VIII. Financial Management and Accountability

The LME will adhere to state and federal guidelines and best practices in its business operations. The LME will adhere to a financial management plan that assures proper internal controls that meet state, federal and professional requirements. Internal control procedures will be in place that limits duties and responsibilities so as to safeguard agency assets and maintain a professional level of integrity. A series of financial reports will be issued monthly, quarterly and annually to keep management, the Area Board, Boards of County Commissioners and the Division of MH/DD/SA Services informed of the financial status of the LME. A single audit will be performed on an annual basis that certifies that the LME is in compliance with appropriate rules and regulations. All real property owned by the LME will be properly accounted for and management of this property will be maintained. There will be proper monitoring and auditing of contracts as required by the Division of MH/DD/SA Services.

IX. Information Systems and Data Management

The LME will manage compliance with the Integrated Payment and Reporting System and the Medicaid Management Information Systems. The supplier of the software that the LME will use agrees by contract to make any changes and enhancements to keep the LME in compliance with state and federal requirements.

The LME will invest in technology and will adhere to changes in the state technology standards as they are published.

The LME will deploy sufficient resources to comply with all security procedures for the protection and safeguarding of electronic data, financial assets, and other material resources. The LME will comply with the Health Insurance Portability and Accountability Act of 1996.

X. Collaboration

The Local Management Entity will continue to have a strong presence in the community. As an integral component of the community social service delivery system the LME will create a process to support such **community collaboration**. This process will ensure presence on local committees, task forces, and advisory boards. The LME will act as a liaison with other community agencies. The LME will assist community collaboratives with the identification of service needs and gaps for both the targeted and non-targeted population.

The LME will participate in various community meetings to assess community needs and service gaps. LME staff will act as a liaison with other community agencies. In addition the LME will play a leadership role in community committees, workgroups, and task forces. The following methodology identifies ways or guidelines to ensure broad based

active participation. Where and when possible the Local Management Entity (LME) will:

- Identify existing community and organization community resource manuals.
- Identify key community organizations and leaders.
- Invite all identified organizations to collaborate with the Local Management Entity.
- Notify organizations of the local business plan through direct and media contact.
- Seek support for the objectives outlined in the local business plan.
- Evaluate the value of collaboration as perceived by the participating agencies.
- Share needed information with all collaborating agencies.
- Follow up with notification of upcoming events and meetings.
- Request suggestions from participating organizations for additional organizations to contact.
- Develop electronic and other means, such as a Local Management Entity web page to communicate and inform participating and non-participating organizations of the local business plan.
- Routinely evaluate and modify these guidelines for supporting and encouraging collaboration among community organizations.
- Assign a staff member to monitor and coordinate the collaborative process.
- Establish a Collaborative Advisory Committee of participating agencies to assist the Local Management Entity in refining the collaborative process.

In addition a community resource manual will be created which will establish resources for targeted and non-targeted population. It will be the responsibility of the LME to promote the communication of the resources with other state agencies. Also identify, build-on, and develop a network of informal services and resources such as faith based, civic groups, and non-profit.

The LME will meet the federal regulation to reduce youth access to tobacco products. This will be accomplished by a community wide educational program that works with local merchants in assisting their compliance with the State and Federal laws.

