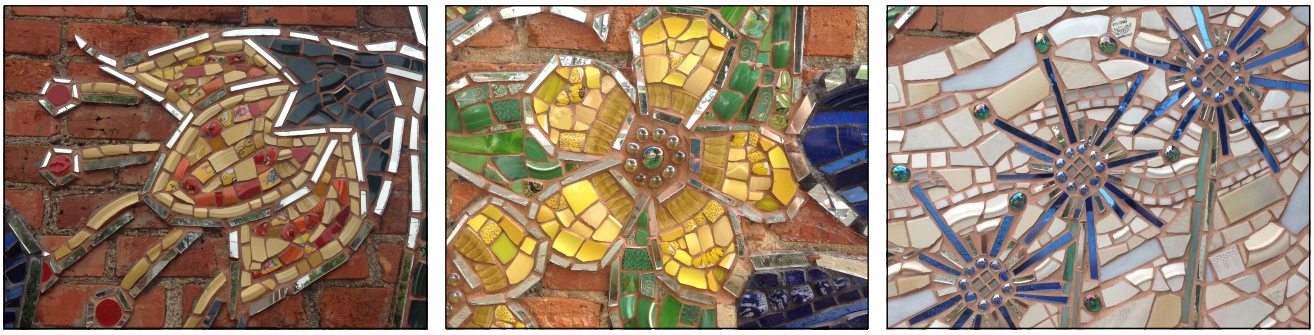
Data Workbook

For Community Collaboratives

Introduction

In North Carolina, Community Collaboratives focus on ensuring better outcomes for children with mental health and substance use challenges and their families.

Community Collaboratives must be clear on their focus and priorities and use local data to drive and monitor progress on their priorities. Community Collaboratives can help create a community where children with mental health and substance use challenges are identified early and supported in accessing effective, community-based, trauma-informed, coordinated, and family-driven services possible. In these Systems of Care, families have the support, information, training, and voice to make decisions and plans for their child and family and in improving the system for all families.



Coach/Facilitator

Having a coach/facilitator can be a tremendous help to a Community Collaborative that is committed to data supported decision making. Coach/facilitators could be found in the LME/MCO Quality Management Departments, in local Department of Social Services involved in REAP*, and in other partner agencies engaged in a continuous quality improvement processes including mental health provider agencies.

The role of the coach/facilitator is not to do all the research, data analysis, and interpretation for a Community Collaborative but rather to train, support, teach, facilitate, and coach a Community Collaborative or one of its subcommittees in accessing, understanding, using, and monitoring information.

*REAP (Reaching for Excellence and Accountability in Practice) is a continuous quality improvement system being piloted in eIght Department of Social Services in North Carolina. While REAP may initially focus on internal DSS processes for improving outcomes for families involved with social services, REAP intends to engage community partners in its quality improvement system.
https://nccwta.org/index.php?/Knowledgebase/Article/GetAttachment/69/24

This workbook is divided into two sections:

1) Sources of data to consider
2) Developing a continuous quality improvement process

Part 1: Multiple Sources of Data

Community Collaboratives have a wealth of data available to them. Depending on the questions the Collaborative wants to answer, some data is easily available and some data would take more time to uncover. While Community Collaboratives should use data to support decisions and select and track priorities, there is no perfect data set. Sometimes Collaboratives have to make decisions with incomplete or imperfect information. On the other hand, using data can allow a Collaborative to quantify goals and track progress on those goals.

Data Sources:

- **NC Child**: County Specific Information of Poverty, DSS and Juvenile Court Involvement, Insurance Coverage and more
- **Health Department Community Assessments**
- **State Center for Health Statistics**: Carolina Adverse Childhood Experiences Reports
- **Community Child Protection Team Annual Reports**
- **Child Fatality Team Annual Reports**
- **LME/MCO System Performance Indicators**
- **Juvenile Justice Aggregate Risk and Needs Data**
- **Local school systems** may have information on suspensions and graduation rates for different groups of students. Some school systems collect survey data from students on

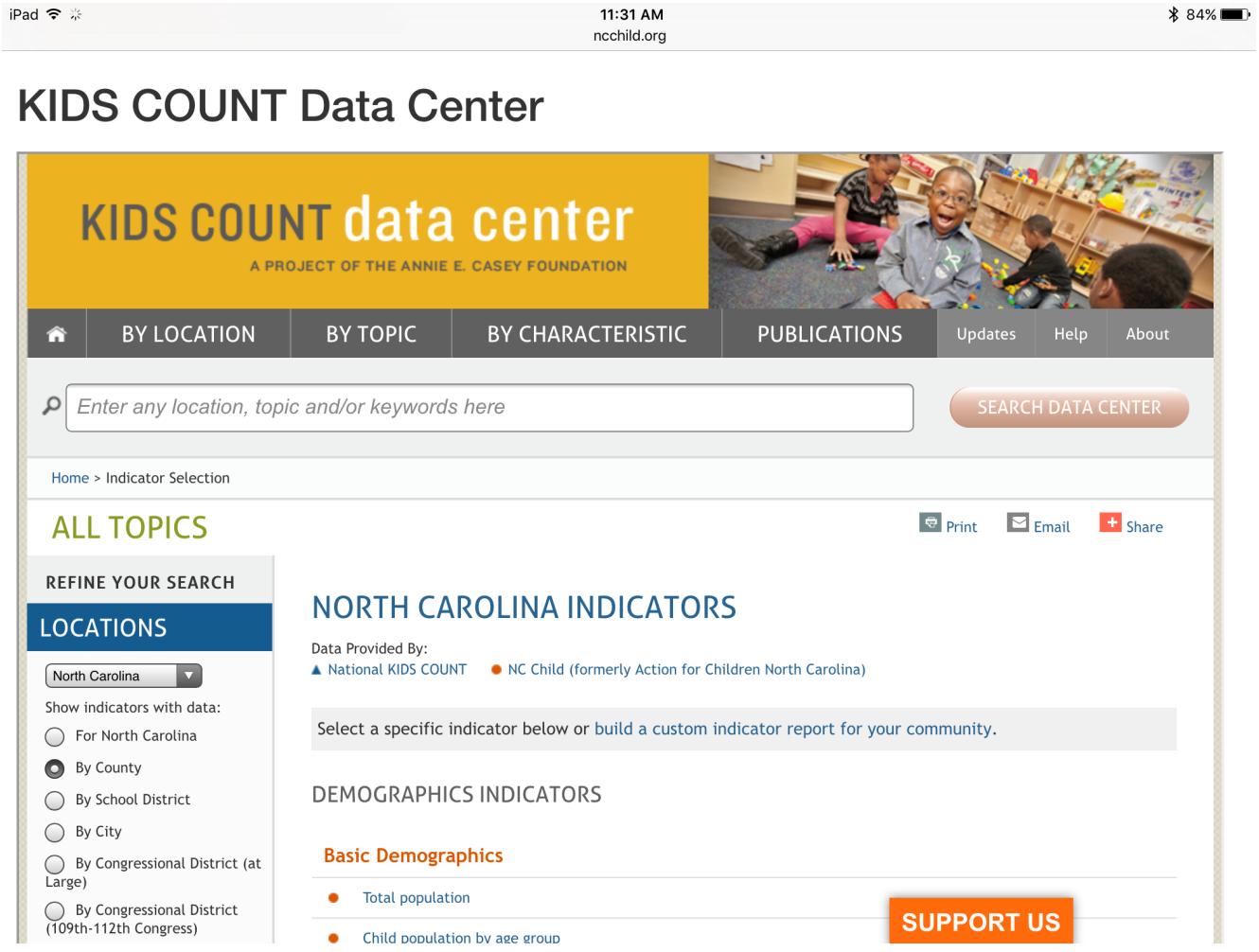
patterns of substance use and some school systems routinely collect Youth Risk Behavior Surveillance surveys.

Let's explore some of these data sources:

NC Child

NC Child offers a portal to the Kids Count Data Center.
http://www.ncchild.org/what-we-do/data/kids-count-data-center/

Information by county is available regarding demographics, race/ethnicity, economic wellbeing, education indicators, health indicators, child abuse and neglect, and juvenile justice. The screenshots below show the variety of the information available.



Demographics
Economic Well-Being
Education
Health
Safety & Risky Behaviors
National KIDS COUNT Publications

CHARACTERISTICS

Choose one characteristic.
See All Indicators
Age
Family Nativity
Race/Ethnicity
Choose characteristics >

DATA PROVIDER

NATIONAL KIDS COUNT
Learn More >

NC CHILD (FORMERLY ACTION FOR CHILDREN NORTH CAROLINA)
Learn More >

ECONOMIC WELL-BEING INDICATORS

Employment and Income

- Unemployment
- Median household income

Public Assistance

- Children receiving Work First
- Children receiving Supplemental Security Income (SSI)
- Children receiving Social Security (OASDI)

Poverty

- Children in poverty

EDUCATION INDICATORS

Early Childhood

- Number of children (0-5) enrolled in child care centers
- Number of children (0-5) enrolled in family child care homes
- Total enrollment in child care centers
- Total enrollment in family child care homes
- Total number of child care centers
- Total number of family child care homes

iPad 11:42 AM 82%
ncchild.org

School Age

- Average daily membership
- Four-Year cohort graduation rate
- *Teens ages 16 to 19 not attending school and not working*

Explain series

Test Scores

- Average SAT scores

Other Education

- Percent of students enrolled in free and reduced lunch
- Per pupil expenditures

Indicators by Race and Ethnicity

- *Teens ages 16 to 19 not in school and not working by race and ethnicity*

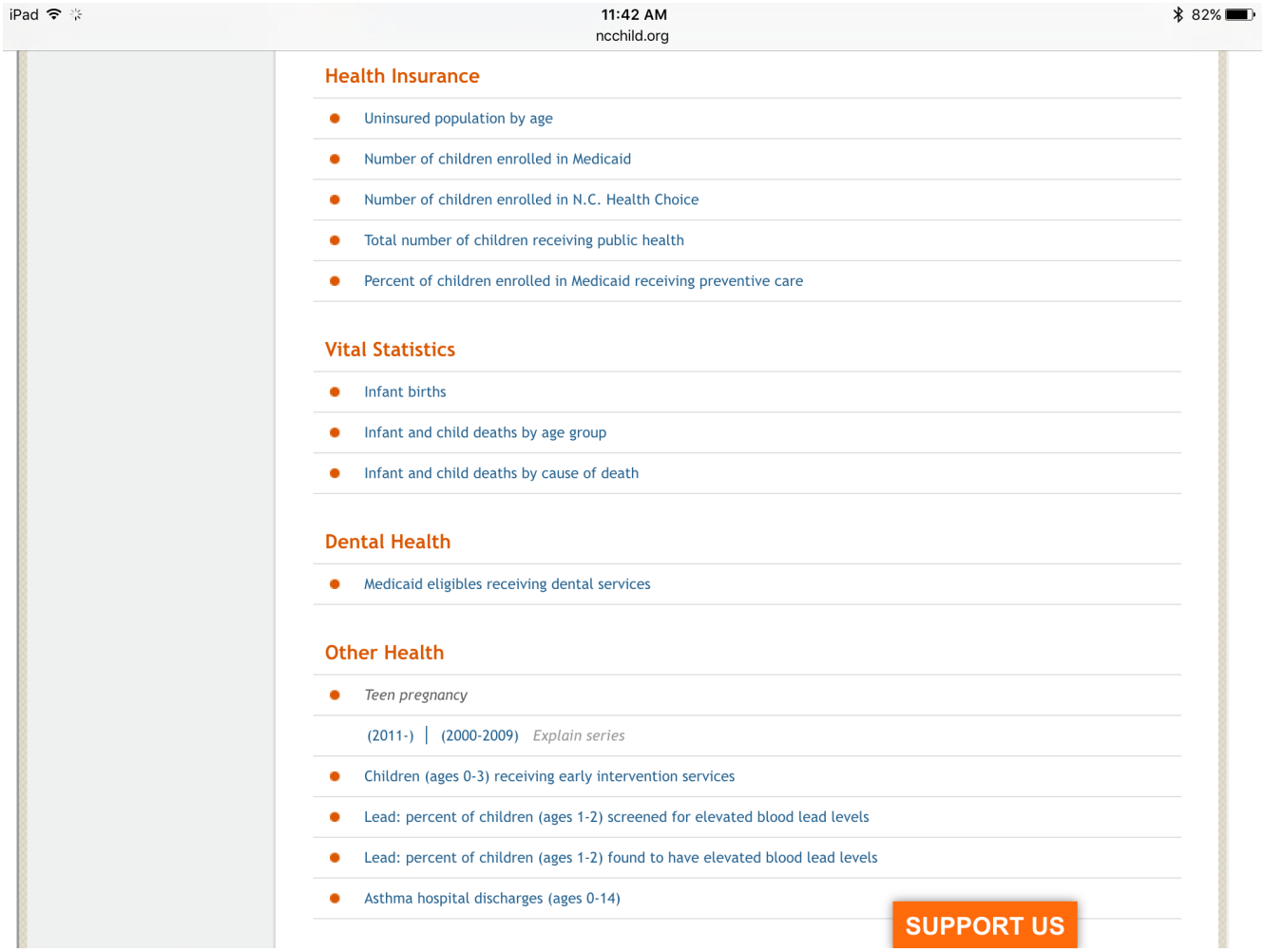
Explain series

HEALTH INDICATORS

Birth Outcomes

- *Percent of low birthweight births*

2011- | 1995-2010 *Explain series*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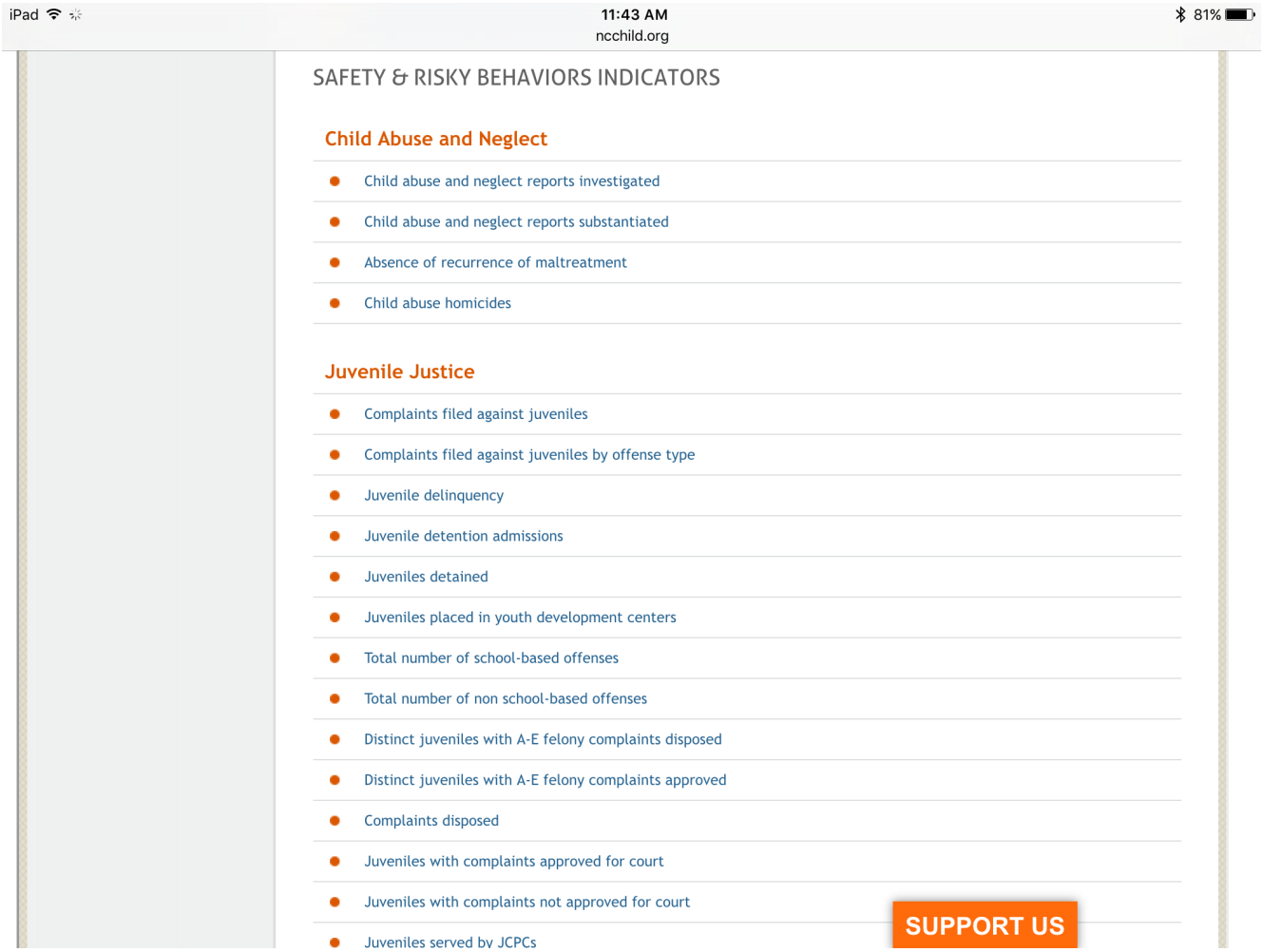
82%
Health Insurance
Uninsured population by age
Number of children enrolled in Medicaid
Number of children enrolled in N.C. Health Choice
Total number of children receiving public health
Percent of children enrolled in Medicaid receiving preventive care
Vital Statistics
Infant births
Infant and child deaths by age group
Infant and child deaths by cause of death
Dental Health
Medicaid eligibles receiving dental services
Other Health
Teen pregnancy
(2011-) | (2000-2009) Explain series
Children (ages 0-3) receiving early intervention services
Lead: percent of children (ages 1-2) screened for elevated blood lead levels
Lead: percent of children (ages 1-2) found to have elevated blood lead levels
Asthma hospital discharges (ages 0-14)
SUPPORT US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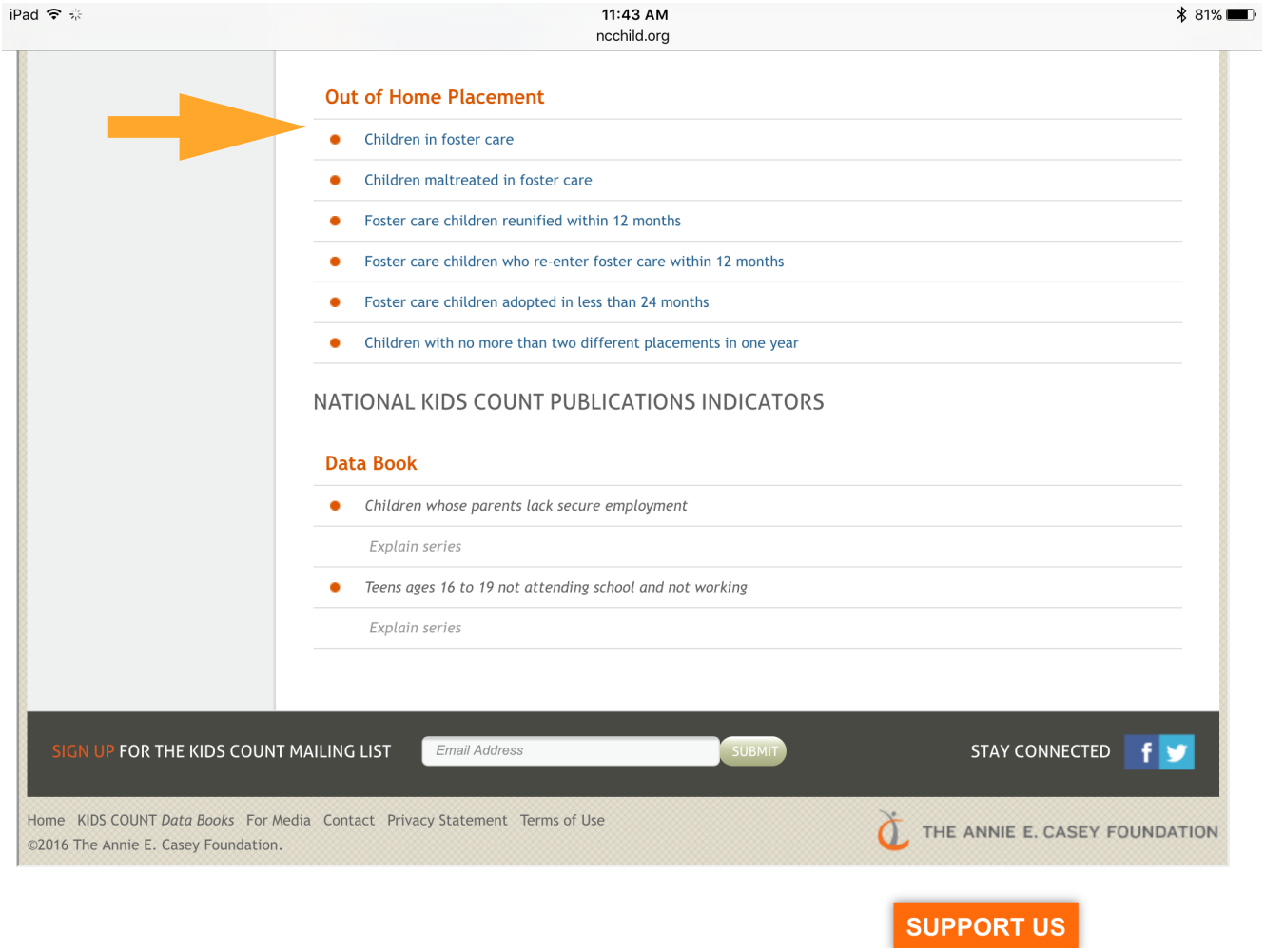
SAFETY & RISKY BEHAVIORS INDICATORS
Child Abuse and Neglect
Child abuse and neglect reports investigated
Child abuse and neglect reports substantiated
Absence of recurrence of maltreatment
Child abuse homicides
Juvenile Justice
Complaints filed against juveniles
Complaints filed against juveniles by offense type
Juvenile delinquency
Juvenile detention admissions
Juveniles detained
Juveniles placed in youth development centers
Total number of school-based offenses
Total number of non school-based offenses
Distinct juveniles with A-E felony complaints disposed
Distinct juveniles with A-E felony complaints approved
Complaints disposed
Juveniles with complaints approved for court
Juveniles with complaints not approved for court
Juveniles served by JCPCs
SUPPORT US

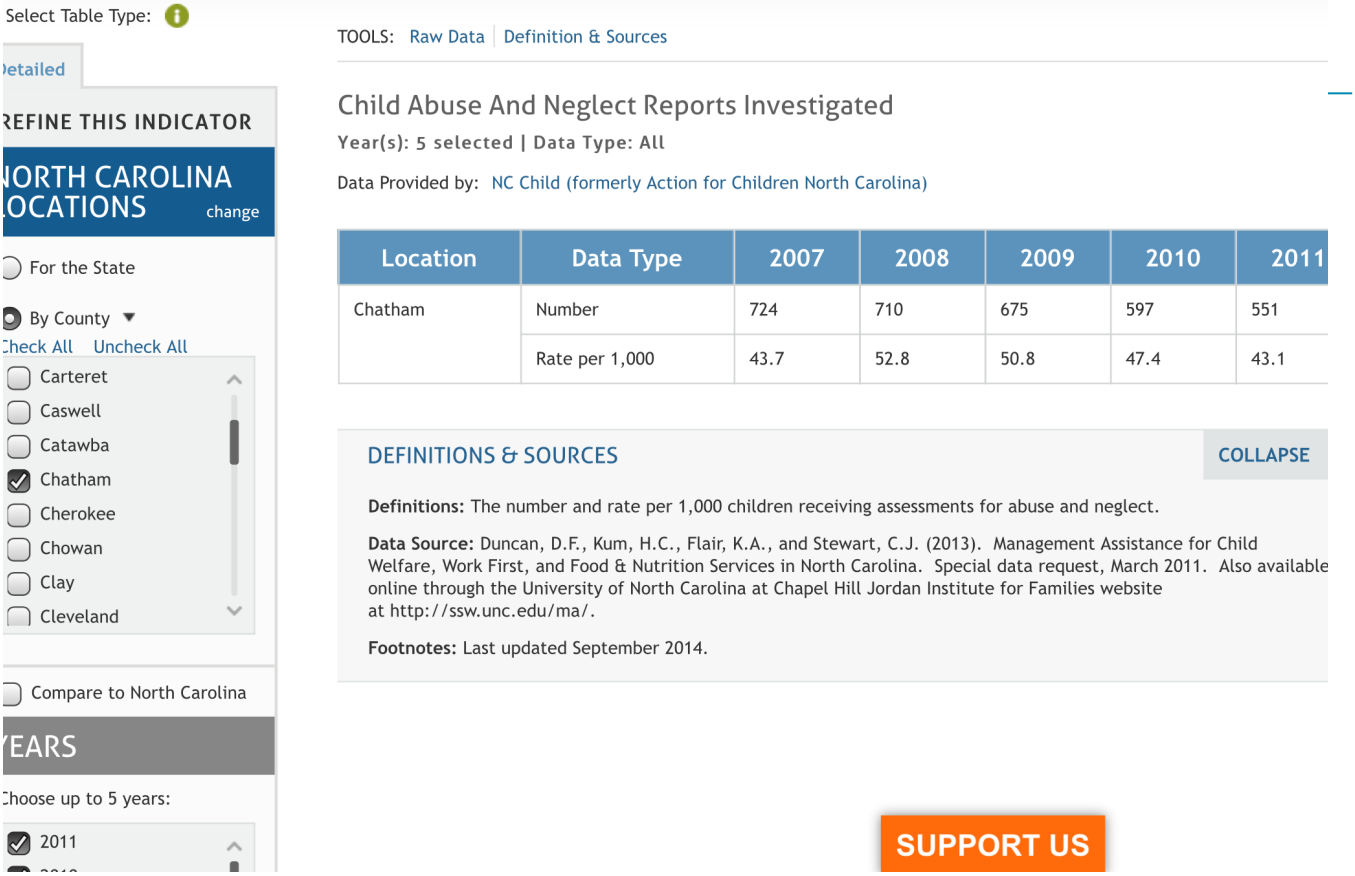


If the Collaborative is interested in information on children and families involved with social services, the Collaborative should invite the DSS representative to share information. This information could include the annual Community Child Protection Team report and any annual report DSS compiles for its county commissioners or board of directors. In addition, the Collaborative could gather some preliminary data from NC Child/Kids Count and some more detailed data from the **Management Assistance for Child Welfare, Work First, and Food & Nutrition Services in North Carolina System.**

For example, if the Collaborative in Chatham County is interested in

- number of child abuse and neglect reports investigated
- number of child abuse and neglect reports substantiated
- number of children in social service custody for their county

The Collaborative could start with NC Child/Kids Count county databases (see orange arrow above).

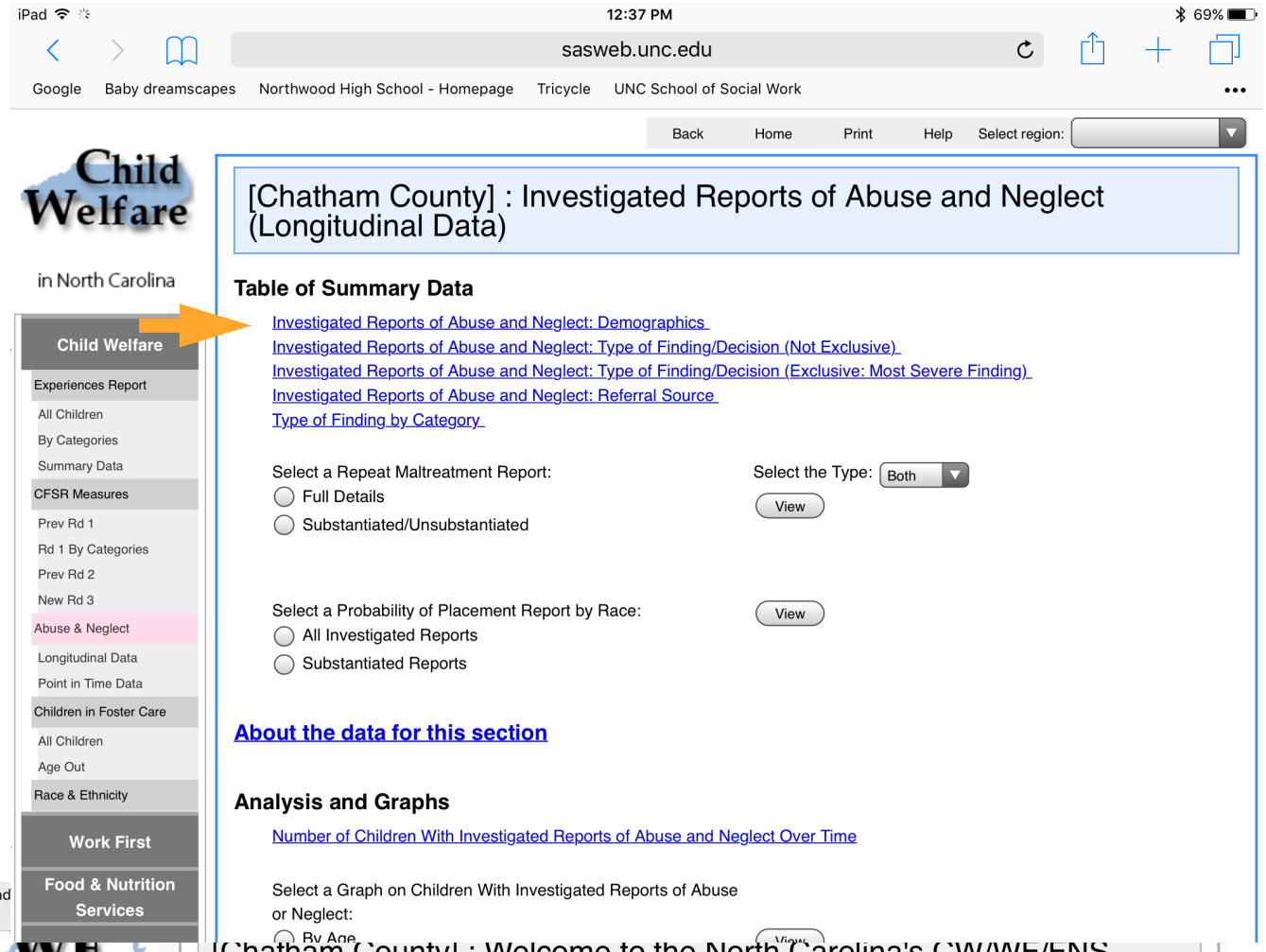


If one of those indicators is chosen and a county is chosen, then five years worth of data is reported. Also, the source of the data is listed if the Collaborative wanted to dive deeper.

In our example, we see the number of child abuse and neglect reports investigated in Chatham County over 5 years with the last year being 2011. If the Collaborative wants to learn if more recent data is available, it can delve into the source of the data which is listed below the table. In this case, the source is the **Management Assistance database** found at http://ssw.unc.edu/ma/.

Below are a series of screen shots showing you how to get more recent data from this Management Assistance website. If you click on options noted by the orange arrows, you will find rich, detailed, and more current data on the number of child abuse and neglect investigations in Chatham County.

You can use data from NC Child for information in broad strokes and the DSS Management Assistance site for more detailed information. But to put the information in context always ask the DSS representatives to explain their data. You can ask your DSS representative to share their annual **Community Child Protection Team report** which is prepared for the county commissioners. This report identifies gaps in the county's response to protecting children and includes strategies to address the gaps.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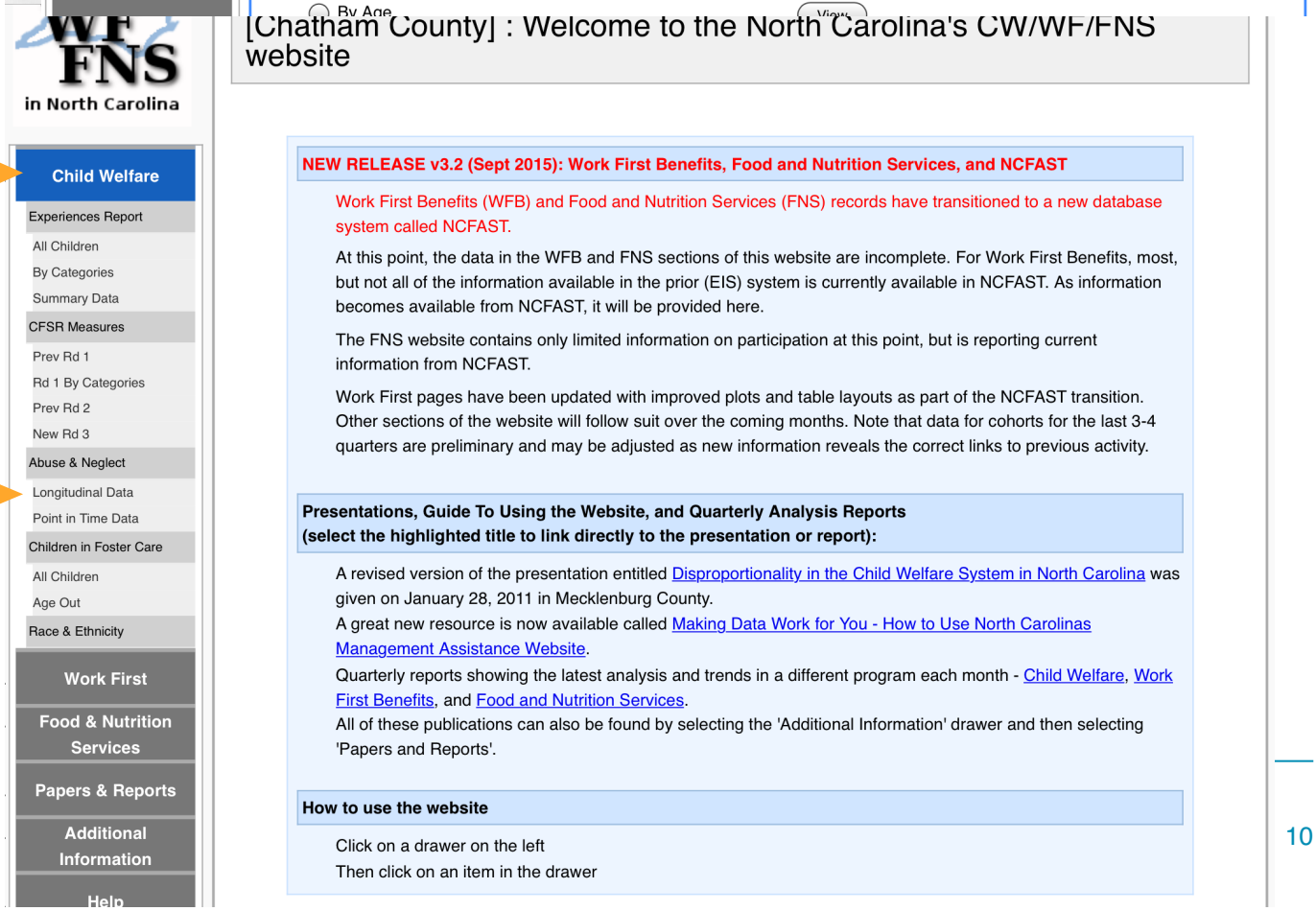
Baby dreamscapes
Northwood High School - Homepage
Tricycle
UNC School of Social Work
Back
Home
Print
Help
Select region:
Child Welfare
in North Carolina
Child Welfare
Experiences Report
All Children
By Categories
Summary Data
CFSR Measures
Prev Rd 1
Rd 1 By Categories
Prev Rd 2
New Rd 3
Abuse & Neglect
Longitudinal Data
Point in Time Data
Children in Foster Care
All Children
Age Out
Race & Ethnicity
Work First
Food & Nutrition Services
[Chatham County] : Investigated Reports of Abuse and Neglect (Longitudinal Data)
Table of Summary Data
Investigated Reports of Abuse and Neglect: Demographics
Investigated Reports of Abuse and Neglect: Type of Finding/Decision (Not Exclusive)
Investigated Reports of Abuse and Neglect: Type of Finding/Decision (Exclusive: Most Severe Finding)
Investigated Reports of Abuse and Neglect: Referral Source
Type of Finding by Category
Select a Repeat Maltreatment Report:
Full Details
Substantiated/Unsubstantiated
Select the Type:
Both
View
Select a Probability of Placement Report by Race:
All Investigated Reports
Substantiated Reports
View
About the data for this section
Analysis and Graphs
Number of Children With Investigated Reports of Abuse and Neglect Over Time
Select a Graph on Children With Investigated Reports of Abuse or Neglect:
By Age
View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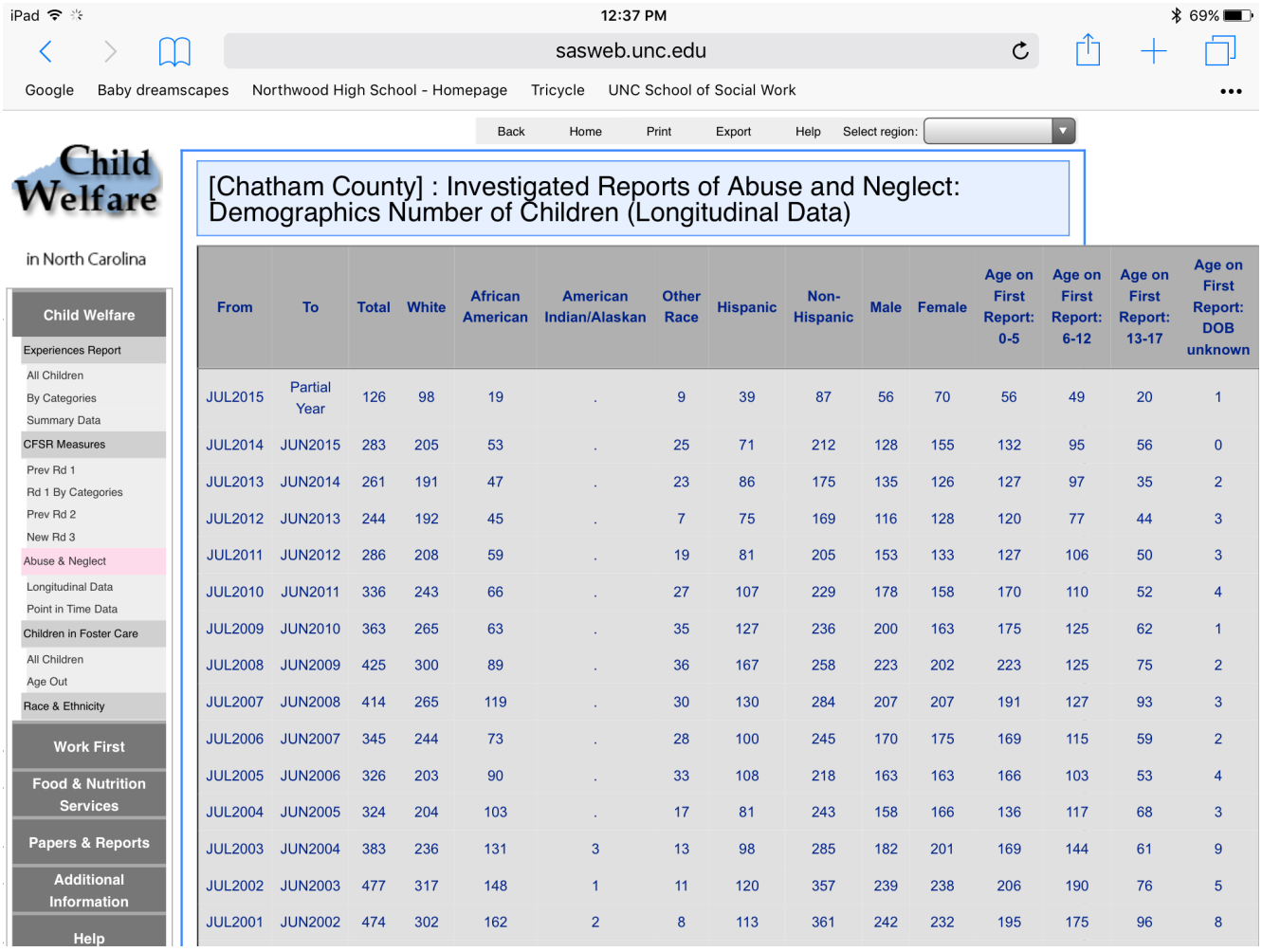
WF FNS
in North Carolina
[Chatham County] : Welcome to the North Carolina's CW/WF/FNS website
Child Welfare
Experiences Report
All Children
By Categories
Summary Data
CFSR Measures
Prev Rd 1
Rd 1 By Categories
Prev Rd 2
New Rd 3
Abuse & Neglect
Longitudinal Data
Point in Time Data
Children in Foster Care
All Children
Age Out
Race & Ethnicity
Work First
Food & Nutrition Services
Papers & Reports
Additional Information
Help
NEW RELEASE v3.2 (Sept 2015): Work First Benefits, Food and Nutrition Services, and NCFAST
Work First Benefits (WFB) and Food and Nutrition Services (FNS) records have transitioned to a new database system called NCFAST.
At this point, the data in the WFB and FNS sections of this website are incomplete. For Work First Benefits, most, but not all of the information available in the prior (EIS) system is currently available in NCFAST. As information becomes available from NCFAST, it will be provided here.
The FNS website contains only limited information on participation at this point, but is reporting current information from NCFAST.
Work First pages have been updated with improved plots and table layouts as part of the NCFAST transition. Other sections of the website will follow suit over the coming months. Note that data for cohorts for the last 3-4 quarters are preliminary and may be adjusted as new information reveals the correct links to previous activity.
Presentations, Guide To Using the Website, and Quarterly Analysis Reports
(select the highlighted title to link directly to the presentation or report):
A revised version of the presentation entitled Disproportionality in the Child Welfare System in North Carolina was given on January 28, 2011 in Mecklenburg County.
A great new resource is now available called Making Data Work for You - How to Use North Carolinas Management Assistance Website.
Quarterly reports showing the latest analysis and trends in a different program each month - Child Welfare, Work First Benefits, and Food and Nutrition Services.
All of these publications can also be found by selecting the 'Additional Information' drawer and then selecting 'Papers and Reports'.
How to use the website
Click on a drawer on the left
Then click on an item in the drawer



From	To	Total	White	African American	American Indian/Alaskan	Other Race	Hispanic	Non-Hispanic	Male	Female	Age on First Report: 0-5	Age on First Report: 6-12	Age on First Report: 13-17	Age on First Report: DOB unknown
JUL2015	Partial Year	126	98	19	.	9	39	87	56	70	56	49	20	1
JUL2014	JUN2015	283	205	53	.	25	71	212	128	155	132	95	56	0
JUL2013	JUN2014	261	191	47	.	23	86	175	135	126	127	97	35	2
JUL2012	JUN2013	244	192	45	.	7	75	169	116	128	120	77	44	3
JUL2011	JUN2012	286	208	59	.	19	81	205	153	133	127	106	50	3
JUL2010	JUN2011	336	243	66	.	27	107	229	178	158	170	110	52	4
JUL2009	JUN2010	363	265	63	.	35	127	236	200	163	175	125	62	1
JUL2008	JUN2009	425	300	89	.	36	167	258	223	202	223	125	75	2
JUL2007	JUN2008	414	265	119	.	30	130	284	207	207	191	127	93	3
JUL2006	JUN2007	345	244	73	.	28	100	245	170	175	169	115	59	2
JUL2005	JUN2006	326	203	90	.	33	108	218	163	163	166	103	53	4
JUL2004	JUN2005	324	204	103	.	17	81	243	158	166	136	117	68	3
JUL2003	JUN2004	383	236	131	3	13	98	285	182	201	169	144	61	9
JUL2002	JUN2003	477	317	148	1	11	120	357	239	238	206	190	76	5
JUL2001	JUN2002	474	302	162	2	8	113	361	242	232	195	175	96	8

Community Health Assessments

County Health Departments complete a comprehensive community health assessment every four years. Here is the description of the community health assessment from the Division of Public Health website: "Community health assessment is the foundation for improving and promoting the health of community members. The role of community assessment is to identify factors that affect the health of a population and determine the availability of resources within the community to adequately address these factors. It is a 'systematic collection, assembly, analysis, and dissemination of information about the health of the community'."

According to the Division of Public Health's website, "During the three interim years between Community Health Assessments, the local health departments are required to do a State-of-the-County's Health (SOTCH) Report that will:

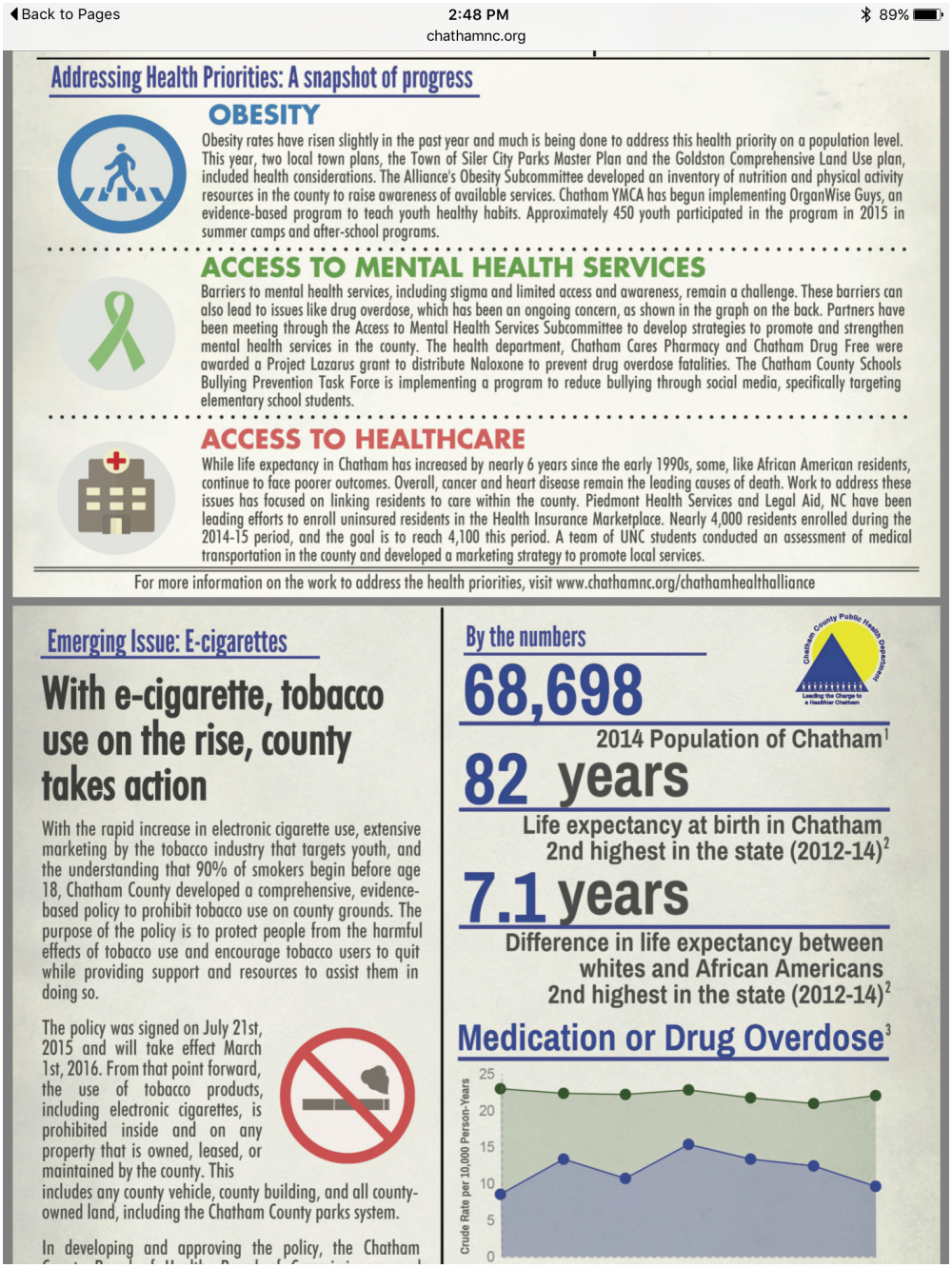
- track priority issues identified in the Community Health Assessment;
- identify emerging issues; and
- highlight new initiatives.

http://publichealth.nc.gov/lhd/cha/about.htm

Continuing with the example of Chatham County, the Collaborative could invite the Health Department Representative to provide an overview of the results of the community health assessment. Mental health and substance abuse services are considered as part of the community health assessment.

Click here to assess to Chatham's Community Assessments.
http://www.chathamnc.org/Index.aspx?page=783
2014 Chatham Community Health Assessment
http://www.chathamnc.org/modules/showdocument.aspx?documentid=27407
Executive Summary
http://www.chathamnc.org/modules/showdocument.aspx?documentid=27407
2015 Update of Progress
http://www.chathamnc.org/modules/showdocument.aspx?documentid=27407

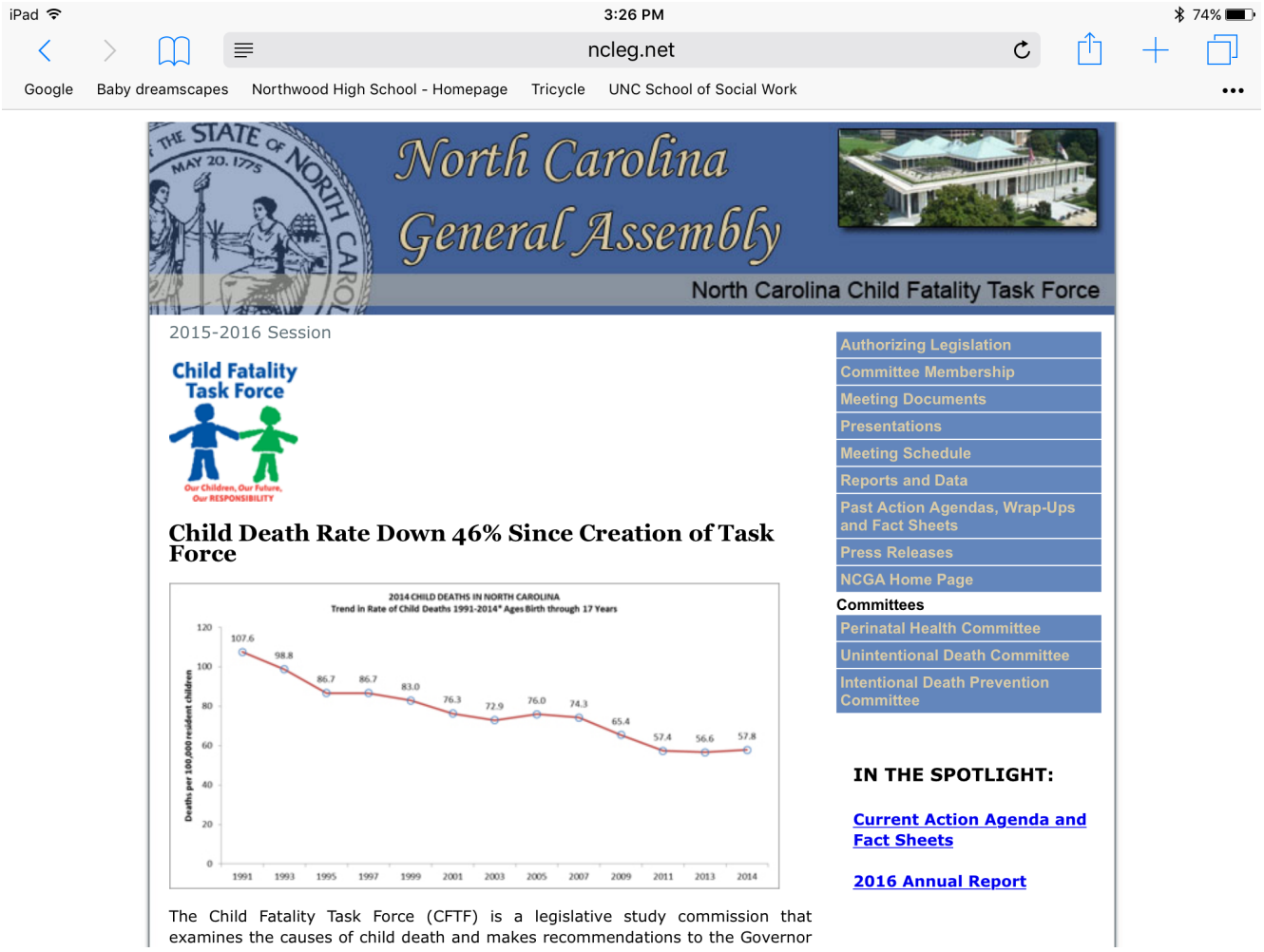
We can see below in the screenshot of a part of Chatham's 2015 Update that the use of graphics can help convey complex information quickly.



The Division of Public Health also oversees the three prong child fatality prevention system. One of the prongs is a local Child Fatality Team which conducts a structured review of every child fatality in a county. In many counties, the Child Fatality Review and the Community Child Protection Team are combined but each group submits an annual report. The child fatality prevention system is an excellent example of how a structured review

process combined with monitoring can lead to positive outcomes which in this case is less child deaths.

In the last 20 years of this child fatality prevention system, these are some of the noted accomplishments:



- "Infant mortality has declined more than 28%. A variety of strategies have contributed to this reduction, including state and local Safe Sleep campaigns, breast feeding promotion, and 17-Progesterone distribution to reduce recurring preterm births.
- Reductions in deaths due to unintentional causes have been substantial, largely due to declines in motor vehicle deaths. With the passage of the graduated driver license in North Carolina, driver crashes are down 38% for 16 year olds and 20% for 17 year olds. Since the requirement for child safety seats, the number of motor vehicle related deaths for children birth through age nine declined more than 25%. Additionally, the number of

children killed by fire and flame decreased by 44% following policies promoting broader use of smoke alarms.

- The caseloads of Child Protective Services staff have been cut in third – from about 1 worker for every 30 abused and neglected children in 1991 to about 1 worker for every 10 or 11 abused and neglected children today. This lower rate allows staff more time to provide services to vulnerable children to assure that they can grow up in permanent, stable families. Thanks to other improvements in the child welfare system, the rate of children removed from their homes to live with foster families has declined more than 10%."

https://www2.ncdhhs.gov/dph/wch/aboutus/childfatality.htm

Division of Public Health in conjunction with the **State Center for Health Statistics** collects North Carolina specific data on **Adverse Childhood Experiences** (ACEs), **Behavioral Risk Factor Surveillance System** (**BRFSS) Injury Data, and the Youth Risk Behavior Surveillance.** While not county specific information, it could be useful for your community.

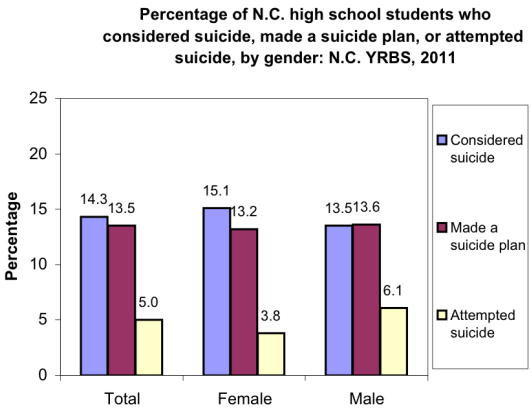
To see NC reports on ACES, click here
http://www.injuryfreenc.ncdhhs.gov/DataSurveillance/BRFSSInjuryData.htm

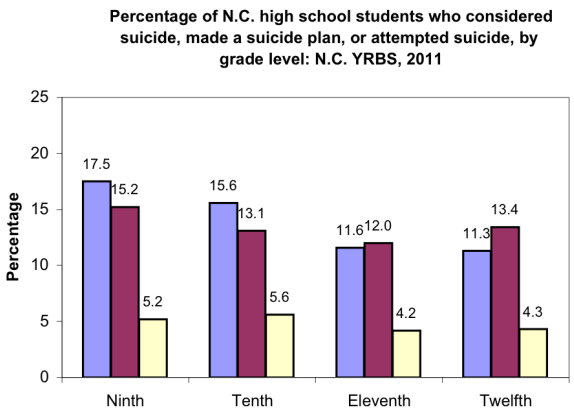
To see the North Carolina Adverse Childhood Experiences Report (2012) click here:
http://www.schs.state.nc.us/schs/pdf/SCHS_Study_167_FIN_20140505.pdf

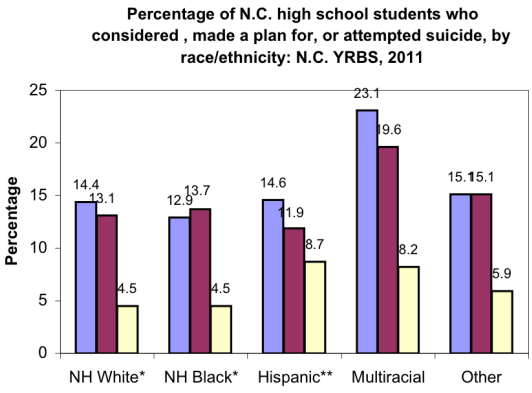
The Youth Risk Behavior Survey also provides interesting information on NC youth. Below is information on adolescents and suicide in NC. Below is a screen shot of some of the information available from the Youth Risk Behavior Surveillance.

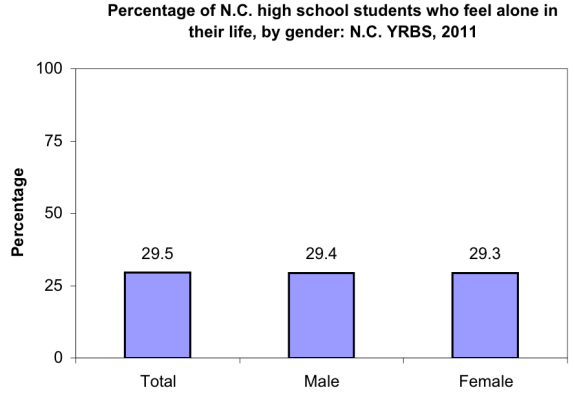
http://www.injuryfreenc.ncdhhs.gov/DataSurveillance/YRBS/2011HSSuicideGraph.pdf

Considered, Planned & Attempted Suicide: 2011 N.C. Youth Risk Behavior Survey









LME/MCO Data on Children's Behavioral Health

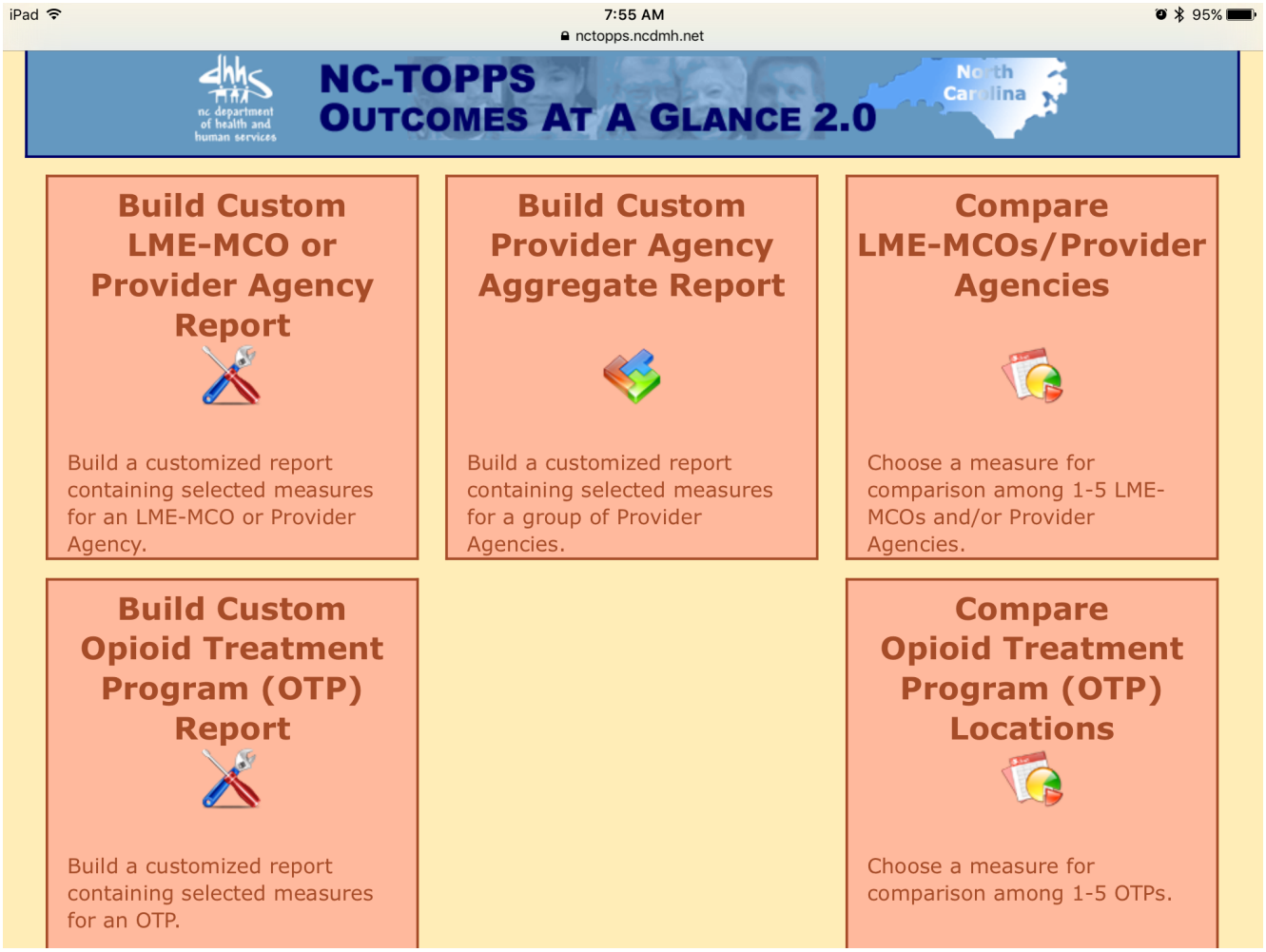
LME/MCOs can share with the Community Collaboratives its System Performance Indicators. Ask someone from the LME/MCO's Quality Management Department to come to the Collaborative to review and explain this LME/MCO information. LME/MCOs report on the following indicators every quarter to the Division of Mental Health, Developmental Disabilities, Substance Abuse Services:

- Average length of stay in community mental health psychiatric hospitals (mental health and substance use disorders; 3-17 years; for those with Medicaid, state funding, or combined)
- Emergency room readmissions within 30 days (child mental health, substance abuse, and IDD)
- State psychiatric hospital readmissions within 30 days and 180 days (all ages)
- Community Mental Health Inpatient Readmissions (6+ years)
- Community Mental Health Psychiatric Residential Treatment Facilities (PRTFs)

- Community Mental Health Readmissions in Facility Based Crisis Services, PRTFs, and Inpatient Combined
- Community Substance Use Inpatient Readmissions
- Follow-up Appointments After Discharge from State Psychiatric Hospitals (3+ years, 0-7 days, 0-30 days)
- Follow-up Appointments After Discharge form Community Hospital (6+ years, 0-7 days, 0-30 days)
- Follow-Up after Crisis Service (6+ years, 0-3 days, 0-5 days)
- Medical Care Coordination (% of people receiving MH/SA services who received ambulatory or preventative care visit) for children (3-17 years) and adults (18-20 years and 21+)
- Timely access to emergent care (2 hours)
- Timely access to Urgent Care/Appointment Kept (2 days; 3+ years, Medicaid, state funded, or combined)
- Timely access to Routine Care/Appointment Kept (14 days)
- Timely Support to Persons with IDD
- Penetration Rates (3-17 years; MH, SA, and IDD; Medicaid and State Funded)
- Initiation and Engagement Rates for SA (3-17 years)
- Initiation and Engagement Rates for MH (3-17 years)
- Short term care in state psychiatric hospital (0-7 days, 3+ years)
- Average length of stays in community psychiatric hospital (MH and SA; 3-17 years)

NC TOPPS (NC-Treatment Outcomes and Program Performance System) is another important data set for your Collaborative to know about and use. NC TOPPs is NC DMHDDSAS' outcome tracking system. LME/MCO staff can inform the Collaborative about the possibility of customizable NC TOPPs reports.

Here is a link to the public query site followed by a screen shot of its home page:
https://nctopps.ncdmh.net/ProviderQuery/Index.aspx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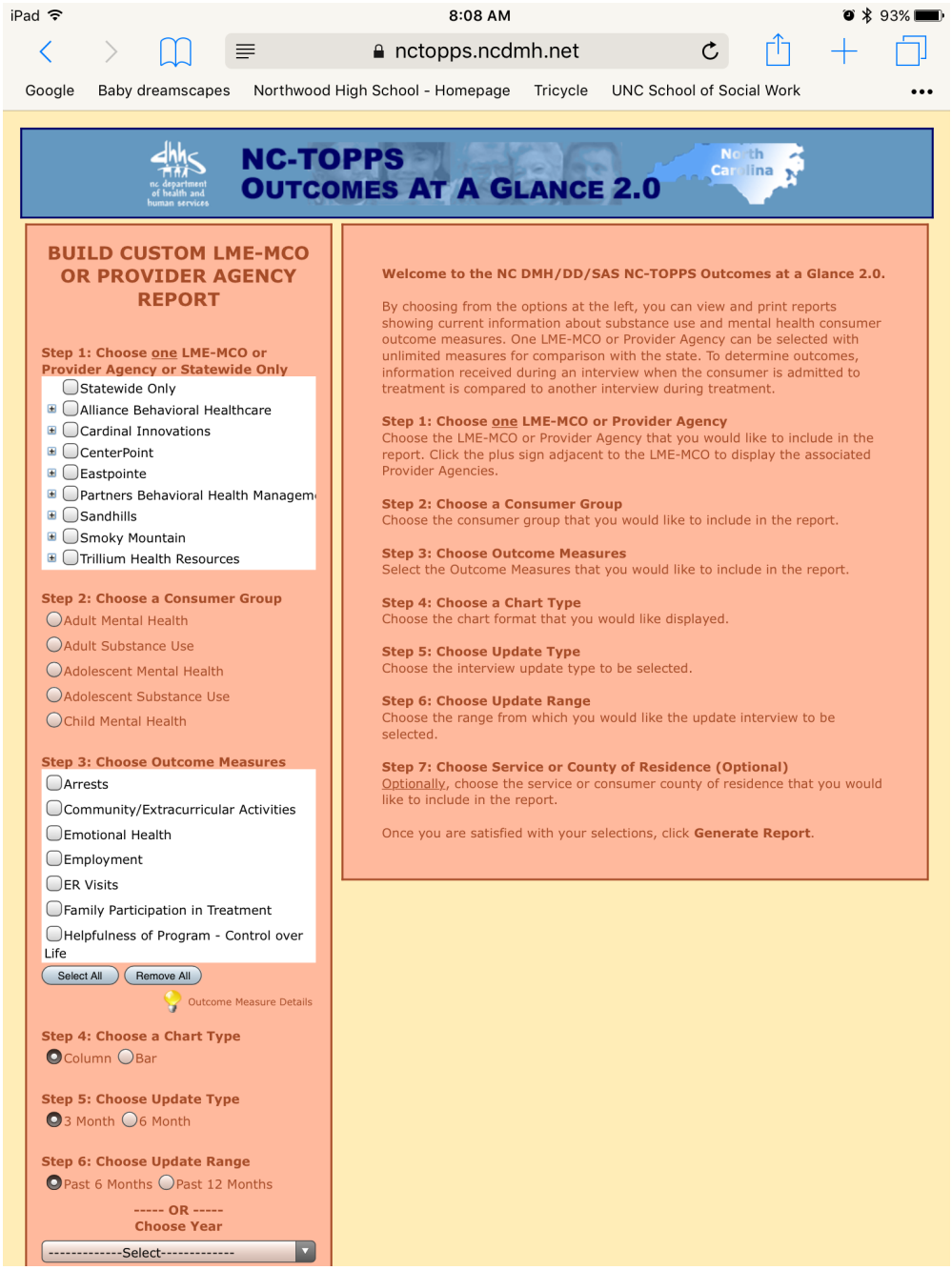
nc department of health and human services
NC-TOPPS
OUTCOMES AT A GLANCE 2.0
North Carolina
Build Custom LME-MCO or Provider Agency Report
Build a customized report containing selected measures for an LME-MCO or Provider Agency.
Build Custom Provider Agency Aggregate Report
Build a customized report containing selected measures for a group of Provider Agencies.
Compare LME-MCOs/Provider Agencies
Choose a measure for comparison among 1-5 LME-MCOs and/or Provider Agencies.
Build Custom Opioid Treatment Program (OTP) Report
Build a customized report containing selected measures for an OTP.
Compare Opioid Treatment Program (OTP) Locations
Choose a measure for comparison among 1-5 OTPs.

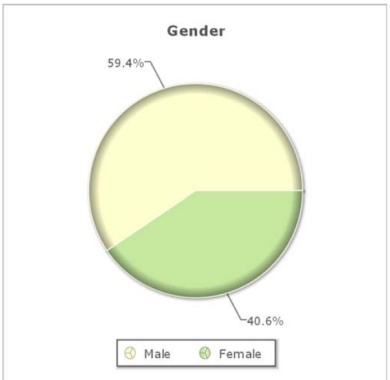


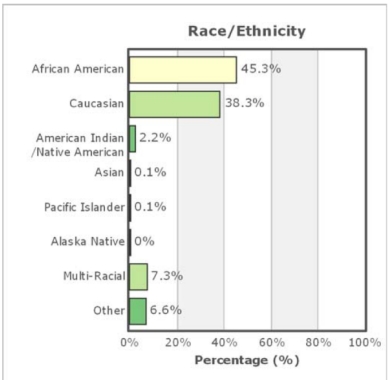
Specialized reports for both children's mental health and children's substance abuse can also be requested from the LME/MCO Quality Management Department. Below is the first page of a report that can be requested from the LME/MCO. A full report can be seen at this link:

NC-TOPPS Simple Query Report

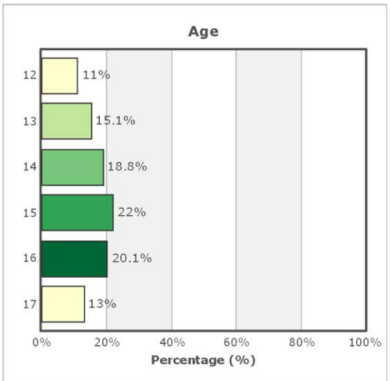
Alliance Behavioral Healthcare
Cardinal Innovations
CenterPoint
CoastalCare
Eastpointe
Partners Behavioral Health Management
Sandhills
Smoky Mountain
Trillium Health Resources
Adolescent Mental Health Consumers
Episode Completion Interviews started *Tuesday, July 01, 2014* through *Tuesday, June 30, 2015*
Number of Episode Completion Interviews: 8,659

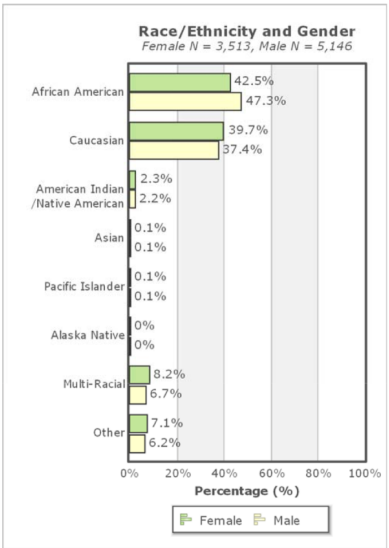
Demographics





883 *(10.2%)* consumer(s) indicate that they are of Hispanic, Latino, or Spanish origin.





Juvenile Justice Data

The juvenile justice system offers rich sources of information including:

1) Data workbooks on youth involved in the juvenile justice system on each county
2) Juvenile Crime Prevention Council (JCPC) Planning Process which includes reviewing aggregate risk and needs data on the youth involved with juvenile justice
3) JCPC Services by County
4) Juvenile Justice Substance Abuse Mental Health Partnership/Reclaiming Futures data on following young people through the system to ensure timely access to services.

If your Collaborative is not already viewing this information, ask your Chief Court Counselor and JPCP Chairperson to review and explain this information to the Collaborative. Let's consider some of these sources of information:

1) **Data workbooks** on youth involved in the juvenile justice system on each county. Below is the information captured by county in the data workbooks. The data workbooks can be found at:

http://www.ncdps.gov/Juvenile-Justice/Community-Programs/Juvenile-Crime-Prevention-Councils/JCPC-Planning-Process/County-Databooks

Juvenile Population Data

- Juveniles Ages 6 to 17
- Juveniles Ages 6 to 15
- Juveniles Ages 10 to 17

Complaints Received:

- Violent –Felony A-E
- Serious – Felony H-I, A1 Misdemeanor
- Minor – Misdemeanor Class 1, 2, or 3
- Infractions
- Undisciplined/Status
- Total Delinquent Complaints
- Total Complaints
- Delinquent Rate
- Undisciplined Rate
- Number of Juveniles Transferred to Superior Court (trial as Adult)

Detention

- Distinct Juveniles Served in Detention
- Number of Detention Admissions

Youth Development Centers

- Number of Commitments
- Commitment Rate

Program

- JCPC Admissions
- SOS Admissions
- Eckerd Camp Admission

YDC Statistics

- Commitments grouped by County, Race and Gender
- Commitments by County, Race and Age

2) Juvenile Crime Prevention Council (JCPC) Planning Process

The following planning process outline below is from the Department of Public Safety website which can be accessed here: http://www.ncdps.gov/Juvenile-Justice/Community-Programs/Juvenile-Crime-Prevention-Councils

"The N.C. Juvenile Crime Prevention Planning Process begins with a collaborative assessment of community risks, answering the following questions pertaining to community risks, resources and needs:

- What are the factors in our county that have been proven to contribute to local juvenile crime or delinquency?
- What are the county resources currently in place to offset the specified risks?
- What are the county resources needed to prevent juvenile crime and to get juveniles the help they need?

The Comprehensive Strategy seeks to mobilize communities to create a multi-disciplinary continuum of care that includes prevention programs for children, early intervention in the lives of juvenile offenders, and graduated sanctions for repeat offenders. The new planning process also incorporates the essential elements outlined in the N.C. Juvenile Justice Reform Act.

Working with the Jordan Institute for Families, the Division of Adult Correction and Juvenile Justice developed a research-based profile of risk factors for juvenile delinquency by age in five different domains: individual, family, peer group, school, and community. A county-by-county profile of statistical indicators, N.C. Community Risk Assessment Data, is available on the division's website.

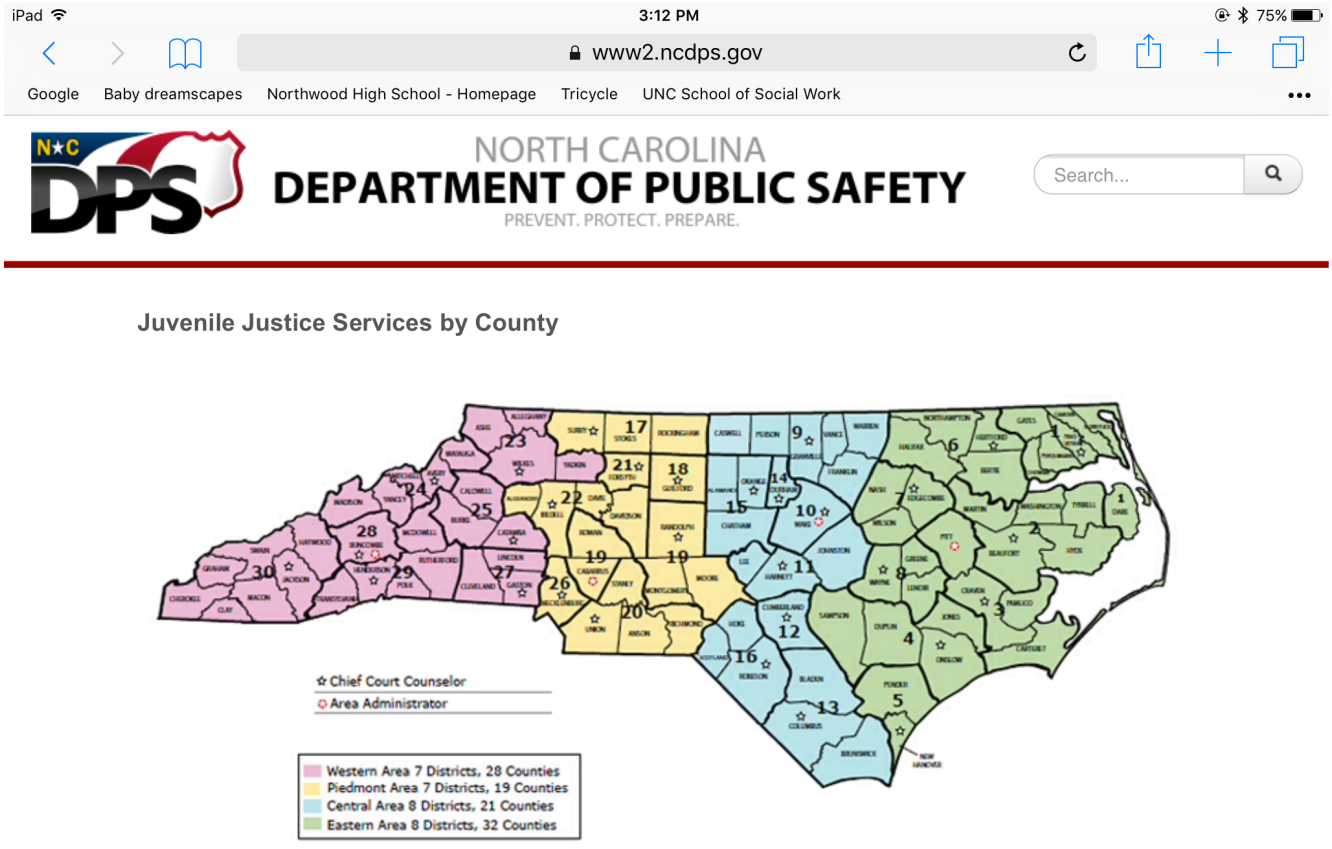
JCPCs can make data-based decisions to determine the need for prevention programs and disposition options from the actual indicators of the risk factors in each county and from juvenile justice data maintained by DPS. The Juvenile Community Programs Section works to guide local communities in developing an appropriate continuum to serve local youth based on collected data.

- Review the needs of juveniles in the county who are at risk of delinquency or who have been adjudicated undisciplined or delinquent.
- Review the resources available to address those needs
- Prioritize community risk factors
- Determine the services needed to address those problems areas
- Develop a request for proposal for services in need
- Submit a written funding plan to the county commissioners for approval
- Evaluate program performance
- Increase public awareness of the causes of delinquency and strategies to reduce the problem
- Develop strategies to intervene, respond to and treat the needs of juveniles at risk of delinquency
- Provide funds for treatment, counseling, or rehabilitation services."

3) **Services by county** (also includes contact information for the chief court counselor and the JCPC Chairperson):

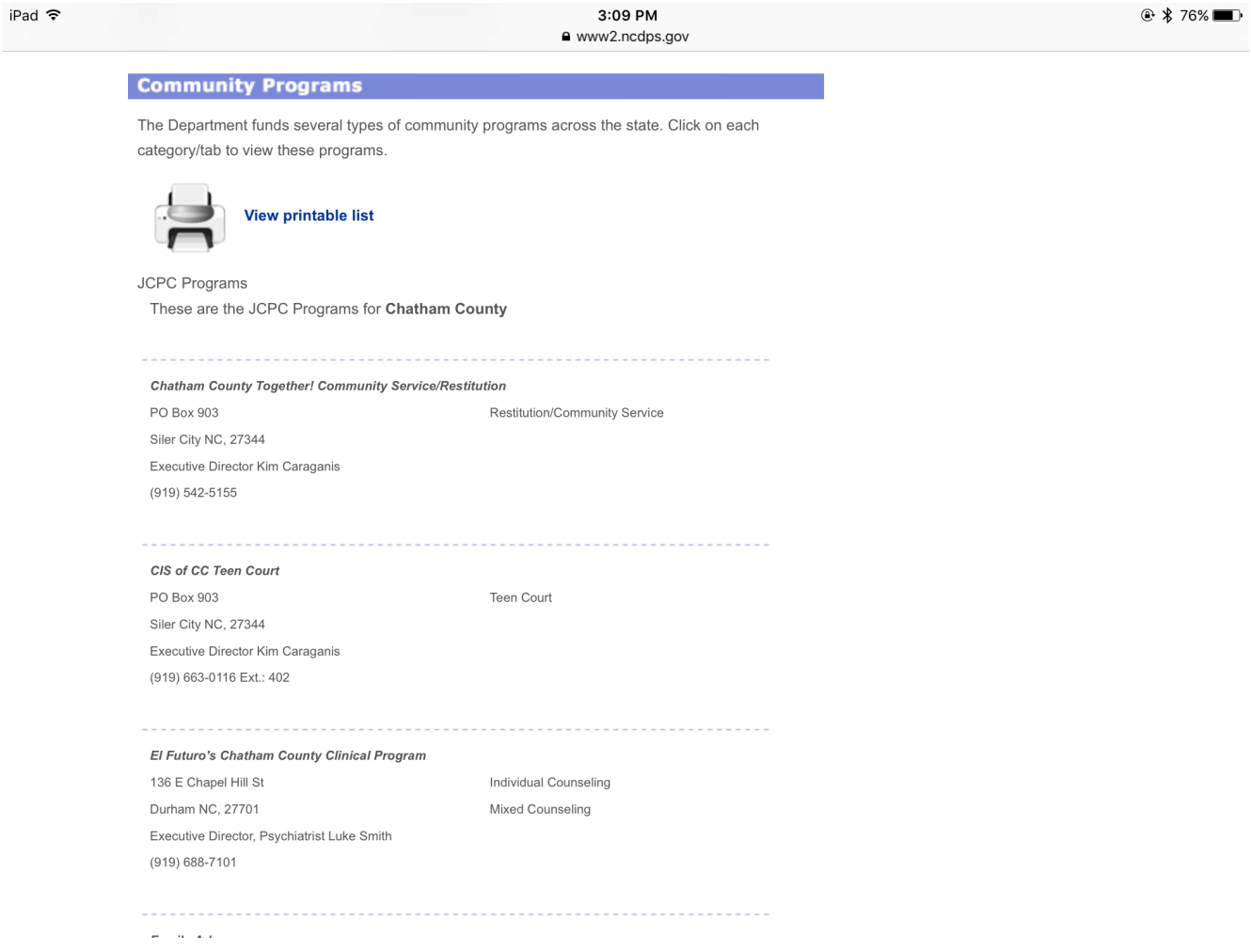
The DPS website also provides information about JCPC programs available to youth in your counties. This information can be found at this link:

https://www2.ncdps.gov/sbc/



To continue with the example of Chatham county, if you were to go to the link below you would find available JCPC programs and contact info for the JCPC Chairperson.

https://www2.ncdps.gov/sbc/sbc.cfm?cty=chatham-15



Family Advocacy

PO Box 903
Siler City NC, 27344
Executive Director Kim Caraganis
(919) 663-0116

Parent/Family Skill Building
Social Skills Training

Juvenile Court/School Liaison

P. O. Box 1088
Hillsborough NC, 27278
Programs and Special Projects Manager Marie Lamoureaux
(919) 644-4659

Interpersonal Skill Building
Behavioral Contracting/Contingency Management

Wrenn House

600 W. Cabarrus Street
Raleigh NC, 27603
Executive Director Michelle Zechmann
(919) 833-3312 Ext.: 115

Runaway Shelter Care

County JCPC Information

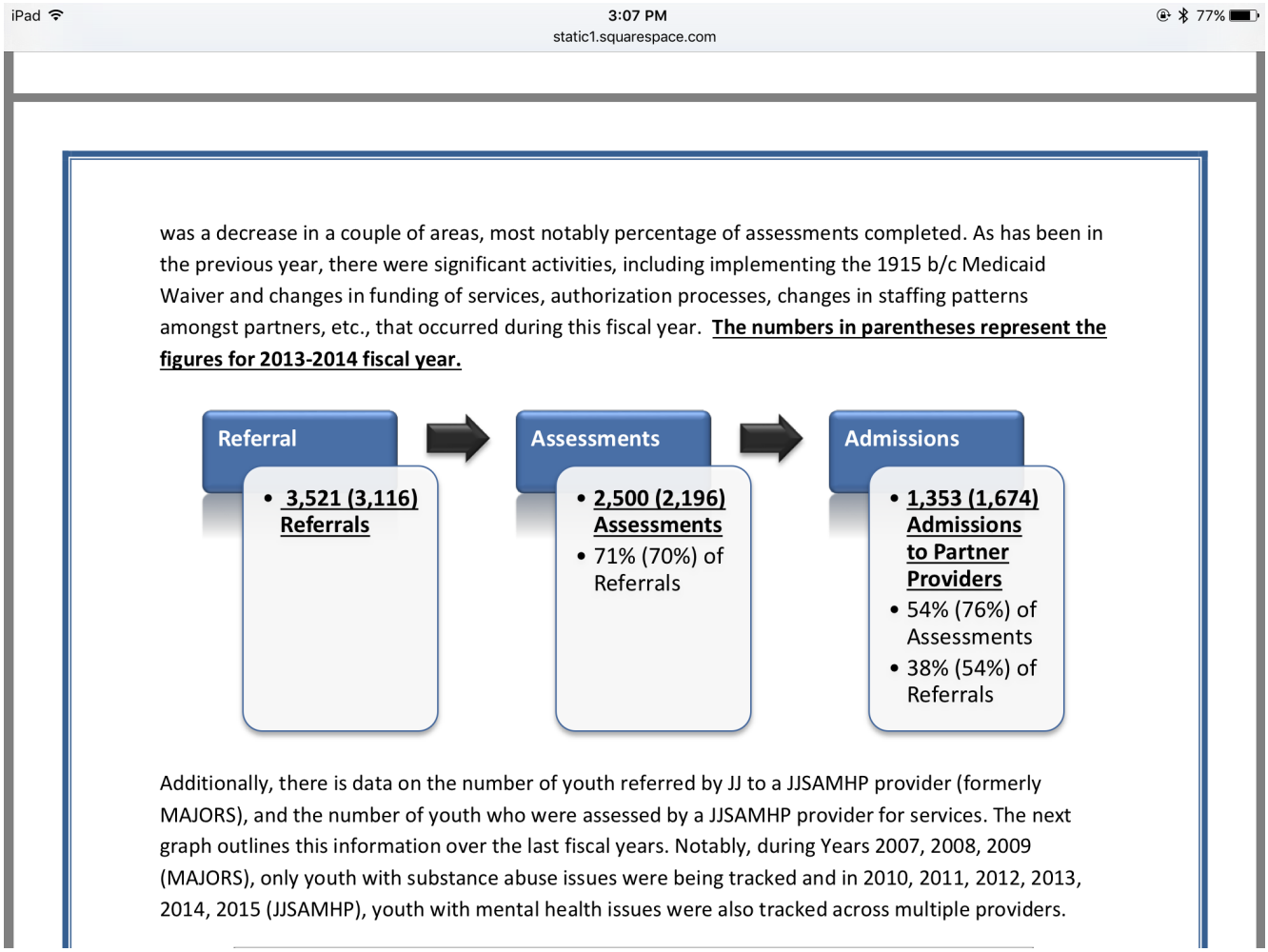
The Department partners with Juvenile Crime Prevention Councils in each county to galvanize community leaders, locally and statewide, to reduce and prevent juvenile crime.

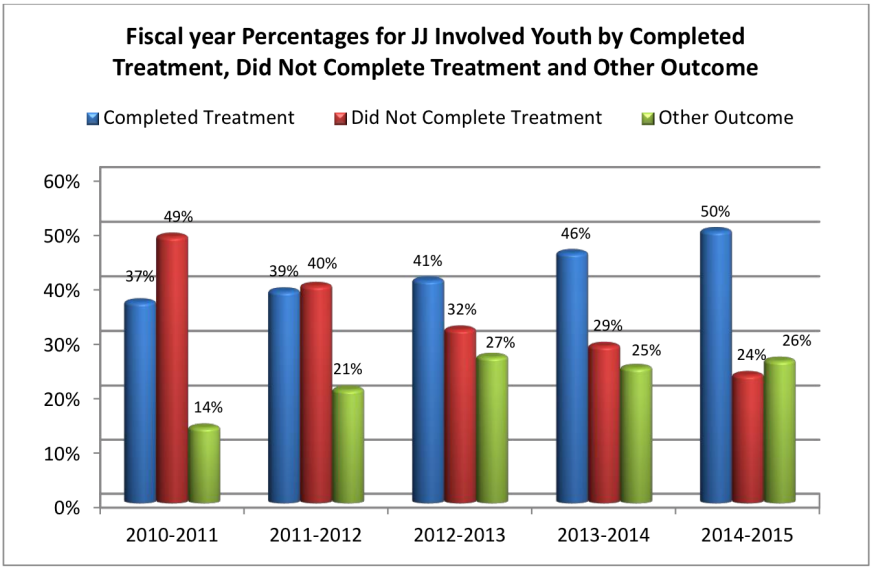
Chairperson George Greger-Holt
Address 184 Nicks Bend West,

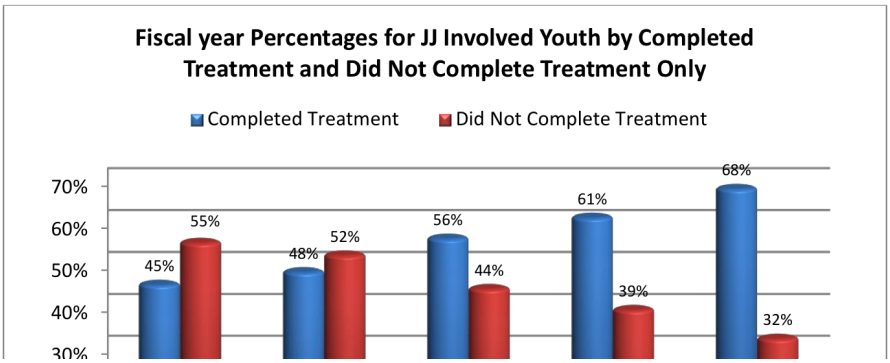
4) **Juvenile Justice Substance Abuse Mental Health Partnership/Reclaiming Futures**

JJSAMH Partnerships and Reclaiming Futures are excellent examples of how multi-agency collaborative efforts have used local data to improve behavioral health services for a group of young people. JJSAMHPs track the movement of youth who are involved with juvenile justice as they travel through the behavioral health system and by reviewing the aggregate data on these youth these partnerships can engage in selected continuous quality improvement projects to improve coordination, services, and outcomes. The 2014 JJSAMHP report can be found at the link below and a few screenshots from that report follow.

http://static1.squarespace.com/static/541349e2e4b0d105c2930b14/t/56d4fcadf8baf3314c8b0ac1/1456798957350/jjsamhp+2014+2015+annual+report.pdf







Part 2: Developing a Continuous Quality Improvement Process with your Community Collaborative

Let's start with a definition for Continuous Quality Improvement. Here is the definition provided by Friends: National Center for Community Based Child Abuse Prevention:

"Continuous Quality Improvement is a process to ensure programs are systematically and intentionally improving services and increasing positive outcomes for the families they serve. CQI is a cyclical, data-driven process; it is proactive, not reactive.

A CQI environment is one in which data is collected and used to make positive changes —even when things are going well—rather than waiting for something to go wrong and then fixing it. CQI is an ongoing process that involves the Plan, Do, Study, Act cycle."

http://friendsnrc.org/continuous-quality-improvement

CQI is an on-going, intentional use of data to improve outcomes for children and their families. CQI is what will move a Community Collaborative from a group of caring participants interested in helping children and families to a coalition that is clear on its priorities, has a plan to make those priorities happen, and is not afraid to make adjustments in their efforts if the data tells them they are not on track to meet their desired goals. When Collaboratives use data, they can get things done instead of just meeting to share updates.

Based on the Community Collaborative Assessment, a Collaborative can chose if they want to work on a **process and/or outcome goal**.

Examples of a **process goal:**

- **I**mproving trust among Collaborative members if the scores on the Community Partnership section of the Collaborative Self Assessment were low.
- Increasing membership and diversity of membership
- Increasing access to Trauma Focused CBT for youth in foster care

Examples of an **outcome goal**:

- Decreasing the length of time between assessment and start of behavioral health services for youth in the custody of social services
- Increasing the penetration rates for child mental health for those with Medicaid and state funded services
- Improving Initiation and Engagement Rates for child mental health (3-17 years)
- Increasing symptoms of children who completed a course of Trauma Focused CBT

Your Collaborative can use a systemic approach to address either process or outcome goals. You can find 4, 5, and 6 step models for CQI. Here is 6 step model from the website, *A Lean Journey*, where Tim McMahon articulates the following six step problem solving process.

The Six-Step Problem-Solving Process:

"Step 1: Identify The Problem

- Select the problem to be analyzed
- Clearly define the problem and establish a precise problem statement
- Set a measurable goal for the problem solving effort
- Establish a process for coordinating with and gaining approval of leadership

Step 2: Analyze The Problem

- Identify the processes that impact the problem and select one
- List the steps in the process as it currently exists
- Map the Process
- Validate the map of the process
- Identify potential cause of the problem
- Collect and analyze data related to the problem
- Verify or revise the original problem statement
- Identify root causes of the problem
- Collect additional data if needed to verify root causes

Step 3: Develop The Solutions

- Establish criteria for selecting a solution
- Generate potential solutions that will address the root causes of the problem
- Select a solution
- Gain approval and support for the chosen solution
- Plan the solution

Step 4: Implement A Solution

- Implement the chosen solution on a trial or pilot basis

Step 5: Evaluate The Results

- Gather data on the solution
- Analyze the data on the solution
- Achieve the desired results?

If YES, go to Step 6.
If NO, go back to Step 1.

Step 6: Standardize The Solution (and Capitalize on New Opportunities)

- Identify systemic changes and training needs for full implementation
- Adopt the solution
- Plan ongoing monitoring of the solution
- Continue to look for incremental improvements to refine the solution
- Look for another improvement opportunity

The Six-Step Problem-Solving Process is an easy approach to dealing with issues and problems that you face. It is a systematic way to approach a problem with clearly defined steps so that an individual or team doesn't get bogged down in, "WHAT DO WE DO NEXT?"
http://www.aleanjourney.com/2012/05/six-step-problem-solving-process.html

Let's walk through a few examples using the six steps from McMahon's *A Lean Journey*.

Example 1: Process Goal-- Increasing Membership and Diversity in Community Collaborative Membership

1) **Identify the Problem**: A review of the Collaborative membership reveals some gaps in the membership especially youth and family representatives, representatives from juvenile justice, and the faith community. Also, even though the percentage of Latinos in the community is 20% there are no representatives from organizations that serve Latino families and no representatives who are Latino. In addition, the attendees in the last six months were predominantly from provider agencies who did not send the same staff each month but rotating staff. Initial goal focused on increasing membership in all these identified areas.

	Jan 2016	April 2016	July 2016	October 2016	Jan 2017	April 2017	July 2017
Family Reps	0	0	0				
Youth Reps	0	0	0				
DSS Reps	1	1					
DJJ Reps	0	0	0				
LME/MCO reps	2	2	2				
School Reps	2	2	2				
GAL reps	0	1	1				
Non-profit reps	5	5	5				
Provider reps	8	8	8				
Faith community	0	0	0				

2) **Analyze the Problem**: This Collaborative has once had more robust participation from family representatives and juvenile justice. There had never been participation from the faith communities and youth as well as no representation from the Latino serving agencies or communities. Collaborative members considered what was different when they had better family and juvenile participation and they noted that previously they had paid stipends for family participation and the LME/MCO had a staff person who helped recruit family members. Two years ago the chief court counselor reigned and after a few attempts to interest the new court counselor, the Collaborative stopped expecting Juvenile Justice Participation. Since this Collaborative had never had representatives from the faith communities, youth, and agencies serving Latinos, they asked the SOC Coordinator to talk to other SOC Coordinators in areas where they had succeeded in these areas.

3) **Develop solutions**:

- The Collaborative asked the LME/MCO to reinstate stipends for family representatives.
- A representative from the Collaborative became a liaison with the LME/MCO Consumer Affairs and CFAC (Consumer and Families Advisory Committees to brainstorm ways to recruit families for the Collaborative.
- Since the Collaborative felt they could not change their morning meeting time, they realized it would be hard to recruit youth voice. A. Collaborative members volunteered to

check with the local Community College about opportunities to recruit young adults. The Collaborative agreed to run priorities and other decisions by a DSS LINKS (adolescents in DSS custody) group for feedback instead of asking young people to come to their Collaborative meetings.

- The SOC Coordinator agreed to arrange a visit to the chief court counselor in conjunction with the Collaborative chair to talk about the Collaborative's priorities and ask for participation for the next three months.
- Various Collaborative members agreed to do personal outreach to several organizations who served Latino families.
- The Collaborative chairs asked participating provider agencies to send consistent staff.

4) Implement the solution. The Collaborative membership committee had a written plan with the agreements of who would do which tasks. The plan provided accountability.

5**) Evaluate The Results**: Every three months the membership committee updated their membership grid and shared with the Collaborative. Slowly, they started to see the results they sought.

	Jan 2016	April 2016	July 2016	October 2016	Jan 2017	April 2017	July 2017
Family Reps	0	0	0	1	1	3	4
Youth Reps	0	0	0	0	LINKS	LINKS	LINKS
DSS Reps	1	1	0	1	1	1	1
DJJ Reps	0	0	0	0	1	1	1
LME/MCO reps	2	2	2	2	2	2	2
School Reps	2	2	2	3	3	3	3
GAL reps	0	1	1	1	1	1	1
Non-profit reps	5	5	5	5	5	5	5
Provider reps	8	8	8	8	8	8	8
Faith community	0	0	0	0	0	0	2

6) **Standardize The Solution**: Stipends for family representatives and asking for feedback from the LINKS group became institutionalized. The membership committee decided on several additional strategies to try including the development of a Collaborative Orientation manual and assigning of an established Collaborative member to new Collaborative attendees in order to answer questions and Crete a welcoming environment.

Let's use the same steps for an outcome goal. Let's imagine that there have been growing complaints from your local DSS that it takes too long to get young people in their custody to get started in behavioral health services.

Step 1: Identify The Problem

Your Collaborative decides to learn how long it take young people involved with DSS to 1) get an assessment and 2) go from assessment to start of services**.**

Step 2: Analyze the Problem

If your county is a Project Broadcast county or involved with Partnering for Excellence, there may already be efforts to track children through the system. If your county has a JJSAMH (Juvenile Justice Substance Abuse Mental Health) Partnership or is a Reclaiming Futures site, you can learn from these initiatives how they track young people as they move from screening, assessment, first service appointment, first Child and Family Team, completion of treatment, and engagement into prosocial activities. You might be able to adapt their tracking spreadsheet and protocols.

You will need to get in a room with your DSS partners to learn how, why, and who refers children to behavioral health services. You'll need to work out how you will share data across systems. This step can take time and can not be overlooked. This is one area where having a change leader/champion can be vital or the project can stall.

Once the data sharing agreements are in place, you'll need to start a spreadsheet that can be used to track the movement of individual children through each step. This leads to many questions including who will enter information into the spreadsheet and how will that person(s) have access to all the information needed.

Step 3: Develop Solutions

Once you have some baseline data (ex. 10 kids who have gone from screening to start of services) your data team may notice that there is a longer than desired time between referral and completed assessment. Your data team may need information from DSS worker, the involved providers, and the LME/MCO. Based on the information, the data team can develop potential solutions. Here are some examples of some of the potential challenges with assessments being completed in a timely manner:

A). One provider consistently has a waitlist but DSS workers prefer to work with the provider because the provider consistently provides information to the DSS worker which helps with their case planning.

B). A preferred provider has a waitlist because DSS workers prefer the provider because the provider has three clinicians trained in Trauma Focused CBT.

C). The delay seems to be only in the rural part of the county where there is not good provider coverage.

D). The delay seems to be because the providers can not complete the assessment in a timely manner because the DSS workers are not providing background information or access to key informants (foster parents, biological parents). A transportation worker brings the children to appointments.

Sometimes there can be multiple hypotheses as to what is causing a challenging. The data team could come up with several strategies to address multiple issues or could attack the problems one at a time (the one at a time method is preferred in rapid cycle testing which we'll discuss later).

In this example the data team works out a set of strategies that include:

- Developing a working agreement between the provider and the local DSS on a protocol that spells out the minimal frequency of contact of the clinician to the DSS worker and increases access of key informants. Foster parents now take the children to their mental health appointments and biological parents are routinely involved in the assessments. In addition, DSS workers provide their case summaries and access to other evaluations at assessment so the clinicians have more information to base their recommendations. Part of the working agreement also includes the timeframes for completing the assessment and interpretive sessions with the foster and biological parents as well as the DSS worker.
- The data team worked with the LME/MCO provider network to request more clinicians trained in TF-CBT in the rural part of the county. This was a longer term solution but one the data team and Collaborative felt would lead to positive results which they could track over time with their spreadsheet if how children involved with DSS moved through the system.

Step 4: Implement Solutions

It took two months to complete the work on the working agreement between the local DSS and the providers. During that time and throughout the use of the working agreement, the data group continued to track how children in DSS custody moved through the system.

As there were glitches in the development of the protocol and the movement of youth through the system, the data team continued to meet together and solve the myriad of challenges that developed.

Step 5: Evaluate the Results

Because the data team had continued to track the flow of children through the system using their excel spreadsheet, the data team was able to see that after the working agreement was put into place the completion of assessments became more timely. As children moved through the behavioral health system, more challenges with delays in starting services or Child and Family Teams were noted which lead to more hypotheses and testing of potential solutions.

Step 6: Standardize the Solution

The working agreement with DSS and the providers was renegotiated each year as they learned more about the challenges and solutions of children moving through the system. The working agreement included both timeliness of children getting services but also standards of care including improving the comprehensive clinical assessments. More clinicians were in time trained in TF-CBT and the Collaborative felt their encouragement to the LME/MCO to set an enhanced rate for TF-CBT aided in providers being willing to have clinicians participate in TF-CBT Learning Collaboratives.

NIATx Model and its Five Principles

NIATx is "an easy to use model of process improvement designed specifically for behavioral health." Many communities involved in Reclaiming Futures or JJSAMH Partnerships have been trained in NIATx's process improvement process.

NIATx explored the research on process improvement and lists the five principles that most influence process improvement efforts. These five principles are:

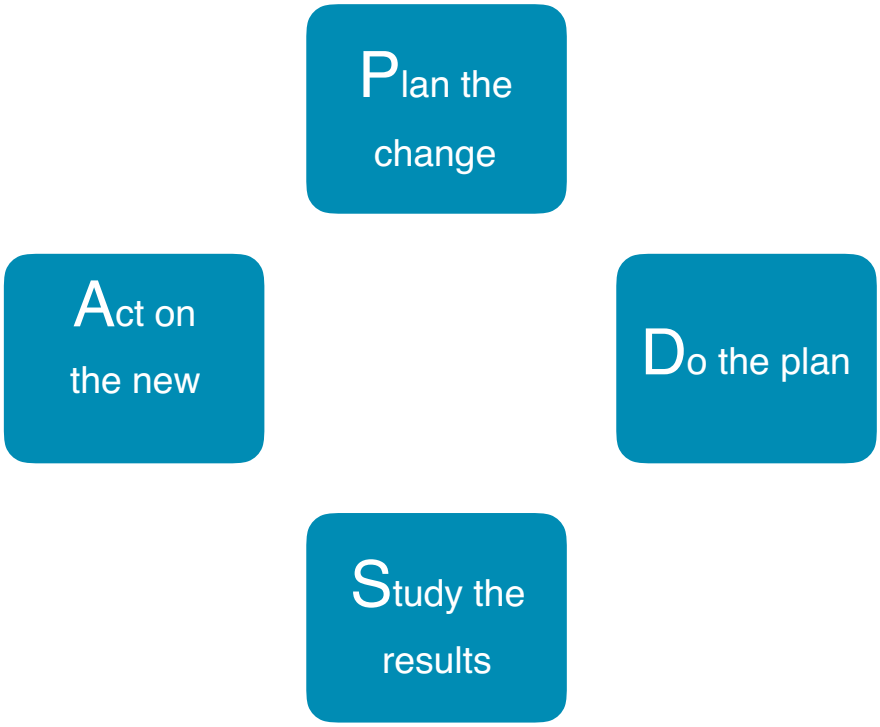
1). Understand and involve the customer
2). Fix key problems; help the CEO sleep
3). Pick a powerful Change Leader
4). Get ideas from outside the organization or field
5). Use rapid-cycle testing to establish effective changes

You can read more about these five principles and watch a short video at this link: http://www.niatx.net/Content/ContentPage.aspx?NID=131

Let's consider two of the five principles: involving consumers and rapid cycle testing. Beyond having family and youth voice in your data teams which is critical, NIATx encourages walk-throughs where your data team or a pretend consumer walks through the process you

are studying. In the case of children in DSS custody having assessments completed in a timely way, you could have a pretend guardian call to set up an appointment. In this situation you can have the pretend guardian go through the LME/MCO and or directly go to the provider. The NIATx website provides additional information and worksheets on planning a walk through.

NIATx also encourages rapid cycle testing which are small and time limited experiments in change following a Plan-Do-Study-Act (PDSA) flow. PDSAs are a simplified version of the 6 step continuous improvement process outlined above. The advantage of rapid cycle testing is you test small experiments in change (one clinician or DSS worker doing something different for two weeks) to learn if you should widen that approach. Rapid cycle testing gets the team in the mindset of change and teaches that a process improvement process does not take months or years to implement. You can do small tests immediately and then consider if you should continue and widen that approach or try something different.



If you have a Reclaiming FuturesTeam or a JJSAMH Partnerships, learn from their experience with use of spreadsheets to track movement of children through a system as well as in using a process improvement process that involves rapid cycle testing, walk-through, and developing priorities and work plans from local data.

Conclusion:

Data can empower, enliven, inform, and drive the work of a Community Collaborative. It can unite partners in a common goal. There are many sources of local data and multiple options for a coach for your data team. Those options for coaches include LME/MCO Quality Management staff, staff from your DSS involved in CQI projects, and providers who all have CQI projects and staff.

As North Carolina moves toward the next round of Medicaid reform where physical and behavioral health are both managed, the Triple Aims of Health Care will become more critical. The Triple Aims as developed by the Institute for Healthcare Improvement in Cambridge, Massachusetts (www.ihi.org) are:

- Improving the client's experience of care (safe, effective, patient-centered, timely, efficient, and equitable).
- Improving population health
- Reducing per capita costs of health care

Having a robust continuous quality improvement lays the foundation for on-going progress in meeting the Triple Aims. Meeting the Triple Aims also requires working across agencies. For children's behavioral health, the Community Collaborative offers a venue and opportunity to improve processes across multiple agencies involved in children and families' lives.