Semi-Annual Report to the

Joint Legislative Oversight Committee

on Health and Human Services

on

Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2012-13: Fall Report

North Carolina General Statute 122C-102

October 1, 2012

North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Executive Summary

The General Statute continues to require the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the Division) to report to the Joint Legislative Oversight Committee on Health and Human Services every six months on progress made in seven statewide performance domains. This semi-annual report builds on the measures in previous reports.

Highlights

Domain 1: Access to Services – (1) Overall, in recent years there has been an increase in the number of persons served by Local Management Entities (LMEs) across the state which can be attributed to both improvements in LME data submission and an increase in admissions. The number of persons enrolled by LMEs increased in the past year for adults in every disability group and for adolescents with a primary developmental disability diagnosis, but decreases were noted in enrollment for children/adolescents with a primary mental health or substance abuse diagnosis. (2) Based on the consistent level of reporting for emergent care (100%) a decision was made to remove this measure from the report. 81% of persons seeking urgent care were seen within 48 hours of requesting services; and three-fourths of persons seeking routine care (non-urgent) were seen within fourteen calendar days.

Domain 2: Individualized Planning and Supports – (1) The majority (69%) of consumers with intellectual and developmental disabilities report choosing the case manager at a much higher rate than reports of families in other states. In addition, an overwhelming number (87%) of consumers with intellectual and developmental disabilities report their case manager is helpful in getting necessary services and supports. In the future, the Division will determine satisfaction with the newly defined care coordination definition and how this change has impacted consumers. (2) The vast majority of consumers with mental health and substance abuse disorders report choosing the services they received as well as their treatment goals. However, fewer adolescents report being involved in choosing their services than other age groups and fewer adolescents and adults (as compared to parents of children under twelve) report deciding their treatment goals.

Domain 3: Promotion of Best Practices – (1) North Carolina Systemic Therapeutic Assessment, Respite and Treatment (NC START) teams, mobile crisis management teams and walk-in crisis and psychiatric aftercare programs are serving mh/dd/sa consumers in crisis in their communities, reducing the need for psychiatric hospitalization. The number of evidence-based mental health services and substance abuse services has generally increased over the past three years. In some cases a slight decrease was seen during the last quarter of SFY 2010-2011, possibly due to the lag time needed for claims to be reported. The only exception to this is community support team (CST) which has seen a steady decline since the beginning of SFY 2010-11. (2) Admissions to the state alcohol and drug abuse treatment centers have increased in the last five years, while there has been a significant drop in admissions to state psychiatric hospitals since SFY 2006-07. This is likely due both to increases in community inpatient capacity and to policies to delay admissions when state hospitals are over capacity. (3) Readmissions to state psychiatric hospitals continue to remain slightly higher for North Carolina than the nation.

Domain 4: Consumer-Friendly Outcomes – (1) While the majority of consumers with developmental disabilities report choosing where they work and the staff who assist them at home and work, less than half of them report choosing where they live (which is the same pattern seen in all other states). (2) Mental health and substance abuse consumers continue to show meaningful improvements in various aspects of their lives after three months of service.

Domain 5: Quality Management Systems – (1) A preliminary review was conducted on monitoring, reporting, rule creation, incident reporting and other items that could be streamlined in order to allow both Local Management Entities/Managed Care Organizations (LME-MCOs) and provider agencies a more

consistent process for submitting information to the North Carolina Department of Health and Human Services (the Department). The "Action Plan Steps" created by the Department is outlined in this domain. (2) The Department is in the process of expanding the 1915 (b)/(c) Medicaid Waiver. As a part of this expansion process, the Department is preparing a strategic plan indicating strategies and agency responsibilities for the achievement of the objectives and deadlines as well as how the Division and the Division of Medical Assistance (DMA) will monitor and evaluate progress of these objectives. The main method for evaluating the progress of LMEs as they assume responsibilities of managed care organizations is a standardized performance dashboard. In addition to the performance dashboard, various monitoring teams and committees will be formed to ensure best practices are implemented, to provide oversight of implementation activities, to review quality of care concerns and quality improvement activities, and to develop plans for improvement. As a final quality management/evaluation effort, there will be annual on-site reviews of the LMEs to verify the data reported by the LME/MCOs.

Domain 6: System Efficiency and Effectiveness – (1) LMEs' timely and accurate submission of data to the Division has stabilized from the first quarter of SFY 2009-10 to the fourth quarter of SFY 2010-11.

Domain 7: Prevention and Early Intervention – (1) North Carolina was awarded the Screening, Brief Intervention and Referral to Treatment (SBIRT) grant that began in the Fall of 2011. This is a five year grant designed to increase access to alcohol and substance abuse treatment services to consumers through primary care practices and local health centers. Screening for alcohol and drug use is provided by health navigators while interventions and referrals are provided by substance abuse professionals at the primary care sites. (2) The Strategic Prevention Framework-State Prevention Enhancement (SPF-SPE) capacity building grant was awarded in September 2011 and will be administered by the North Carolina Office of Prevention. The SPF-SPE capacity building grant will provide support to the Division for the development of; (a) Technical Assistance and Training Plan, (b) Data Collection, Analysis and Reporting Plan, (c) Service Coordination Plan, and (e) a Performance/Evaluation Plan.

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Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2012-13: Fall Report

Introduction

The *Mental Health, Developmental Disabilities and Substance Abuse Services Statewide System Performance Report* is presented in response to Session Law 2006-142, Section 2.(a)(c). This legislation was amended by Session Law 2011-291, Section 2.42 (c) which requires this semi-annual report on progress made in seven statewide performance domains to be submitted to the Joint Legislative Oversight Committee on Health and Human Services. This semi-annual report builds on the measures reported in previous reports (See Appendix A).

Domain 1: Access to Services

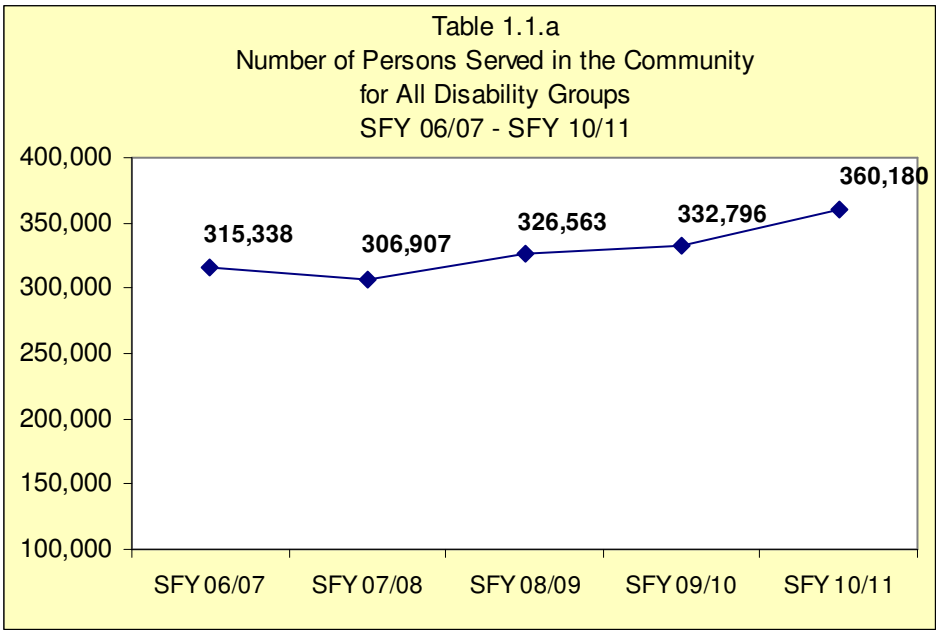
Access to Services refers to the process of entering the service system. This domain measures the system's effectiveness in providing easy and quick access to services for individuals with mental health, developmental disabilities and substance abuse service needs who request help. It is a nationally recognized measure of service performance.

Measure 1.1: Persons Receiving Community Services

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (the Division) is committed to serving individuals with mental health, developmental disabilities, and substance abuse needs in their communities rather than in institutional settings whenever possible. Tracking the number of persons that the Local Management Entities (LMEs) serve in communities provides a barometer of progress on this goal.

Measure 1.1 contains information on the number of persons that the state's mental health, developmental disabilities and substance abuse system has served over the past five state fiscal years, according to the LMEs' data on enrolled consumers. In the following three tables, the number of persons served is determined from data submitted to the Division's Client Data Warehouse (CDW) by the LMEs.[1] As shown in Table 1.1.a on the next page, the number of persons enrolled in LMEs has increased by 14% over the past five years. Most of this increase has been in adult services.

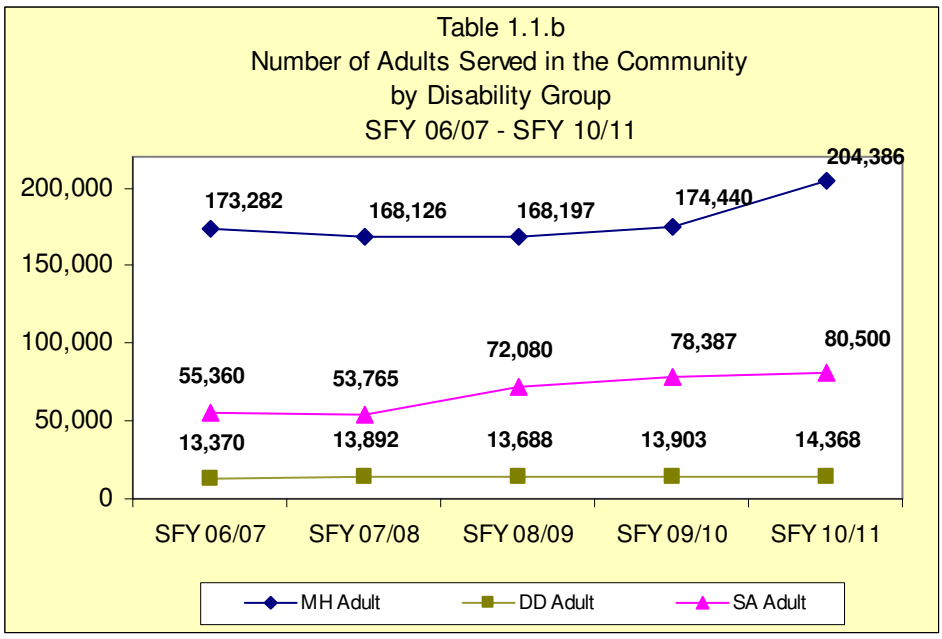
[1] Numbers for SFY 2011-2012 are not available until September 2012 and are not included in the tables. Other numbers in the table have been updated since the Fall 2011 Report.



SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2006 - June 30, 2011.

Table 1.1.b. shows the number of adults who have been enrolled in LMEs over the past five state fiscal years by disability.

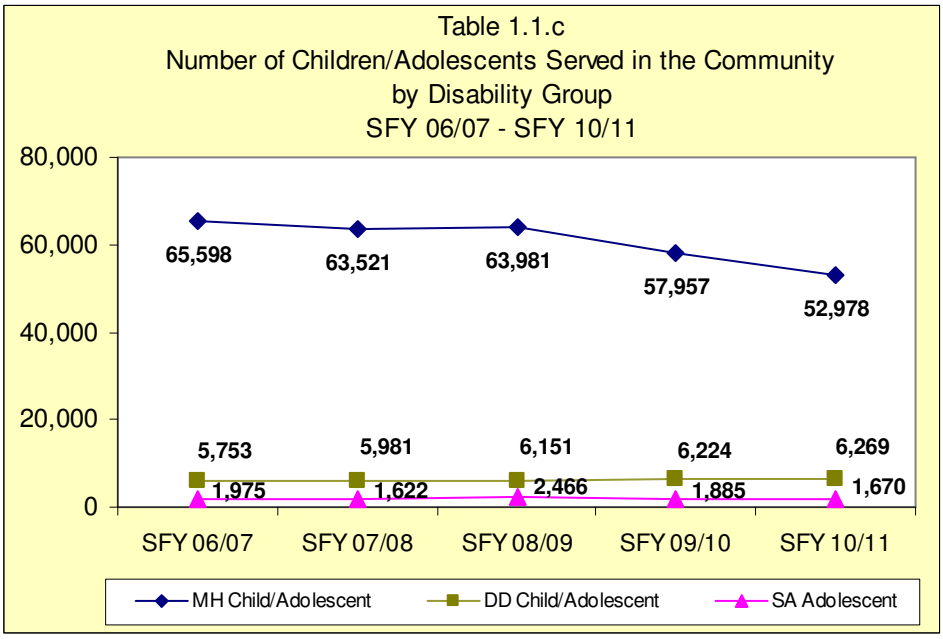
- **Adults with a primary mental health diagnosis:** The number of adults served in the community over the past five years has increased by approximately 18%.
- **Adults with a primary developmental disability diagnosis:** The number of adults served in the community over the past five years has increased by seven percent.
- **Adults with a primary substance abuse diagnosis:** The number of adults served in the community over the past five years has increased by 45 %.



SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2006 - June 30, 2011.

Table 1.1.c shows the number of children and/or adolescents enrolled for publicly-funded services through the LMEs over the past five state fiscal years.

- **Children/Adolescents with a primary mental health diagnosis:** The number of children and adolescents served in the community over the past five years has decreased by 19%.
- **Children/Adolescents with a primary developmental disability diagnosis:** The number of children and adolescents served in the community over the past five years has increased by nine percent.
- **Children/Adolescents with a primary substance abuse diagnosis:** The number of adolescents served in the community over the past five years has decreased by 15%.



SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2006 - June 30, 2011.

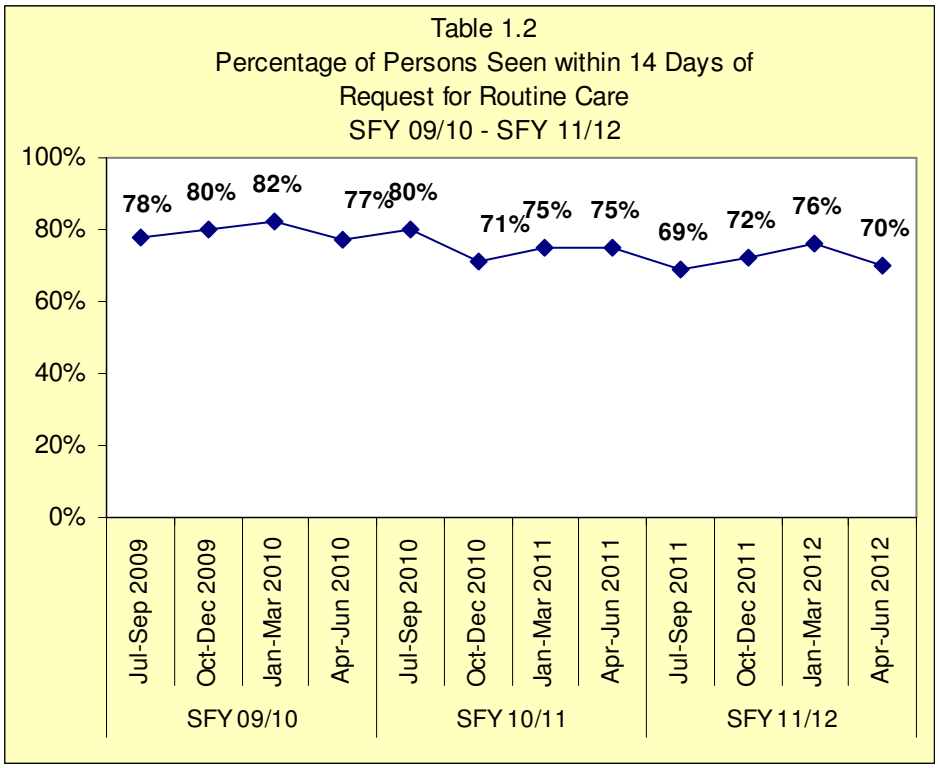
Measure 1.2: Timeliness of Initial Service

Timeliness of Initial Service is a nationally accepted measure[2] that refers to the time between an individual's call to an LME or provider to request service and their first face-to-face service. A system that responds quickly to a request for help can prevent a crisis that might otherwise result in greater trauma to the individual and more costly care for the system. Responding when an individual is ready to seek help also supports his or her efforts to enter and remain in services long enough to have a positive outcome.

Individuals who request service during crisis situations are usually seen very quickly. Approximately 99-100% of those requesting care in emergency situations are seen within two hours, while 78% of those requesting care in urgent situations in April-June 2012 are seen within 48 hours.

[2] Health Plan Employer Data and Information Set (HEDIS©) measures.

During the same period, slightly over three-fourths (76%) of persons requesting routine (non-urgent) services were seen by a provider within two weeks, which is similar to past reports (see Table 1.2). However, over the three year period, access to routine services has tracked slightly downward.



SOURCE: Data from LME screening, triage, and referral logs submitted to the NC Division of MH/DD/SAS, published in Quarterly Performance Contract reports.

Domain 2: Individualized Planning and Supports

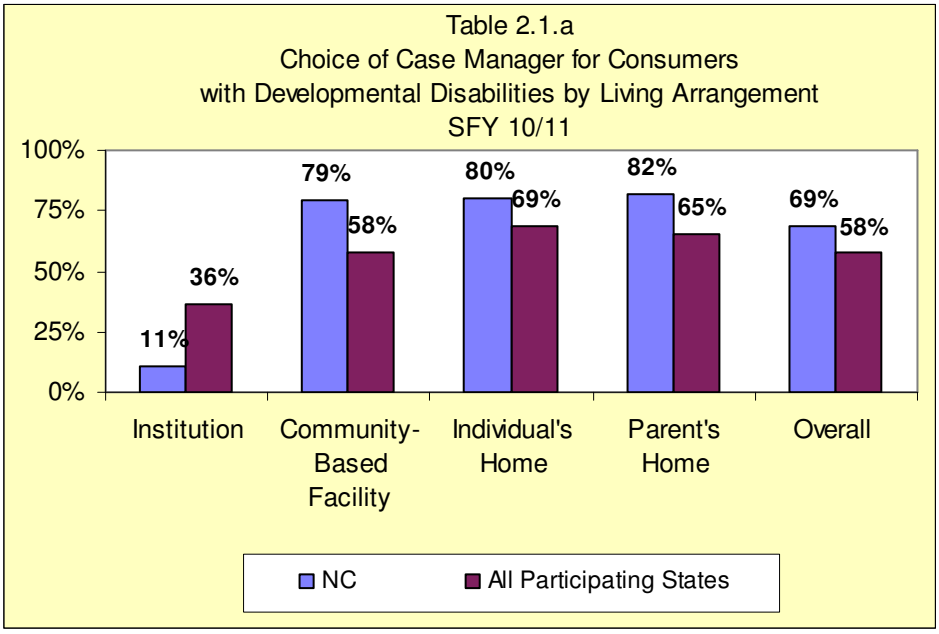
Individualized Planning and Supports refers to the practice of tailoring services to fit the needs of the individual rather than simply providing a standard service package. It addresses an individual's and/or family's involvement in planning for the delivery of appropriate services. Services that focus on what is important to individuals (and to their families when appropriate) are more likely to engage them in service and encourage them to take charge of their lives. In addition, services that address what is important for them to produce improved life outcomes more efficiently and effectively.

Measure 2.1: Consumer Choice of Providers

Offering choice is the initial step in honoring the individualized needs of persons with disabilities. The tables on the following pages address the extent to which individuals report having a choice in who serves them and/or the services they receive.

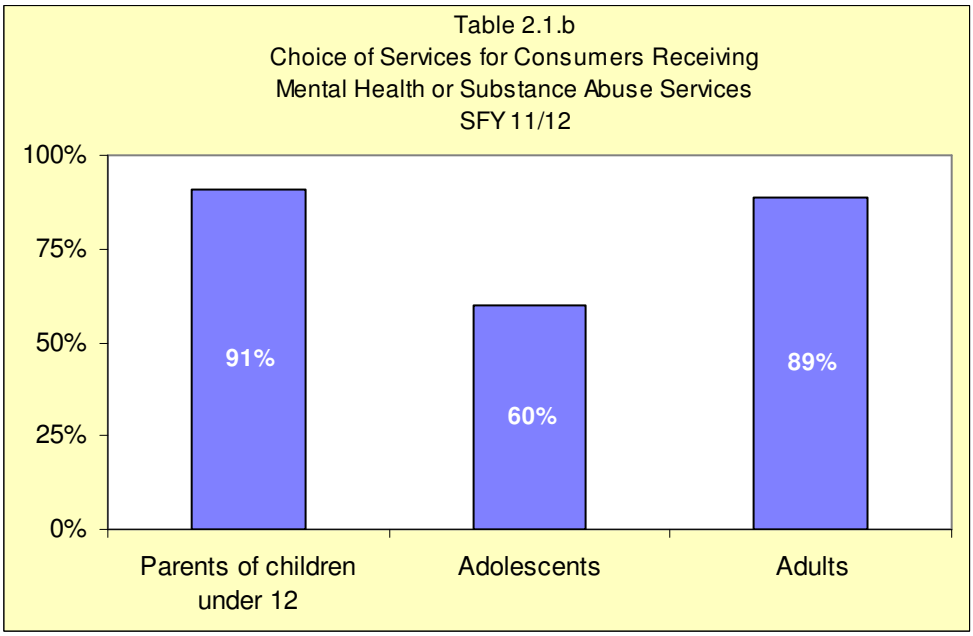
Consumers with Developmental Disabilities (DD) (Table 2.1.a): In annual interviews with DD consumers in SFY 2010-11, just over two-thirds (69%) of the consumers in NC reported choosing their case manager compared to 58% reporting this for all participating states (see Table 2.1.a). Looking at choice of case manager by residence type, consumers in North Carolina who reside in an institution were the least likely to report choosing their case manager (eleven percent) compared to 36% nationally, while those living in their own home or in their parent's home were more likely to report choosing their case

manager (80% and 82%, respectively), slightly higher than comparable national figures of 69% and 65%. (See Appendix B for details on the National Core Indicators Project's Consumer Survey.) In the future, the Division will determine satisfaction with the newly defined care coordination definition and how this has change has impacted consumers



SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2010-11.

Consumers with Mental Health and Substance Abuse Disabilities (Table 2.1.b): In the annual Division survey of persons with mental health or substance abuse disabilities, a large majority reported positive feedback regarding choosing the services they received. Parents of children under the age of twelve and adults were more likely to agree that they had input into the services received than adolescents. (See Appendix B for more information on the Mental Health Statistical Improvement Project Consumer Survey.)

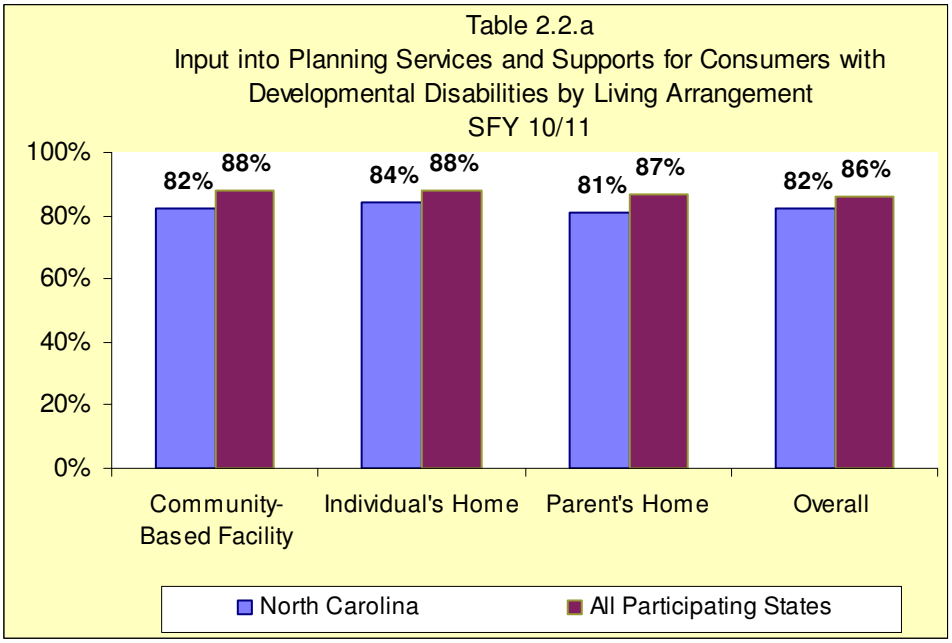


SOURCE: Mental Health Statistical Improvement Project Consumer Survey (MHSIP-CS)

Measure 2.2: Person-Centered Planning

A Person-Centered Plan (PCP) is the basis for individualized planning and service provision. It allows consumers and family members to guide decisions on what services are appropriate to meet their needs and goals and tracks progress toward those goals. Having a voice in choosing personally meaningful goals is a critical step toward recovery and self-determination. The Division requires a PCP for persons with intellectual disabilities who receive Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD) or state-funded services and persons with severe mental illness and/or substance abuse disorders who receive enhanced benefit or residential services.[34] As the following tables show, a large majority of consumers and their family members are involved in the service planning and delivery process.

Consumers with Developmental Disabilities (Table 2.2.a): In SFY 2010-11, most North Carolina consumers with developmental disabilities (84%) reported that their case manager helps get them the services and supports they need (see Table 2.2.a). North Carolina consumers, regardless of where they live, were slightly less likely to report involvement in planning compared to consumers in all states using this survey. (See Appendix B for more information on this survey.)



SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2010-11.

Consumers with Mental Health and Substance Abuse Disabilities (Table 2.2.b): Every year in a consumer survey the Division asks mental health and substance abuse consumers about their having a choice of treatment goals. As Table 2.2.b on the next page shows, the majority of mental health and substance abuse consumers in the annual survey reported choosing or helping to choose their treatment goals. More parents of children under the age of twelve reported having input into their treatment goals than adults and adolescents. (See Appendix B for more information.)

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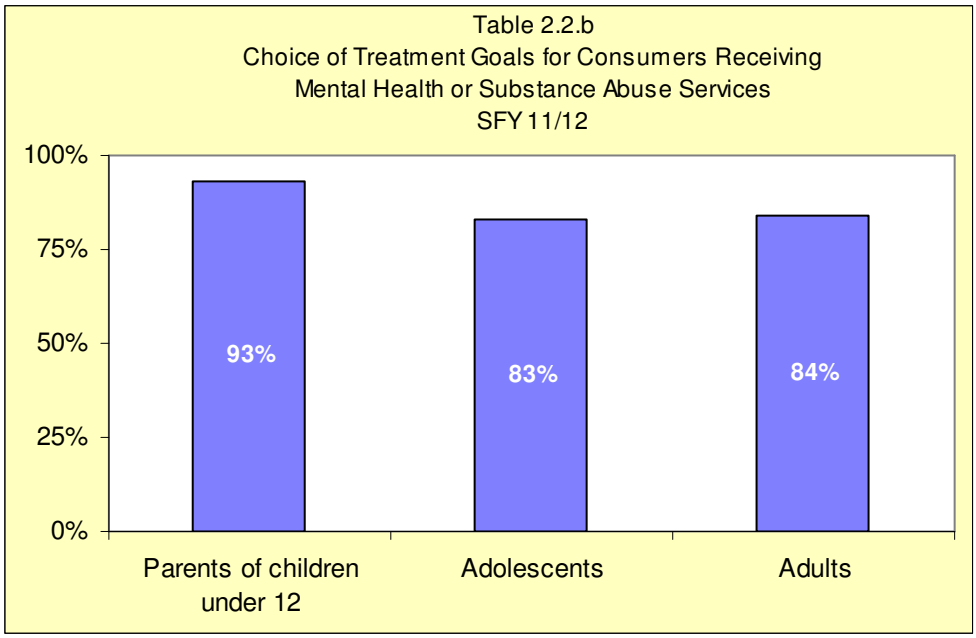
[3] "The enhanced benefit service definition package is for persons with complicated service needs." *State MH/DD/SAS Plan 2005*, p. 58. Details on enhanced and residential services can be found at http://www.ncdhhs.gov/dma/mp/index.htm (Medicaid Clinical Policy 8A through 8M).

[4] A Person Centered Plan is not required for individuals receiving any of the "basic" services (i.e., outpatient treatment, assessment, or medication management) as long as they are not also receiving any other services.



SOURCE: Mental Health Statistical Improvement Project Consumer Survey (MHSIP-CS)

Domain 3: Promotion of Best Practices

This domain refers to adopting and supporting proven models of service that give individuals the best chance to live full lives in their chosen communities. It includes support of community-based programs and practice models that scientific research has shown result in improved functioning of persons with disabilities, as well as promising practices that are recognized nationally. The Substance Abuse and Mental Health Services Administration (SAMHSA) requires states to report on the availability of evidence-based practices as part of the mental health and substance abuse prevention and treatment block grants.

Supporting best practices requires adopting policies that encourage the use of natural supports, community resources and community-based service systems; funding the development of evidence-based practices; offering incentives to providers who adopt those practices; and providing oversight and technical assistance to ensure the quality of those services.

The North Carolina Practice Improvement Collaborative (NC PIC) provides guidance to the Division in determining the evidence-based practices that will be provided through our public system. With representatives of all three disabilities, NC PIC meets quarterly to review and discuss practices that have been submitted for evaluation, examine issues that affect the readiness of the practice for adoption in our state, and to prioritize recommendations for the Division Director.

Measure 3.1: Persons Receiving Evidence-Based Practices

Community-based Crisis Services: An effective community-based service system starts with flexible, responsive crisis services that can come to the person in need and assist other responders on-site. This approach helps to prevent inappropriate, costly and unnecessary hospitalization or detention of persons undergoing a behavioral health crisis.

- NC START: NC START (North Carolina Systemic, Therapeutic Assessment, Respite and Treatment) is a community-based crisis prevention and intervention program for adults with Intellectual/Developmental Disabilities (I/DD) who experience crises due to complex behavioral

health issues. The NC START program is comprised of six clinical teams, with two teams in each of the three regions in the state. In addition, there are three NC START crisis respite homes, one per region. Each home has a four bed capacity with two planned and two crisis beds. During SFY 2011-12, NC START provided services to 668 individuals and had 502 crisis respite admissions.

Additionally, NC START responded to 1,023 referral/crisis calls in SFY 2011-12. The following reflects the disposition of those referral/crisis calls:

64% remained in their current setting,

11% were admitted to crisis respite,

7% were admitted to a community psychiatric hospital,

4% were admitted to a state psychiatric hospital,

8% were referred out for services, and

6% were linked to community resources.

Note: Of the 1,023 referral/crisis calls received, 57 were determined to be inappropriate for NC START services as they did not meet the criteria, i.e. were under age 18, or did not have a diagnosis of intellectual/developmental disability. These individuals were referred out for services or linked to community resources as reflected above.

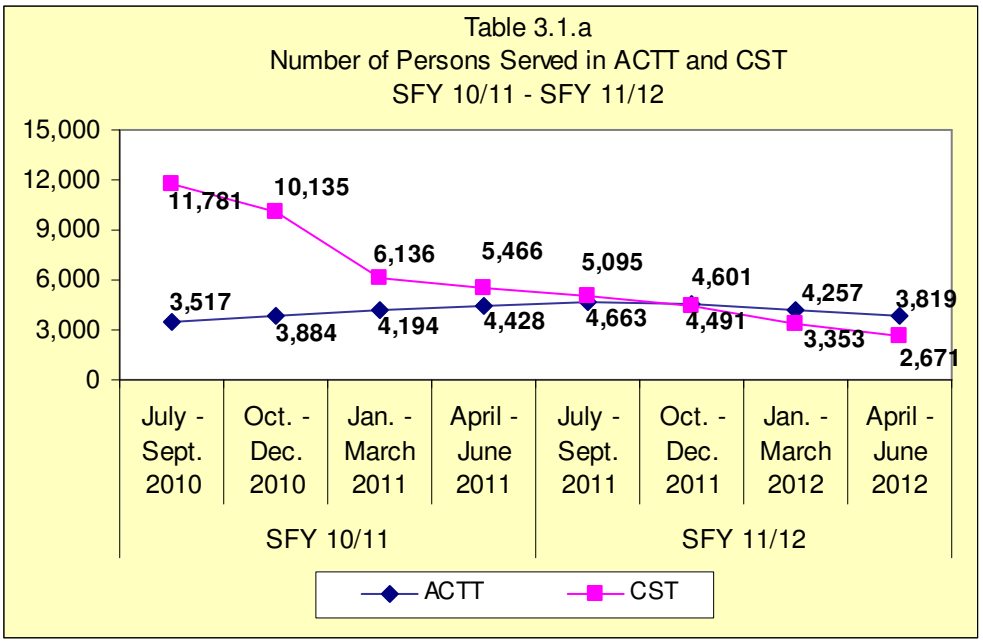
- Mobile Crisis Management: In 2008, the General Assembly appropriated funds for crisis services and Session Law 2008-107 provided support for the development of 30 community Mobile Crisis Management Teams. Mobile Crisis Teams respond to behavioral health emergencies by going where the crisis is occurring rather than requiring that the person in crisis be admitted to an Emergency Department or show up at a local provider's office. From January through December 2011, Mobile Crisis Management Teams provided 25,074 crisis responses[5] Of those, 6,935 (28%) were admitted to state hospitals, state alcohol and drug abuse treatment centers, and community hospitals, and only 353 (1.4%) involved jail or detention. All of the other cases (70%) were referred to community-based services.

- Walk-In Crisis and Psychiatric Aftercare: In SFY 2008-09, the General Assembly provided funds to establish 30 walk-in crisis and psychiatric aftercare programs. These centers provide immediate care to adults, adolescents, or families in crisis directly or through telepsychiatry. From January through December 2011 these walk-in centers provided 168,908 services to consumers, 13.6% (23,010 services) of which were in response to crises. Among consumers who received services at walk-in centers, only 2.2% (3,733) required inpatient hospitalization (state or community psychiatric inpatient, or state Alcohol and Drug Abuse Treatment Centers (ADATCs), while in 91.9% (155,330) of cases, individuals were connected to MH/DD/SAS providers in their communities.[6]

[5] These data reflect 12 months of services provided by Mobile Crisis Management Teams from all Local Management Entities except PBH and Western Highlands Network (WHN), each of which submitted data covering a six-month period.

[6] These data reflect reports submitted by 17 LMEs during the first six months, and only 13 LMEs during the latter six months. Centerpoint, Crossroads, Mecklenburg, and Pathways LMEs did not submit data for the July – December 2011 period.

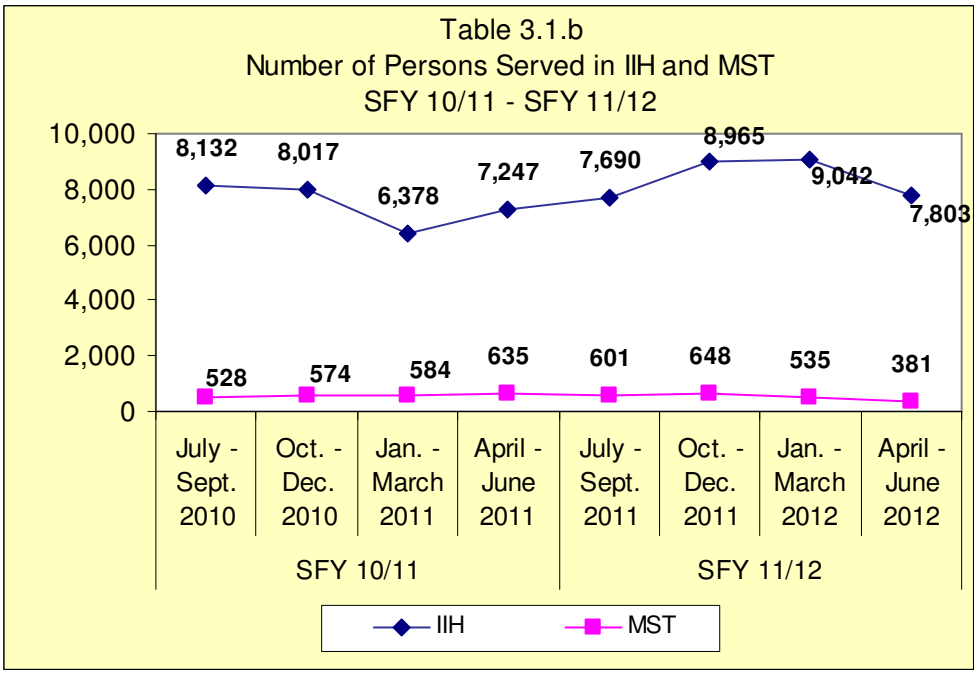
Consumers with Mental Health Disabilities: Adults with severe and persistent mental illnesses often need more than outpatient therapy or medications to maintain stable lives in their communities. Community support teams (CST) and assertive community treatment teams (ACTT) are designed to provide intensive, wrap-around services to prevent frequent hospitalizations for these individuals and help them successfully live in their communities. As shown in Table 3.1.a, the number of adults served in CST has declined significantly over the past two years. This decrease was expected as the Division has worked to restructure services so that consumers who had the greatest need would be able to receive the appropriate level of services through Critical Access Behavioral Health Agencies (CABHAs) which provide a continuum of care for a specified age disability group. Persons receiving these services are either stepped up to more intensive services or stepped down into less intensive services during their continuum of care. Conversely, ACTT has increased by nine percent over the same period.



SOURCE: Medicaid and State Service Claims Data. July 1, 2010 - June 30, 2012.[7]

Best practice to support community living for children and adolescents with severe emotional disturbances and/or substance abuse problems requires involvement of the whole family. Two of these best practices – intensive in-home (IIH) and multi-systemic therapy (MST) – help reduce the number of children placed in residential and inpatient care. Table 3.1.b. on the next page, shows that the number of youth served in IIH decreased four percent over the past two years with a dip during SFY 2010-11. The number of youth receiving MST declined 28% over the same period. These changes can be attributed to the implementation of CABHAs and a reduction in funding for these services.

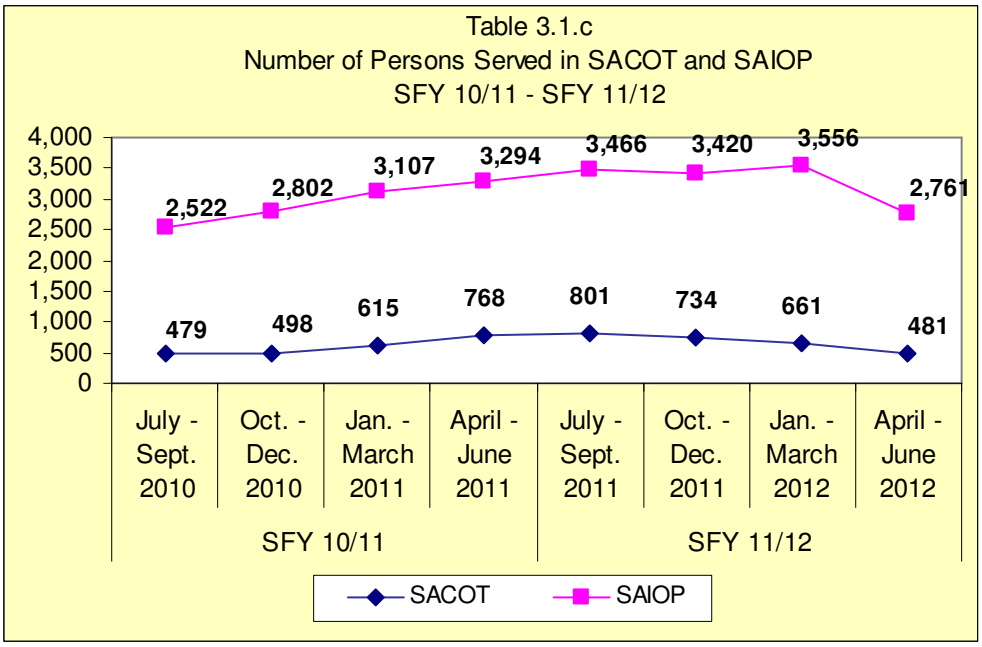
[7] Totals are based on Medicaid and the NC Incident Response Improvement System (IPRS) claims paid through June 2012. Due to billing lag, recent quarters will be incomplete and previous quarters may have updated totals. Due to participation in the Medicaid waiver the tables do not include Medicaid data for PBH (entire period), Alamance-Caswell (beginning Oct 2011), WHN and Five County (beginning Jan 2012), and ECBH (beginning Apr 2012).



SOURCE: Medicaid and State Service Claims Data. July 1, 2010 - June 30, 2012.[8]

Consumers with Substance Abuse Disabilities: Recovery for individuals with substance abuse disorders requires service to begin immediately when an individual seeks care and to continue with sufficient intensity and duration to achieve and maintain abstinence. The substance abuse intensive outpatient program (SAIOP) and comprehensive outpatient treatment (SACOT) models support those intensive services using best practices, such as motivational interviewing techniques. SAIOP has seen a nine percent increase in the number of persons served in the past two years (see Table 3.1.c on the next page). Between the first quarter of both SFY 2011 and SFY 2012, there was a 67% increase in SACOT services. By the fourth quarter of SFY 2011-12 the number of consumers served has decreased to 481.

[8] Totals are based on Medicaid and IPRS claims paid through June 2012. Due to billing lag, recent quarters will be incomplete and previous quarters may have updated totals. Due to participation in the Medicaid waiver the tables do not include Medicaid data for PBH (entire period), Alamance-Caswell (beginning Oct 2011), WHN and Five County (beginning Jan 2012), and ECBH (beginning Apr 2012).



SOURCE: Medicaid and State Service Claims Data. July 1, 2010 - June 30, 2012.[9]

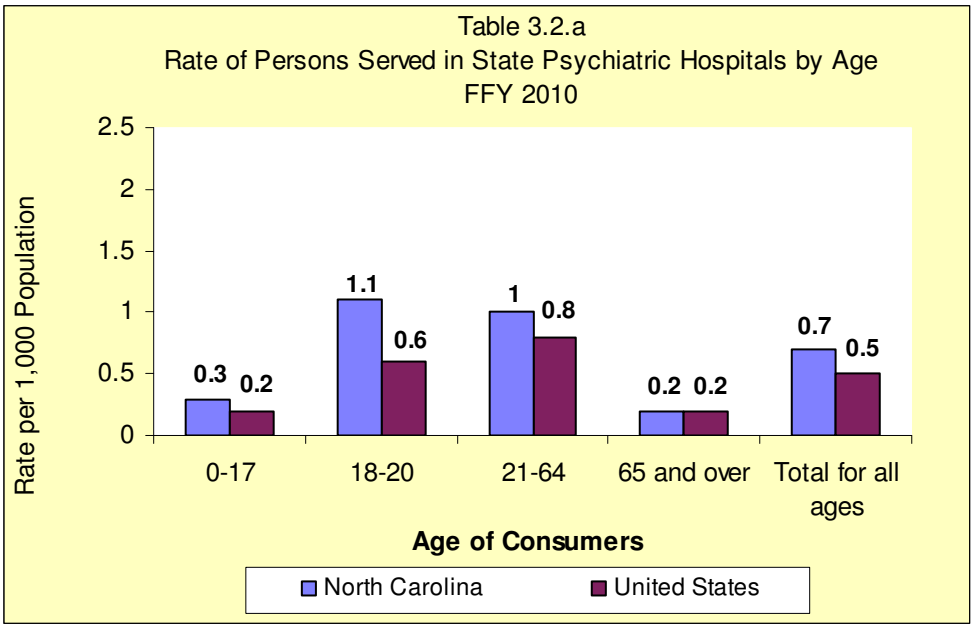
Measure 3.2: Use of State Operated Services

Psychiatric Hospitals: A service system in which individuals receive the services and supports they need in their home communities allows them to stay connected to their loved ones. This is a particularly critical component of recovery or self-determination in times of crisis. As discussed under Measure 3.1, service systems that provide community-based crisis response inpatient services can help individuals maintain support from their family and friends, while reducing the use of state-operated psychiatric hospitals in times of acute crisis.

As stated in previous reports, North Carolina has used its state psychiatric hospitals to provide both acute (30 days or less) and long-term care. In most other states, acute care is provided in community hospitals, reserving the use of state psychiatric hospitals for consumers needing long-term care. North Carolina, however, has historically served more people overall in its state psychiatric hospitals than other states and with shorter average lengths of stay. This is an area of focus for improvement across the state.

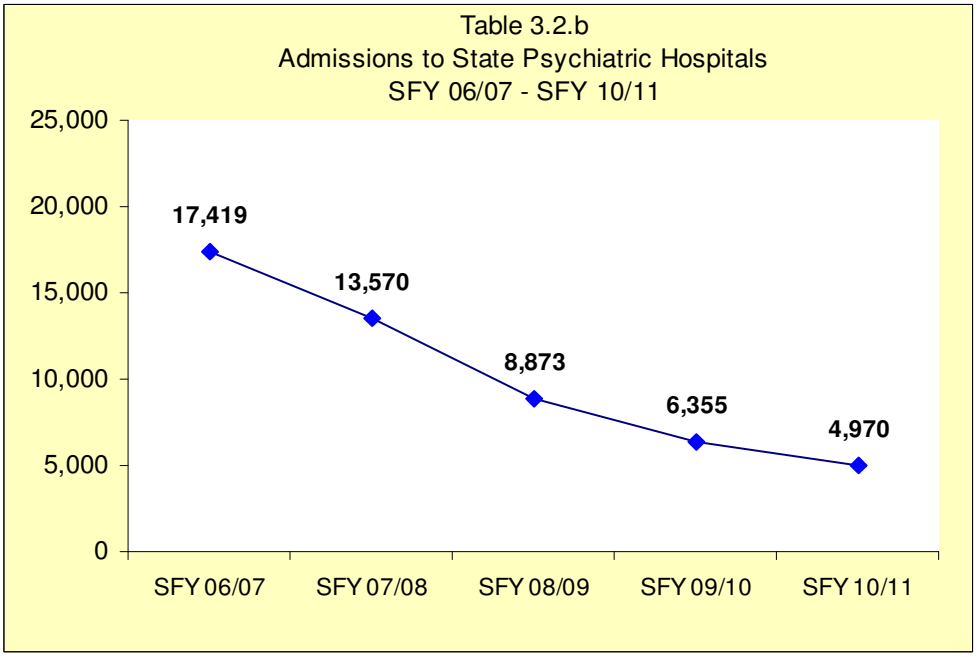
Table 3.2.a on the next page, indicates North Carolina has continued to provide treatment for persons in its state psychiatric hospitals at a rate somewhat higher than the national rate across almost all ages, according to the most recent report (federal fiscal year (FFY) 2010) from the Center for Mental Health Services (CMHS).

[9] Totals are based on Medicaid and IPRS claims paid through June 2012. Due to billing lag, recent quarters will be incomplete and previous quarters may have updated totals. Due to participation in the Medicaid waiver the tables do not include Medicaid data for PBH (entire period), Alamance-Caswell (beginning Oct 2011), WHN and Five County (beginning Jan 2012), and ECBH (beginning Apr 2012).



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data as reported in the North Carolina Community Mental Health Block Grant report, FFY 2010.[10]

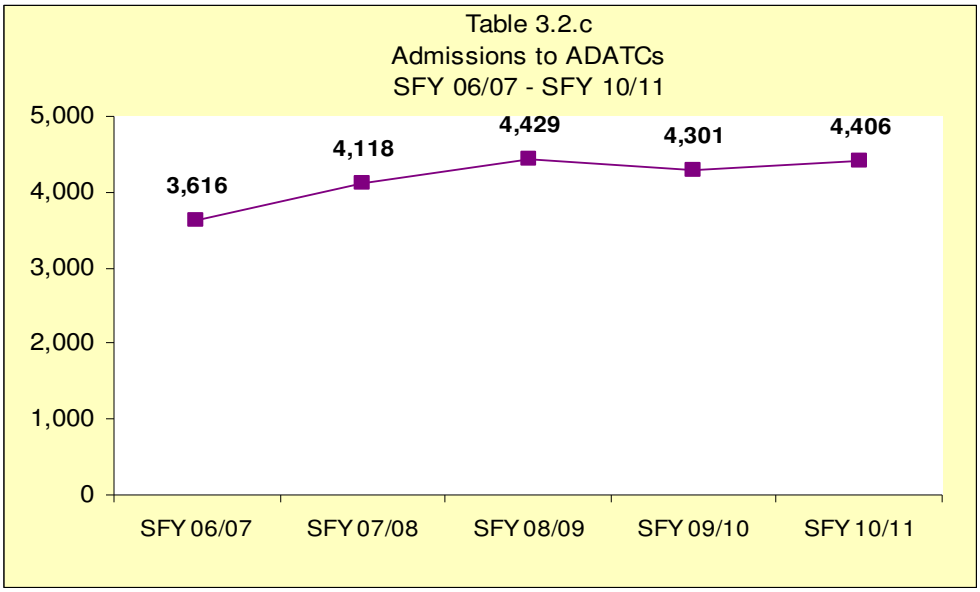
Over the past five years, the number of admissions to the state psychiatric hospitals has however, decreased by over two-thirds. This is likely due to both increases in community inpatient capacity as well as policies to delay admissions when state hospitals are over capacity.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for state psychiatric hospital admissions during July 1, 2006 - June 30, 2011.

[10] The table was generated from the "*North Carolina 2010 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System*," page 6. Additional details can be found at http://www.samhsa.gov/dataoutcomes/urs/2010/NorthCarolina.pdf.

Alcohol and Drug Abuse Treatment Centers: In contrast to efforts to *reduce* the use of state psychiatric hospitals for short-term care, the Division continues to work with the Division of State-Operated Healthcare Facilities (DSOHF) to *increase* the use of state ADATCs for acute care. ADATCs are critical resources to serve individuals who are exhibiting primary substance abuse problems that are beyond the treatment capacity of local community services, but for whom psychiatric hospitalization is not appropriate. Due to an increase in acute capacity in the ADATCs and enhanced management practices, total admissions to ADATCs has climbed from SFY 2006-07 to SFY 2010-11 by 22%. This is a positive development to more effectively utilize this important level of care.

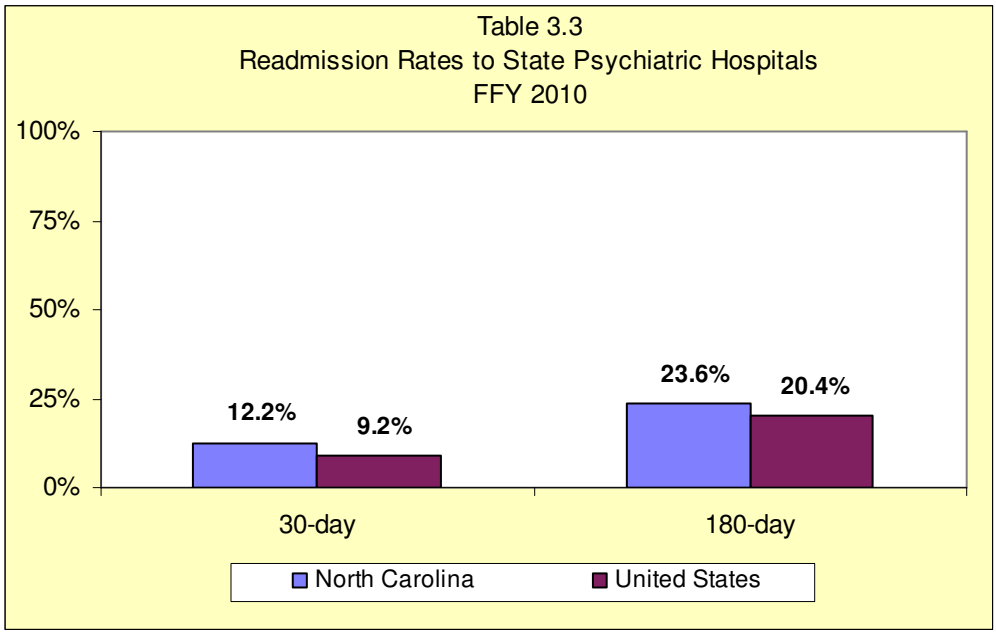


SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for ADATC admissions during July 1, 2006 - June 30, 2011.

Measure 3.3: State Psychiatric Hospital Readmissions

An effective service system provides enough support to help prevent consumer crises and minimize their impact through appropriate planning and treatment. Recurring hospitalization for persons who are likely to experience frequent crises is a signal that additional supports are needed. Tracking hospital readmissions within 30 days of discharge is a critical measure of consumer care (adopted by SAMHSA's Center for Mental Health Services) that provides information on where more comprehensive services might be needed. This indicator measures the percent of persons discharged from state psychiatric hospitals, who are readmitted to a state psychiatric hospital within 1-30 days following discharge and within 1-180 days following discharge.

Table 3.3 shows the percent of consumers requiring readmission to state hospitals within 30 days and within 180 days of discharge. North Carolina state psychiatric hospital readmissions are slightly above the nation for both the 30-day and 180-day time periods, suggesting the need for continued development of community-based services to address this population.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data as reported in the North Carolina Community Mental Health Block Grant report, FFY 2010.[11]

Measure 3.4: Transitions to Community from State Developmental Centers

DSOHF and the Division are working together to increase opportunities for individuals with developmental disabilities to live in community settings, when appropriate and desired. For individuals moving from the developmental centers to the community, transition planning begins many months prior to discharge.[12] This involves multiple person-centered planning meetings between the individual, their guardian, the treatment team and the provider that has been selected by the individual and their guardian. Service delivery begins immediately upon leaving the developmental center. During SFY 2012, a total of four individuals were discharged from the general population of the developmental centers to the community.[13] Table 3.4 on the next page, shows the type of community setting to which the individuals moved.[14]

[11] The table was generated from the "*North Carolina 2010 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System,*" page 1. Additional details can be found at http://www.samhsa.gov/dataoutcomes/urs/2010/NorthCarolina.pdf.

[12] Best practice for persons with DD moving from one level of care to another is to receive immediate follow-up care that adheres to prior planning decisions that involved all relevant parties.

[13] This number does not include persons discharged from specialty programs or respite care in the developmental centers.

[14] The decrease in the number of transitions from the Developmental Centers is attributed to a combination of guardian choice and the lack of available HCBS waiver slots.

Table 3.4.
Follow-Up Care for Consumers with Intellectual and Developmental Disabilities (I/DD)
Discharged from the General Population of the State Developmental Centers
SFY 2012

Time Period	Number of Individuals Moved to Community	Type of Community Setting
July – September 2011	3	2 to natural family 1 to ICF-MR group home
October – December 2011	0	
January – March 2012	0	
April – June 2012	1	1 to skilled nursing facility

Data above includes three developmental centers; J. Iverson Riddle Center, Murdoch Center, and Caswell Center.

Domain 4: Consumer-Friendly Outcomes

Consumer Outcomes refers to the impact of services on the lives of individuals who receive care. One of the primary goals of system improvement is building a recovery-oriented service system. Recovery and stability for a person with disabilities means having independence and control over one's own life, being considered a valuable member of one's community and being able to accomplish personal and social goals.

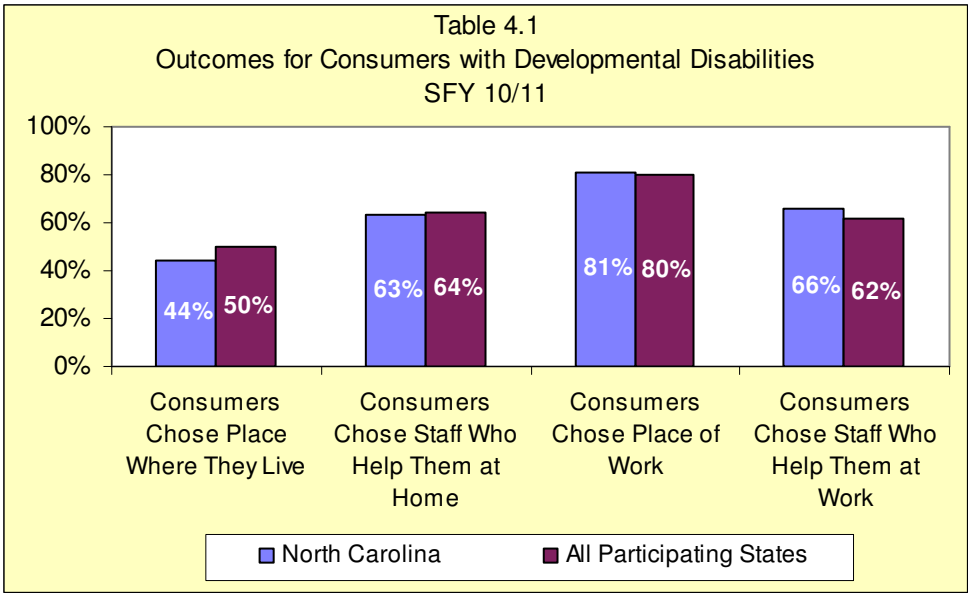
All persons – including those with disabilities – want to be safe, to engage in meaningful daily activities, to enjoy time with supportive friends and family, and to participate positively in the larger community. SAMHSA and the Centers for Medicare and Medicaid Services (CMS) support the use of a wide variety of measures of consumers' perceptions of service outcomes and measures of functioning in areas such as:

- symptom reduction, abstinence, and/or behavioral improvements,
- housing stability and independence,
- enhanced employment and education,
- social connectedness,
- reduction in emergency department and hospital inpatient care,
- reduction in criminal involvement, and
- participation in self-help and recovery groups.

Based on analysis of data on consumer outcomes, the Division adopted improvements in two of these areas – housing and employment/education – as objectives in the *State Strategic Plan 2007-2010*. Results of initiatives in these areas can be found in the *Spotlights on Progress Reports* at http://www.ncdhhs.gov/mhddsas/stateplans/plans_accomplishments/index.htm#spotlight. Current DHHS strategic planning continues emphasis on these items.

Measure 4.1: Outcomes for Persons with Developmental Disabilities

Table 4.1 presents interview data from DD consumers collected during SFY 2010-11 indicating how much input they feel they have on certain decisions in their lives. (See Appendix B for details on this survey.) While less than half (44%) of consumers with DD in North Carolina reported choosing where they live, the majority reported choosing the staff who help them in their home, their place of work and the staff persons who assist them in their work. These outcomes are generally comparable to those in all states participating in the survey.

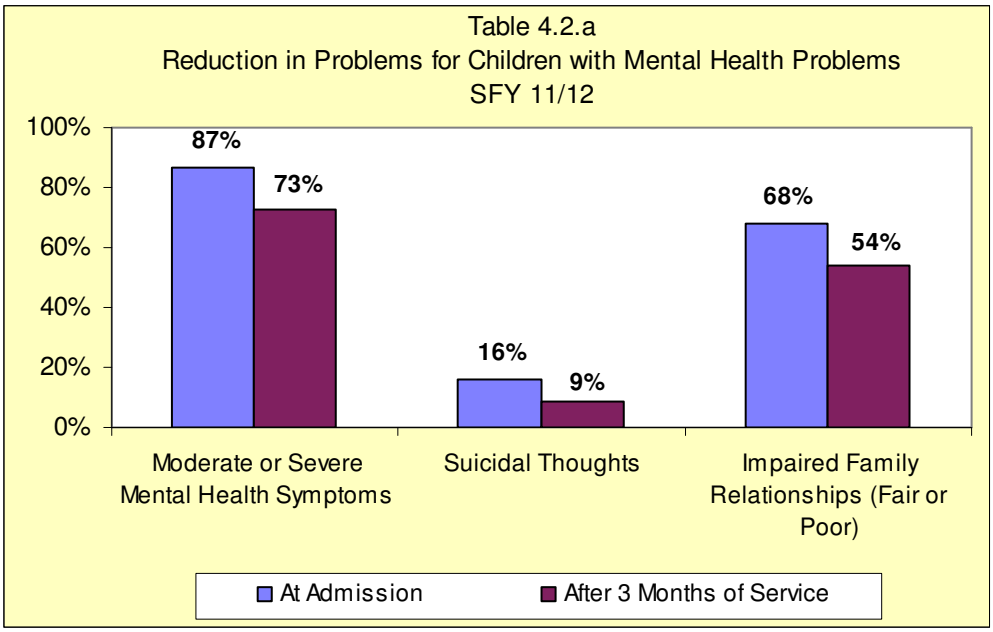


SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2010-11.

Measure 4.2: Outcomes for Persons with Mental Illness

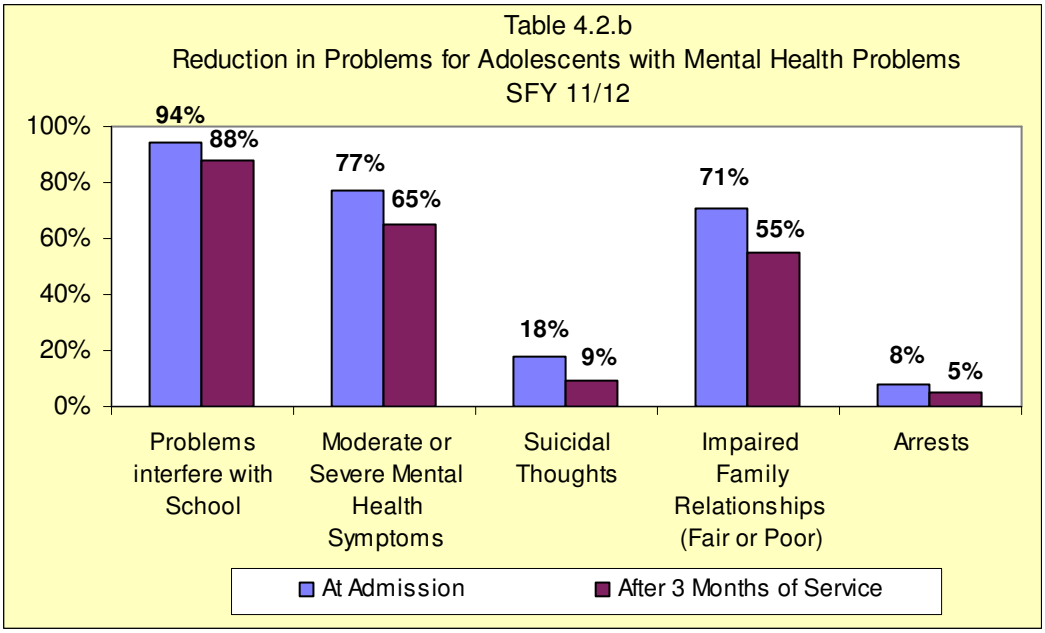
For persons with mental illness, SAMHSA is focusing on reducing symptoms that limit consumers' abilities to maintain positive, stable activities and relationships. Successful engagement in services for even three months can improve consumers' lives, as shown in data from the NC Treatment Outcomes and Program Performance (NC-TOPPS) consumer interviews. (See Appendix B for details on the (NC-TOPPS) system used to collect this data.)

Table 4.2.a on the next page, shows improvement in the lives of children under age twelve with mental health problems after three months of treatment, noted in the areas of reduction in symptom severity, decreased suicidal thoughts, and less impairment in family relationships.



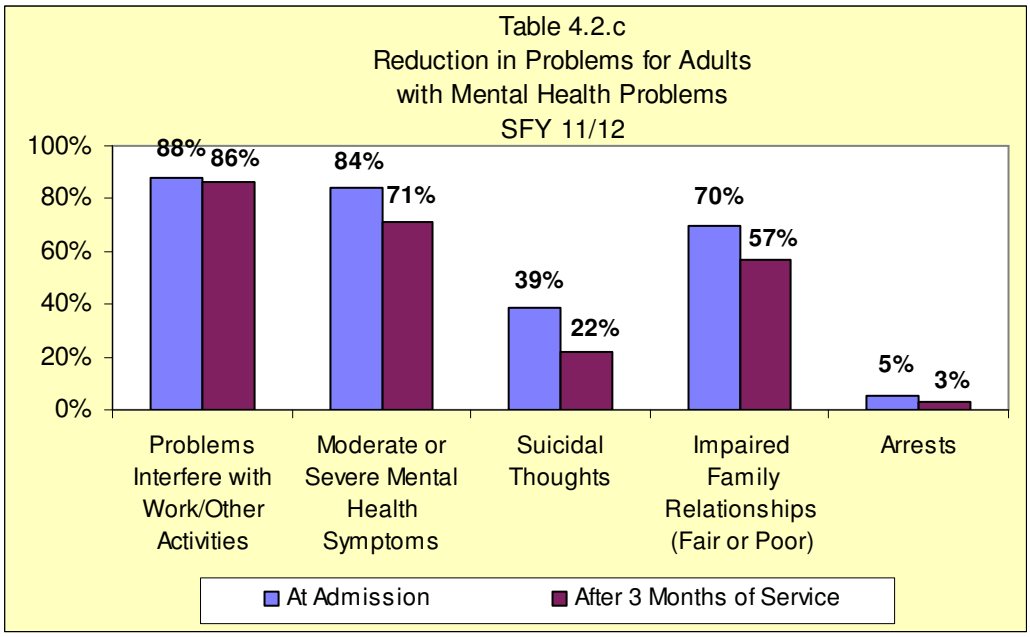
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2011 - June 30, 2012 matched to 3-Month Update Interviews.

Table 4.2.b shows improvement for adolescents (ages 12 to 17) with mental health problems (who received at least three months of treatment during SFY 2011-12 in all of the following areas: problems in school, severe mental health symptoms, suicidal thoughts, impaired family relationships, and trouble with the law. Specifically, the percent of adolescents who were thinking about committing suicide was reduced by half between the time of admission to after three months of treatment. Further, arrests, mental health symptoms, and problems that interfere with school all decreased between the time of admission to after three months of treatment.



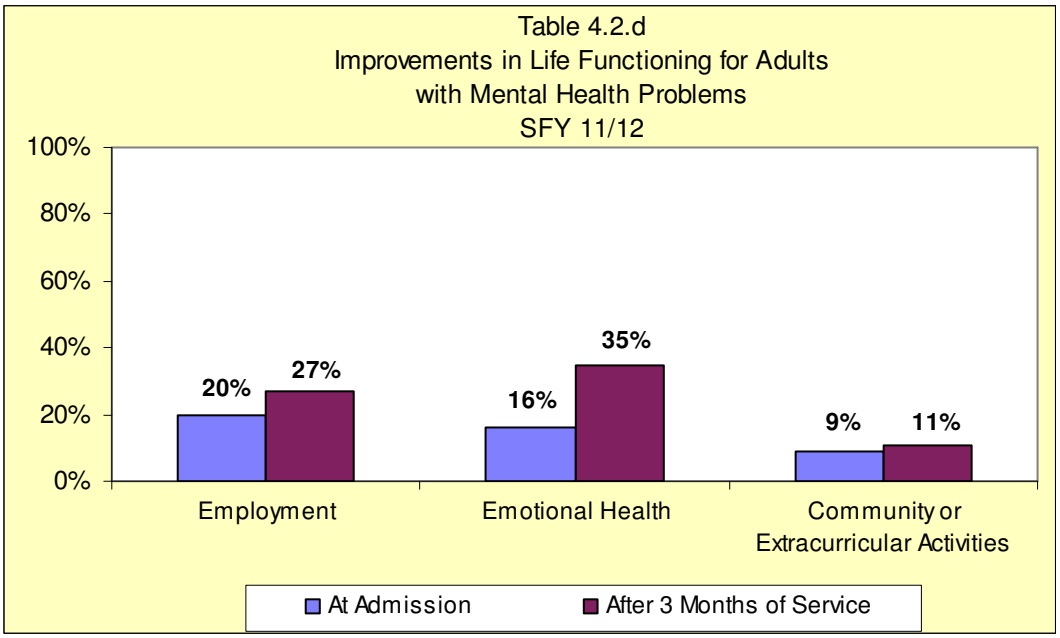
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2011 - June 30, 2012 matched to 3-Month Update Interviews.

As seen in Table 4.2.c, progress was made in the lives of adults with mental health problems in reducing their symptoms and the problems associated with those symptoms after only three months of treatment. The greatest gain was in reduction of suicidal thoughts (down 17%), although improvements were seen in all areas.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2011 - June 30, 2012 matched to 3-Month Update Interviews.

Three months of service also made a positive difference in the quality of life for adults with mental health problems as seen in Table 4.2.d on the next page. The greatest gain was made in the percent of adults reporting positive emotional wellbeing (increase of 19 percentage points). Even in difficult economic times for the state, the percent of adults employed full or part-time increased seven percentage points during treatment. In addition, the percent of adults participating in positive community activities increased from 9% to 11%.

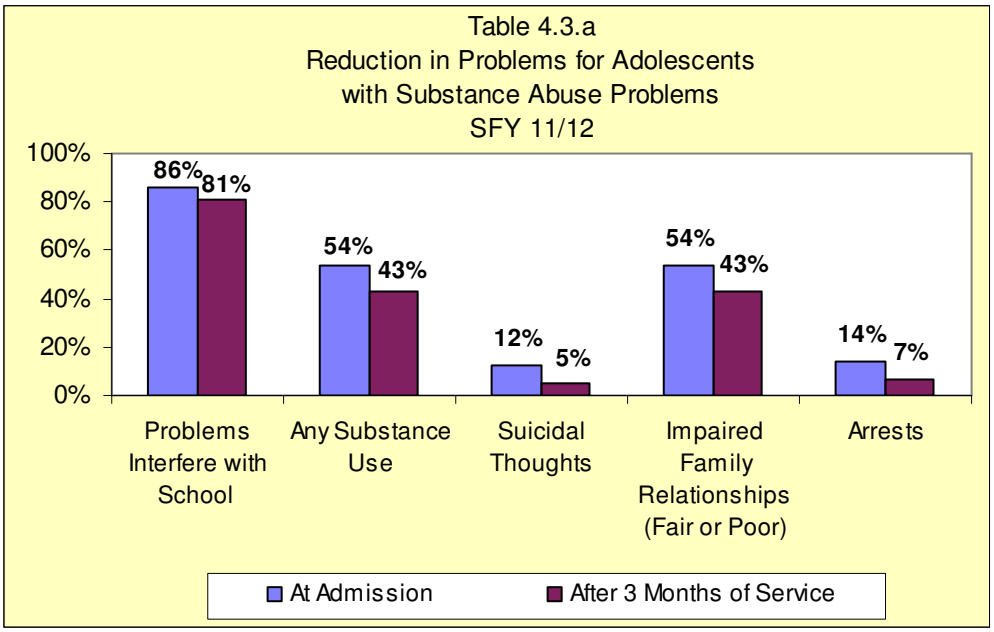


SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2011 - June 30, 2012 matched to 3-Month Update Interviews.

Measure 4.3: Outcomes for Persons with Substance Abuse Disorders

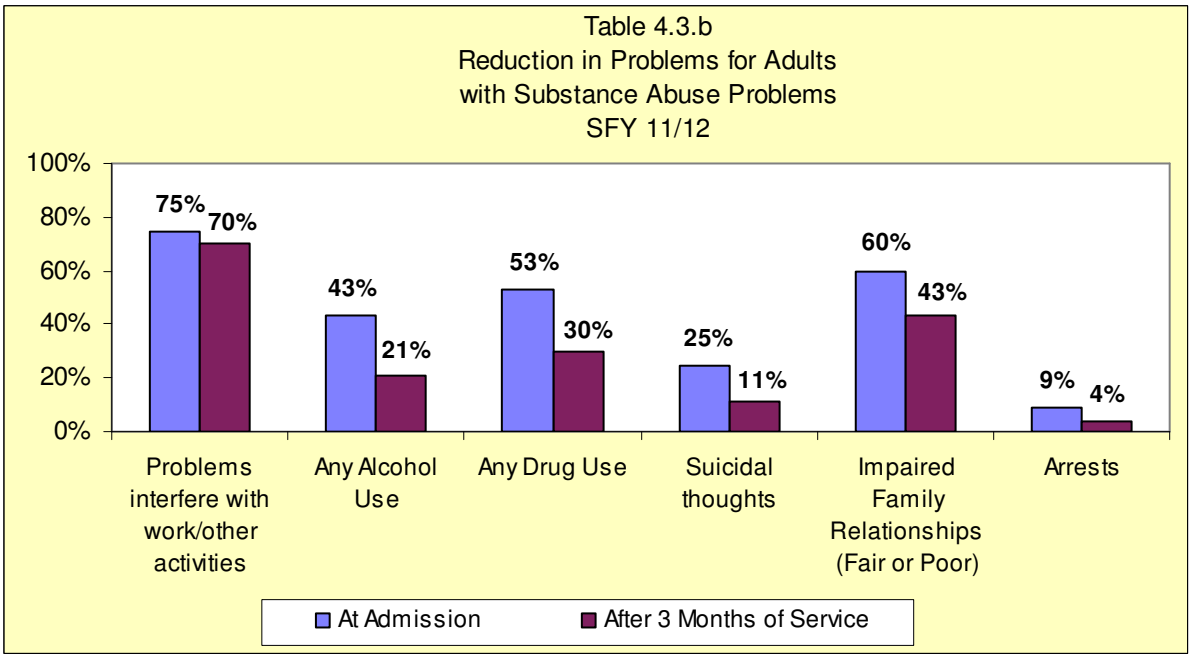
National measures for persons with substance abuse problems focus on eliminating the use of alcohol and other drugs in order to improve consumers' well-being, social relationships and activities. Successful initiation and engagement in services with this population can have very positive results in a short time, as shown in the data from NC-TOPPS consumer interviews. (See Appendix B for details on the NC-TOPPS system used to collect this data.)

Table 4.3.a on the next page, shows that adolescents (ages 12 to 17) with substance abuse problems (who received three months of treatment during SFY 2011-12) showed meaningful improvement in a variety of areas of their lives. Most notably, the percent of youth who used substances decreased by 11 percentage points, while those experiencing suicidal thoughts and in trouble with the law dropped by more than half. In addition, youth with impaired family relationships decreased by 11 percentage points and problems interfering with school saw a decrease of 5 percentage points.



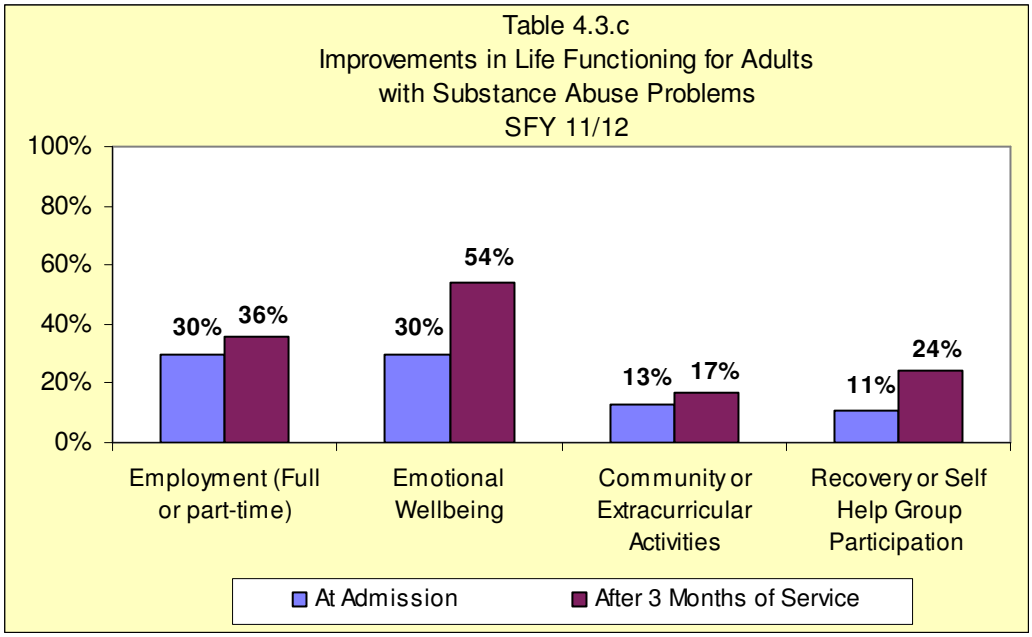
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2011 - June 30, 2012 matched to 3-Month Update Interviews.

Similar progress was made among adults in reducing substance use and related problems as shown in Table 4.3.b. The most notable decreases can be seen in the percent of adult consumers using drugs or alcohol. The decrease in the use of drugs among adult consumers was 23 percentage points and the decrease in the use of alcohol was 22 percentage points. In addition, the percent of adults that had suicidal thoughts was cut in half, while consumer that had problems interfere with their daily activities decreased by 5 percentage points, and adult arrests was cut in half.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2011 - June 30, 2012 matched to 3-Month Update Interviews.

Table 4.3.c shows that services also had a positive impact on the quality of life of adult substance abuse consumers. As with adult mental health consumers, the percent of adults employed full or part-time increased during treatment (from 30% to 36%). The percent of adults reporting positive emotional wellbeing increased from almost one third at admission to a little more than a half after three months of service. Further, the percent of adults participating in positive community activities and recovery or self help groups increased (four percentage points and 13 percentage points, respectively), with the recovery group numbers doubling as a result of treatment.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2011 - June 30, 2012 matched to 3-Month Update Interviews.

Domain 5: Quality Management Systems

Quality Management refers to a way of thinking and a system of activities that promote the identification and adoption of effective services and management practices. The Division has embraced the CMS Quality Framework for Home and Community-Based Services, which includes four processes that support development of a high-quality service system:

- **Design**, or building into the system the resources and mechanisms to support quality.
- **Discovery**, or adopting technological and other systems to gather information on system performance and effectiveness.
- **Remediation**, or developing procedures to ensure prompt correction of problems and prevention of their recurrence.
- **Improvement**, or analyzing trends over time and patterns across groups to identify practices that can be changed to become more effective or successful.

These processes include activities to ensure a foundation of basic quality and to implement ongoing improvements. The first set of activities, often labeled **quality assurance**, focuses on compliance with rules, regulations and performance standards that protect the health, safety and rights of the individuals served by the public mental health, developmental disabilities and substance abuse services system. The

second set of activities, labeled **quality improvement**, focuses on analyzing performance information and putting processes in place to make incremental refinements to the system.

Measure 5.1: Action Plan for Streamlining LME-MCO Reporting

During SFY 2011-12 the Department began discussions with leadership at the Division on how to reduce the LME-MCO administrative reporting to Departmental agencies. A preliminary review was conducted on monitoring, reporting, rule creation, incident reporting and other items that could be streamlined in order to allow both LME-MCOs and provider agencies a more consistent process for submitting information to the Department. The "Action Plan Steps" teams will include staff from all Divisions who have a stake in each area and will be guided by leadership from the Department. The two key Action Steps include:

- Action Plan Step 1: *Streamline Internal Activities across Division's to standardize policies and procedures*
- Action Plan Step 2: *Decrease Provider Regulatory Burden*

In response to the Action Plan Steps the Division has:

1) Streamlined provider enrollment so that the LME-MCOs will manage the process.

2) Adopted the Cardinal Innovations HealthCare Solutions (Formerly Piedmont Behavioral Healthcare) model for provider monitoring and agency oversight, and;

3) Simplified CABHA rules aligning them with Medicaid State Plan.

Additional steps will be taken in the upcoming year to streamline reporting requirements and oversight processes.

Measure 5.2: Statewide Implementation of the 1915 (b)/(c) Medicaid Waiver July 1, 2011 - June 30, 2013

The Department has expanded the 1915 (b)/(c) Medicaid Waiver, which restructures management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders. In SFY 2011-12 four Local Management Entities (LMEs)/Managed Care Organizations (MCOs) have implemented a managed care delivery system to serve individuals in need of such services who are Medicaid eligible. The DHHS Strategic Plan submitted to the Joint Legislative Oversight Committee on Health and Human Services defines how the Division and DMA will monitor and evaluate this initiative.[15]

One method used to track the progress of the LMEs as they assume responsibilities of MCOs is a standardized performance dashboard. This dashboard will comprise a set of standardized measures in the following domains: access to care, consumer experience, clinical management, system performance, integrated care, provider networks, stakeholder perceptions, health and safety, SAMHSA initiatives, prevention, and the Innovations component of the waiver, which focuses on the I/DD population. LME/MCOs will report on these measures to the Division, permitting the evaluation of the impact of

[15] The Joint Legislative Oversight Committee on Health and Human Services has received a copy of this Strategic Plan on October 1, 2011.

managed care on the existing service system. Additionally, results will be shared with providers, LMEs, partner agencies, and consumers and families.

Currently, four LME-MCOs have implemented the waiver and identified their regions. They are:

- Cardinal Innovations Healthcare Solutions (Formerly Piedmont Behavioral Healthcare, Alamance-Caswell LME, Five County LME, and Orange-Person-Chatham LME)--Expansion date April 2012.
- East Carolina Behavioral Healthcare—Implementation date April 2012.
- Smoky Mountain Center—Implementation date July 2012.
- Western Highlands Network—Implementation date January 2012.

Prior to and after their start dates each identified LME/MCO provides weekly, monthly and quarterly reports to DHHS on their progress and performance. In addition to the performance dashboard, DHHS monitoring teams and committees have been formed to ensure best practices are implemented, to provide oversight of implementation activities, to review quality of care concerns and quality improvement activities, and to develop plans for improvement. As a final quality management/evaluation tool, there will be annual on-site reviews of the LMEs by an external quality review organization to validate the data reported by the LME/MCOs. A status update on the Medicaid waiver implementation will be provided in the next Semi-Annual Statewide System Performance Report (Spring 2013).

Domain 6: System Efficiency and Effectiveness

System Efficiency and Effectiveness refers to the capacity of the service system to use limited funds wisely -- to serve the persons most in need in a way that ensures their safety and dignity while helping them to achieve recovery and independence. An effective service system is built on an efficient management system, key features of which include good planning, sound fiscal management and thorough information management.

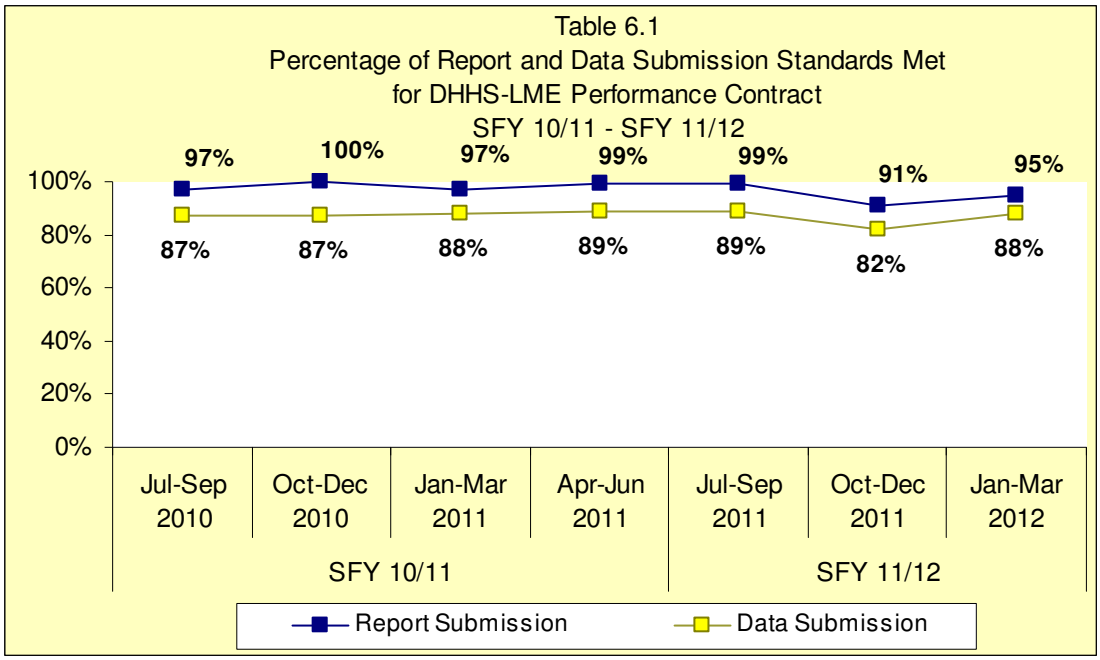
Making good decisions requires the ability to get accurate, useful information quickly, easily and regularly. It also requires efficient management of scarce resources. Staff at all levels need to know the status of their programs and resources in time to take advantage of opportunities, avoid potential problems, make needed refinements and plan ahead.

The *DHHS-LME Performance Contract* serves as the Division's vehicle for evaluating LME efficiency and effectiveness. It includes a standardized scope of work detailing the components of each function that the LMEs are expected to perform, reporting expectations, and critical system performance indicators.

Measure 6.1: Business and Information Management

Consumer data reported by the LMEs is coupled with claims data to generate the information that the Division uses to evaluate local and state system performance and to keep the Legislature informed of system progress through this report. For these reasons, compliance is critical to LME and Division efforts to manage the service system. The *DHHS-LME Performance Contract* includes requirements for timely, complete and accurate submission of consumer and program information. The LMEs' compliance with reporting requirements provides an indication of the system's capacity for using information to manage the service system efficiently and effectively.

As shown in Table 6.1 LMEs' submission of timely and accurate information to the Division has remained stable during the past two state fiscal years. In all quarters, LMEs' have consistently performed better with meeting the report submission requirements than meeting the data submission requirements.



SOURCE: Data from SFY 2010-11 and SFY 2011-12 Quarterly Performance Contract reports.

Domain 7: Prevention and Early Intervention

Prevention and Early Intervention refers to activities designed to minimize the occurrence of mental illness, developmental disabilities, and substance abuse whenever possible and to minimize the severity, duration, and negative impact on persons' lives when a disability cannot be prevented. **Prevention** activities include efforts to educate the general public, specific groups known to be at risk, and individuals who are experiencing early signs of an emerging condition. Prevention education focuses on the nature of mental health, developmental disability, and substance abuse problems and how to prevent, recognize and address them appropriately. **Early intervention** activities are used to halt the progression or significantly reduce the severity and duration of an emerging condition.

Measure 7.1: NC Screening, Brief Intervention, Referral to Treatment Grant

The Division obtained a grant from the SAMHSA, Center for Substance Abuse Prevention (CSAP) to implement Screening, Brief Intervention and Referral to Treatment (SBIRT) in seven primary care practices affiliated with Community Care of North Carolina (CCNC) and one Federally Qualified Health Center (FQHC). This five year project that began in the fall of 2011 is designed to increase access to alcohol and substance abuse treatment services for individuals seen through primary care practices and local health centers. Screening for alcohol and drug use is provided by Care Ambassadors, while interventions and referrals are provided by Licensed Clinical Addictions Specialist at the primary care sites. Participating Local Management Entities/Managed Care Organizations (CenterPoint and Sandhills) provide oversight over local implementation and fidelity to the SBIRT model. Through contractual agreements the Division provides training to physicians and other medical professionals at the primary care sites and to substance abuse professionals who are co-located at the sites.

The goal is for the project to serve at least 37,808 adults in the selected sites. Through this project, access to services will be increased, the continuum of services for alcohol and drug use will be expanded, and substance misuse will be prevented in the targeted population. The project also aims to identify barriers to receiving substance abuse services, gathering outcomes on persons receiving services, and implementing best practices to strengthen service delivery. The Division plans to sustain SBIRT by

integrating the components of screening, motivational interviewing techniques, cognitive behavioral treatments, and linkages with referral systems as a routine standard of care in CCNC sites.

Measure 7.2: Strategic Prevention Framework-State Prevention Enhancement (SPF-SPE) capacity building grant

SAMHSA, CSAP awarded North Carolina the Strategic Prevention Framework-State Prevention Enhancement (SPF-SPE) capacity building grant in September 2011 to be administered by the Division's Prevention Office.

The Division, in close collaboration with substance abuse prevention partners from around the state, is currently developing a five year comprehensive plan for substance abuse prevention services to be completed within this quarter. As a part of that plan and in efforts to align with SAMHSA Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness, North Carolina formed a Substance Abuse and Mental Health Policy Consortium committed to ensuring multi-departmental collaborations on policy issues on a statewide level. The Policy Consortium is responsible for monitoring work related to the deliverables of the grant which include:

- the Technical Assistance and Training Plan to ensure the prevention workforce meets increasing community needs;
- the Data Collection, Analysis and Reporting Plan to enhance the quality and consistency of reliable data necessary to make informed decisions;
- the Coordination of Services Plan to maximize multi-disciplinary collaboration and reach alignment with targeted populations; and
- the Performance/Evaluation Plan to track the quality and effectiveness of the substance abuse prevention and mental health promotion efforts across the state.

The final Comprehensive Plan will incorporate all these elements to impact an effective prevention system.

Appendix A: Legislative Background

Session Law 2006-142 Section 2.(a)(c) revised the NC General Statute (G.S.) 122C-102(a) to read:

> "The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services. The State Plan shall be issued every three years beginning July 1, 2007. It shall identify specific goals to be achieved by the Department, area authorities, and area programs over a three-year period of time and benchmarks for determining whether progress is being made toward those goals. It shall also identify data that will be used to measure progress toward the specified goals…."

In addition, Session Law 2011-291, Section 2.42 (c) revised NC G.S. 122C-102(c) to read:

> "The State Plan shall also include a mechanism for measuring the State's progress towards increased performance on the following matters: access to services, consumer friendly outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, and prevention and early intervention. Beginning October 1, 2006, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Heath and Human Services, on the State's progress in these performance areas."

Appendix B: Description of Data Sources

Domain 1: Access to Services

Tables 1.1.a – 1.1.c Persons Served: The Division Client Data Warehouse (CDW) provides data on persons served. This system is the primary repository for data on persons receiving public mental health, developmental disabilities, and substance abuse services. It contains consumer demographic and diagnostic information from extracts of the LMEs' management information systems and DHHS service reimbursement systems. It also contains information on consumers' use of state-operated facilities and consumer outcomes extracted from the HEARTS and NC-TOPPS systems described below.

The number of persons served (duplicated) is calculated by adding the active caseload at the beginning of the fiscal year (July 1) and all admissions during the fiscal year (July 1 through June 30). The disability of the consumer is based on the diagnosis reported for the consumer on paid IPRS and/or Medicaid service claims. The consumer's age on June 30 at the end of the fiscal year is used to assign the consumer to the appropriate age group (e.g. children or adults).

Table 1.2 Persons Seen within Fourteen Days of Request: This measure is calculated by dividing the number of persons requesting routine (non-urgent) care into the number who received a service within the next 14 days and multiplying the result by 100. The information comes from data submitted by LMEs and published in the *Community Systems Progress Reports*. The sources are LME screening, triage, and referral logs and quarterly reports submitted by the LMEs. The data reflect consumers who requested services from an LME. It does not include data on consumers that directly contacted a provider for an appointment. The Division verifies the accuracy of the information through annual on-site sampling of records. More information on the *Community Systems Progress Report* can be found on the web at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

Domain 2: Individualized Planning and Supports

Tables 2.1.a and 2.2.a Choice among Persons with Developmental Disabilities: The data presented in these tables is obtained through in-person interviews with consumers in the project year 2009-10, as part of the National Core Indicators Project (NCIP). This project collects data on the perceptions of individuals with developmental disabilities via in-person interviews and their parents and guardians via mail surveys. The interviews and surveys ask questions about service experiences and outcomes of individuals and their families. More information on the NCIP, including reports comparing North Carolina to other participating states on other measures, can be found at: http://www.hsri.org/nci/index.asp?id=reports.

Tables 2.1.b and 2.2.b Choice among Persons with Mental Health and Substance Abuse Disabilities: The SAMHSA-sponsored Mental Health Statistical Improvement Project's Consumer Survey (MHSIP-CS) provides this data. This confidential survey asks questions about the individual's access to services, appropriateness of services, service outcomes, and satisfaction with services. More information on the MHSIP-CS can be found at: http://www.mhsip.org/. Annual reports on North Carolina's survey can be accessed at: http://www.ncdmh.net/dsis/LMEdirectory.html.

Domain 3: Promotion of Best Practices

Tables 3.1.a – 3.1.c Persons Receiving Evidence-Based and Best Practices: Information on numbers served in certain services comes from claims data, as reported to Medicaid and the Integrated Payment and Reimbursement System (IPRS).

Tables 3.2.a and 3.2.b Management of State Hospital Usage: The data on the rate of persons served in state psychiatric hospitals by age groups of consumers comes from the North Carolina Community Mental Health Services Block Grant report, which is based on data in the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS), the system used to track consumer care in state-operated facilities. The data on state hospital admissions in SFY 2006-07 through SFY 2010-11 comes from data in the HEARTS, the system used to track consumer care in state-operated healthcare facilities. The Division also reports this information in the North Carolina Psychiatric Hospital Annual Statistical Report, which is published by the Division and based on data in HEARTS. This report can be found at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

Table 3.2.c Admissions to ADATC Facilities: The data on admissions to ADATCs in SFY 2006-07 through SFY 2010-11 come from data in the HEARTS, the system used to track consumer care in state-operated facilities. The Division also reports this information in the North Carolina ADATC Annual Statistical Report. This report can be found at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

Tables 3.3 State Psychiatric Hospital Readmission: The data on state hospital readmissions (30 days and 180 days after discharge) in FFY 2010 come from the North Carolina Community Mental Health Services Block Grant report, which is based on data in the HEARTS, the system used to track consumer care in state-operated healthcare facilities.

Table 3.4 Follow-up Care for Consumers Discharged from State Developmental Centers: These data are for SFY 2010-11 and come from reports submitted quarterly by the developmental centers to the Division of State Operated Healthcare Facilities. The numbers do not include persons discharged from specialty programs (such as programs for persons with both an intellectual/developmental disability and mental illness) or persons who were discharged after receiving respite care only.

Domain 4: Consumer Outcomes

Table 4.1 Outcomes for Persons with Developmental Disabilities: This information is obtained through in-person interviews with consumers as part of the NCIP, described in Tables 2.1.a and 2.2.a above.

Tables 4.2.a - 4.3.c Service Outcomes for Individuals with Mental Health and Substance Abuse Disabilities: This information comes from the NC-TOPPS. This web-based system collects information on a regular schedule through clinician-to-consumer interviews for all persons ages 6 and over who receive specific mental health and substance abuse services. More information on NC-TOPPS, including annual reports on each age-disability group, can be found at http://www.ncdhhs.gov/mhddsas/nc-topps.

Domain 5: Quality Management

Domain 6: Efficiency and Effectiveness

Table 6.1 Business and Information Management: Table 6.1 includes timely, complete and accurate submission of information required in the *DHHS-LME Performance Contract* over the last state fiscal year. This report tracks LME performance in submitting required data and reports to the Division. Some requirements are quarterly while others are semi-annual or annual requirements. For these reasons, the number of requirements included in the denominators for Table 6.1 fluctuates over the four fiscal quarters represented. More information on the *DHHS-LME Performance Contract,* including the quarterly reports, can be found at: http://www.ncdhhs.gov/mhddsas/performanceagreement/.

Domain 7: Prevention and Early Intervention

Table 7.1 NC Screening, Brief Intervention and Referral to Treatment (SBIRT):
Information related to the federal SBIRT project and the NC SBIRT project can be found at: http://www.SAMHSA.gov/prevention/sbirt/ or http://www.sbirtnc.org/ .

Measure 7.2 Strategic Prevention Framework-State Prevention Enhancement (SPF-SPE) Grants:
Information on the SPF-SPE Grant can be found at http://www.SAMHSA.gov/grants/2011/sp_11_004.aspx.