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 2011-12: Fall Report

Session Law 2006-142, Section 2.(a)(c)

as amended by Session Law 2011-291, Section 2.42.(c)

October 1, 2011

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) During the last quarter of states fiscal year (SFY) 2010-11, all persons seeking emergent care were seen by a provider promptly after requesting services (100%); 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 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 developmental disabilities report their case manager is helpful in getting necessary services and supports. (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) 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 two 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) The Department of Health and Human Services (the Department) has approved a definition and description of a new category of provider agency, Critical Access Behavioral Health Agency (CABHA), which is designed to ensure that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a continuum of services. The Division will monitor certified CABHAs during August and

September 2011 to ensure they are in compliance with the Medical Service and Certification and Staffing Requirements. Results will be used to provide feedback to CABHAs for quality improvement purposes. (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 improved by 4 percentage points from first quarter of SFY 2009-10 to the fourth quarter of SFY 2010-11.

Domain 7: Prevention and Early Intervention – (1) The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) 20% set-aside funds make up the largest portion of funding that target substance abuse prevention services in the Division. In North Carolina, SAPTBG set-aside funds are used to support strategies (programs, practices and policies) implemented across all counties and allocated to community providers based on a plan consistent with local needs. In SFY 2010, strategies reached approximately 40,000 youth in evidence based curricula programs and over 100,000 participant strategies that included educational seminars, parent trainings and workshops. (2) North Carolina applied for a Strategic Prevention Framework-State Prevention Enhancement (SPF-SPE) cooperative agreement to promote the adoption of evidence/practice-based strategies to address substance abuse prevention. This grant award from the United States Department of Health and Human Services (USDHHS), Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP) will strengthen the state's current prevention infrastructure by developing a systematic, on-going monitoring system for substance abuse related consumption patterns and consequences, and to track progress on performance measures that address prevention priorities, trends, and outcomes.

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Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2011-12: 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.

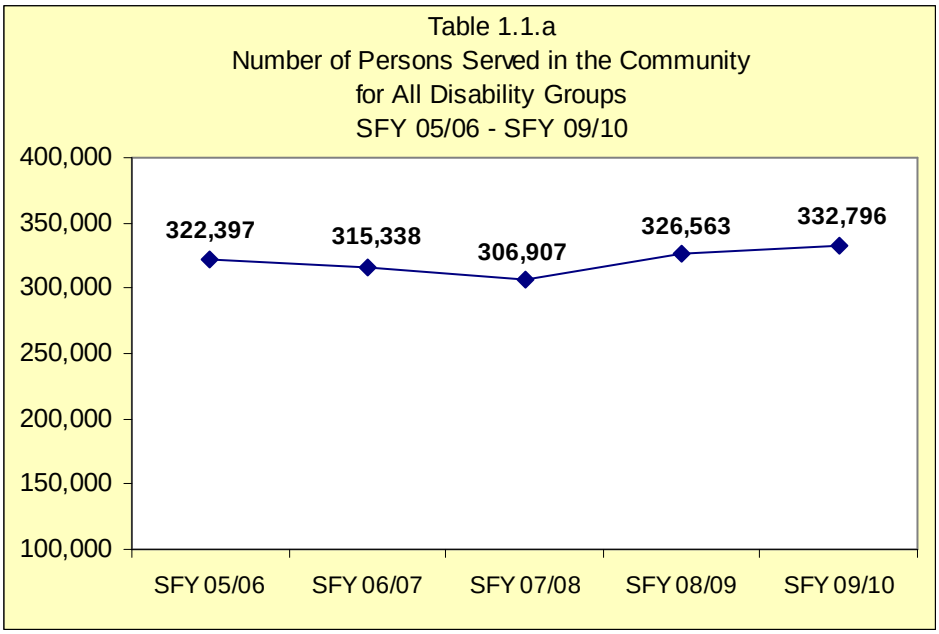
Measure 1.1: Persons Receiving Community Services

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]

Based on data the LMEs submit, Table 1.1.a. on the next page, shows that the number of persons who have been served in the community over the past five state fiscal years experienced a decrease from state fiscal year (SFY) 2005-06 to SFY 2007-08 but has increased eight percent since that time.

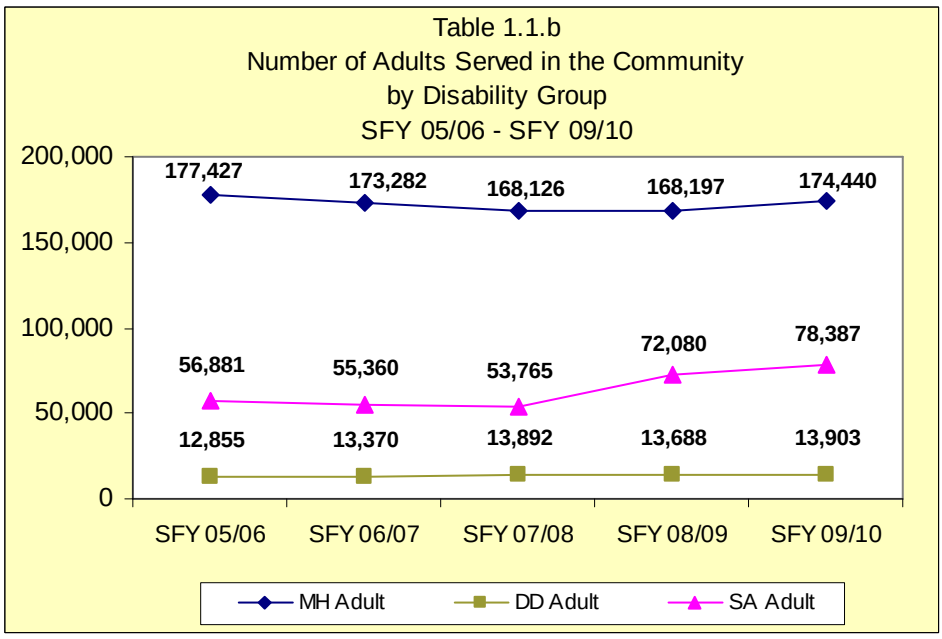
[1] Numbers for SFY 2010-2011 are not available until September 2011 and are not included in the tables. Other numbers in the table have been updated since the Fall 2010 Report.



SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2005 - June 30, 2010.

Table 1.1.b. shows differing patterns by disability for the number of adults who have been served in the community over the past five state fiscal years.

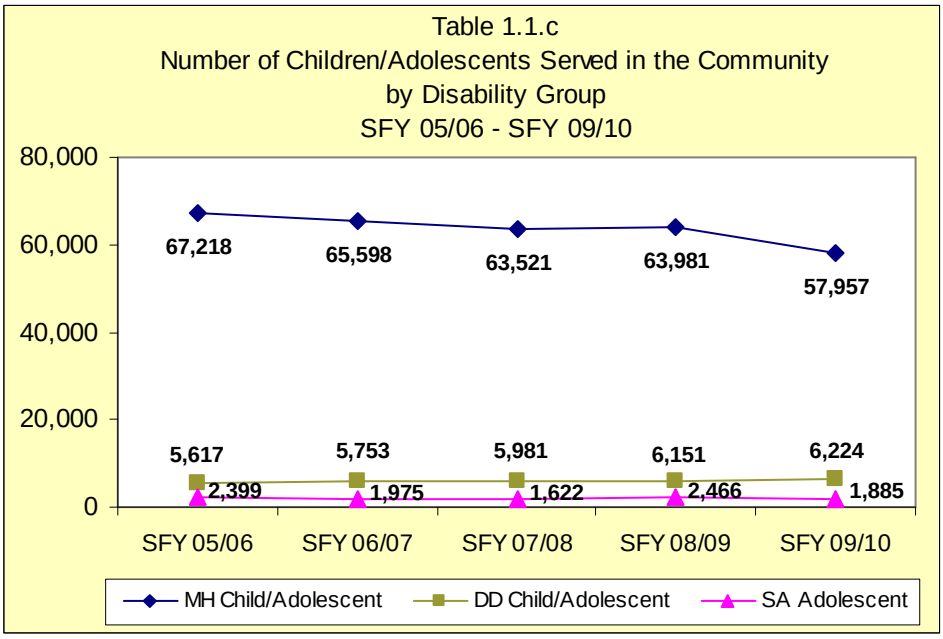
- **Adults with a primary mental health diagnosis:** The number of adults served in the community over the past five years has <u>decreased</u> by approximately two percent.
- **Adults with a primary developmental disability diagnosis:** The number of adults served in the community over the past five years has <u>increased</u> by eight percent.
- **Adults with a primary substance abuse diagnosis:** The number of adults served in the community over the past five years has <u>increased</u> by 38 %.



SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2005 - June 30, 2010.

Table 1.1.c shows the number of children and/or adolescents who received publicly-funded services in the community 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 14%.
- **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 ten 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 21%.



SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2005 - June 30, 2010.

Measure 1.2: Timeliness of Initial Service

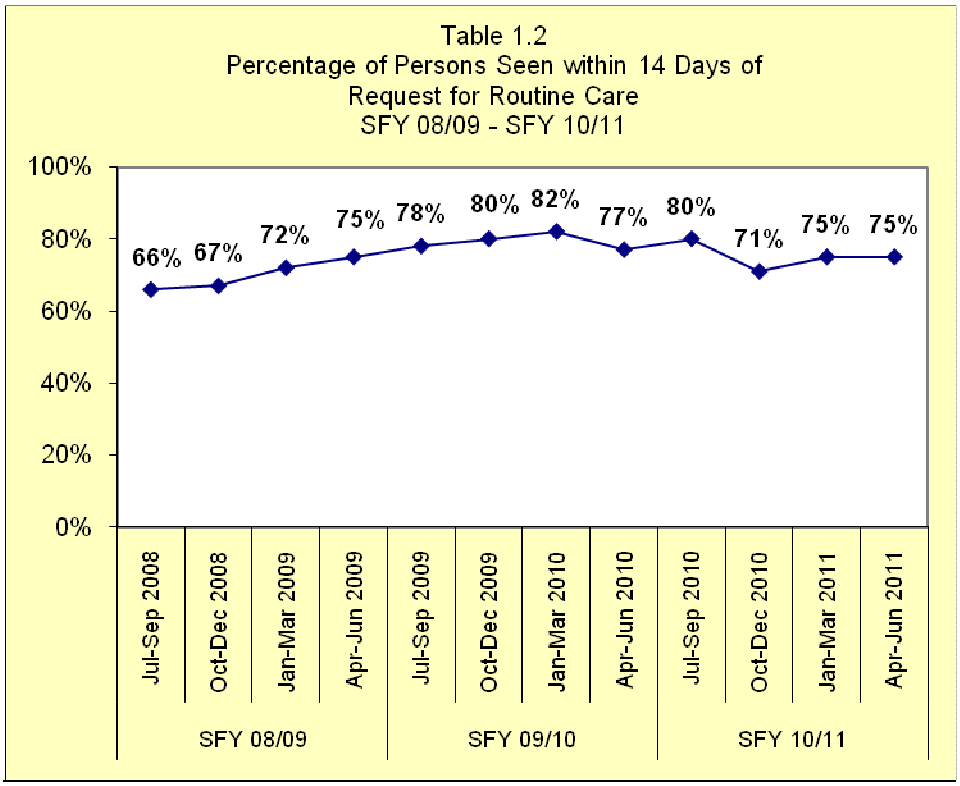
Timeliness of Initial Service is a nationally accepted measure[2] that refers to the time between an individual's call to an LME or provider to request service and their first face-to-face service. A system that responds quickly to a request for help can prevent a crisis that might otherwise result in 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. In the last quarter of SFY 2010-11, 100% of those requesting care in emergency situations were seen within two hours and 81% of those requesting care in urgent situations were seen within 48 hours.

In the last quarter of SFY 2010-11, just under three-fourths (73%) of persons requesting routine (non-urgent) services were seen (see Table 1.2 on the next page). Looking over time, the percentage of all

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

consumers seeking routine care over the past three state fiscal years who were *actually seen* by a provider within the required timeframe of requesting services increased during SFY 2008-09 to a peak of 82% during SFY 2009-10 and has since leveled off. During the last three quarters of SFY 10/11 rates of persons being seen within 14 days of request for routing care ranged from 71% to 75%.



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

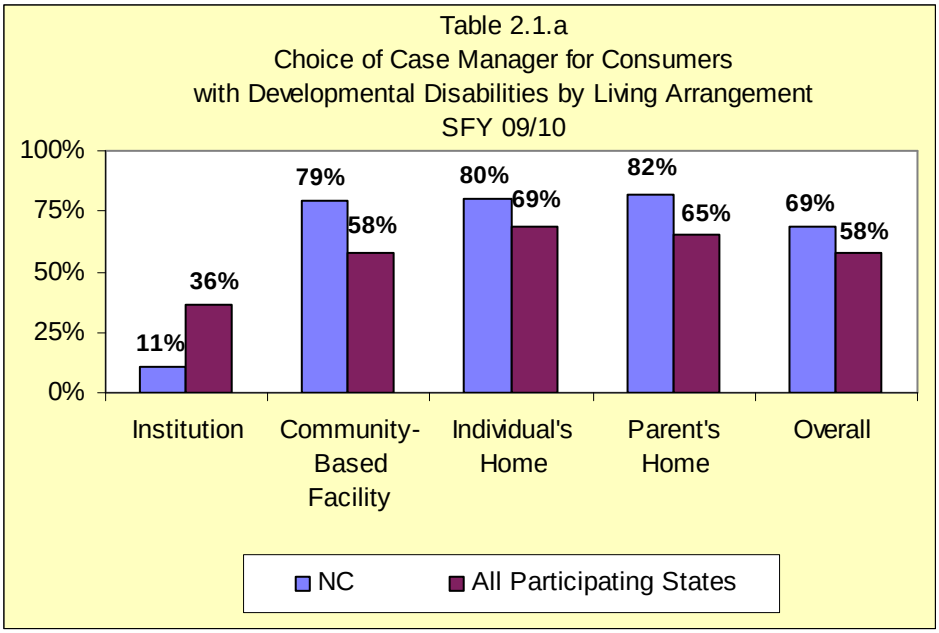
Individualized Planning and Supports refers to the practice of tailoring services to fit the needs of the individual rather than simply providing a standard service package. It addresses an individual's and/or family's involvement in planning for the delivery of appropriate services. Services that focus 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 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.

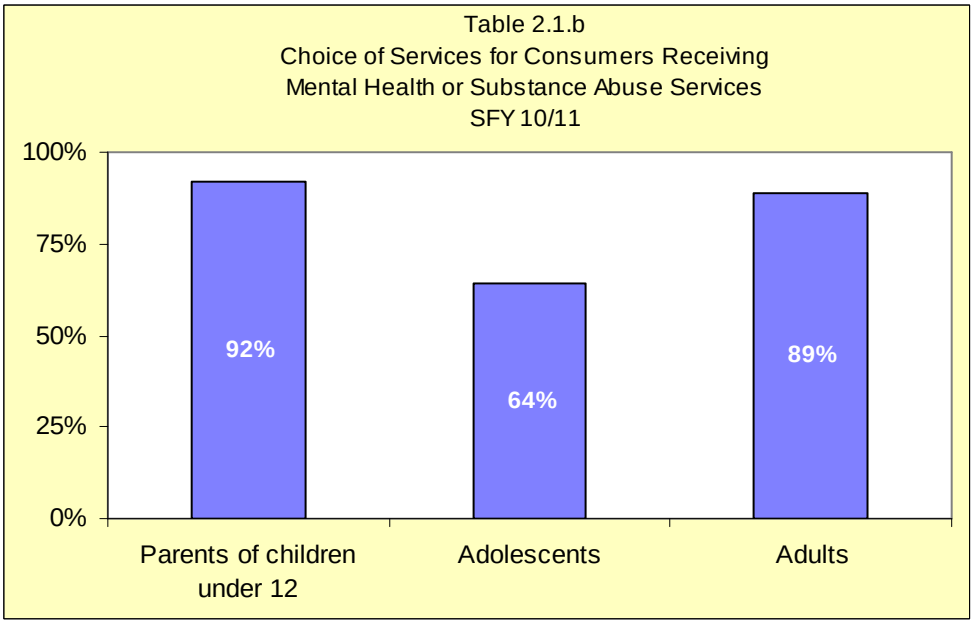
Consumers with Developmental Disabilities (DD) (Table 2.1.a): In annual interviews with DD consumers in SFY 2009-10, just over two-thirds (69%) of the consumers in NC reported choosing their case manager compared to 58% reporting this for all participating states (see Table 2.1.a on the next page). Looking 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) 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). (See Appendix B for details on the National Core Indicators Project's Consumer Survey.)



SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2009-10.

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. While parents of children under the age of twelve and adults were highly likely to agree that they had input into the services received, adolescents were less likely than these two groups to report helping to choose their services. (See Appendix B for more information on the Mental Health Statistical Improvement Project Consumer Survey.)

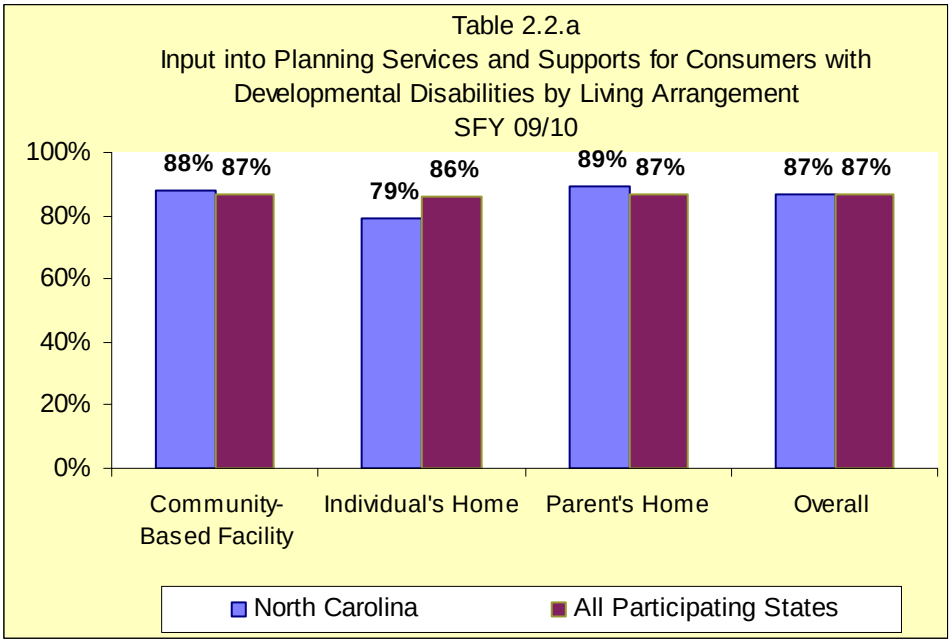


SOURCE: Mental Health Statistical Improvement Project Consumer Survey (MHSIP-CS)

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 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.[3] [4] The Division has implemented a standardized PCP format and training to ensure statewide adoption of this practice. 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 2009-10, the large majority of North Carolina consumers with developmental disabilities (87%) 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 just as likely to report involvement in planning compared to consumers in all states using this survey. (See Appendix B for more information on this survey.)



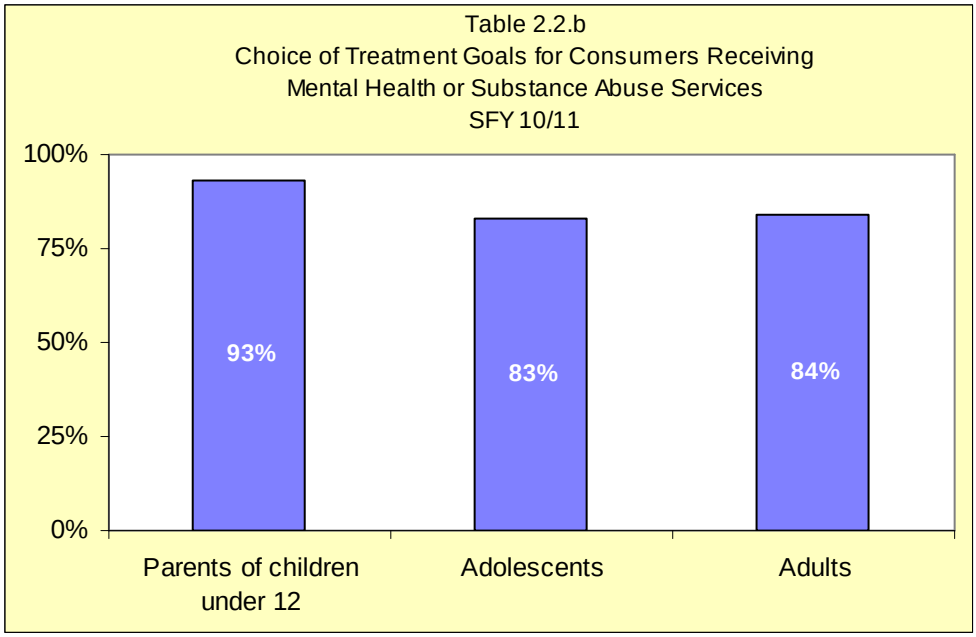
SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2009-10.

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 across all groups reporting: parents of children under the age of twelve, adolescents, and adults.

[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 PCP 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.

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 on the Mental Health Statistical Improvement Project Consumer Survey.)



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. 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, the 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, NC START provided services to 523 individuals and had 544 crisis respite admissions.

  Additionally, NC START responded to 1024 referral/crisis calls in SFY 2011. The following reflects the disposition of those referral/crisis calls:

  - 67 % 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,
  - 7% were referred out for services, and
  - 5% were linked to community resources.

  Note: Of the 1024 referral/crisis calls received, 98 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.

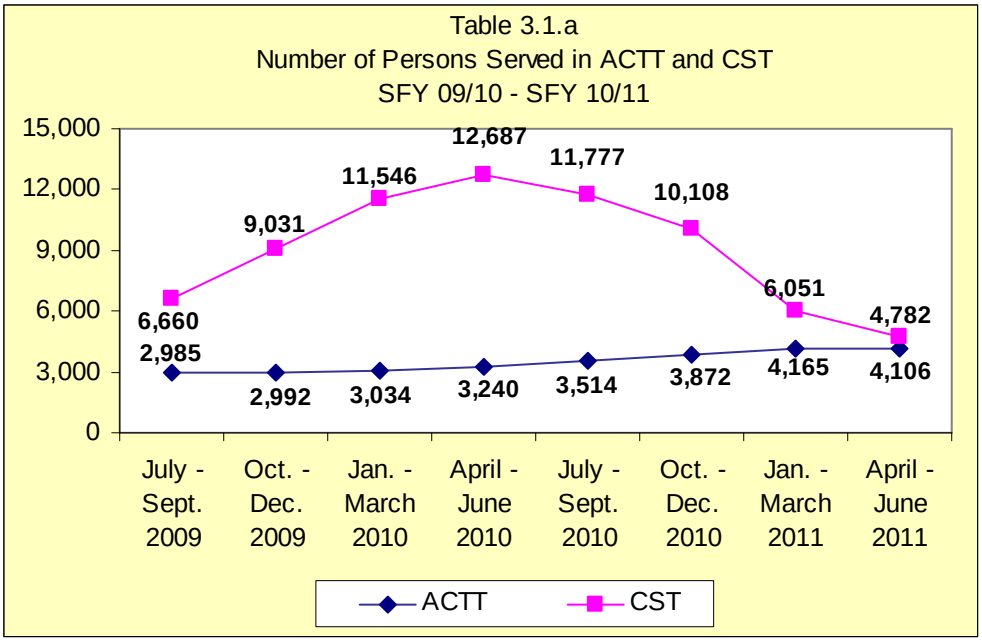
- Mobile Crisis Management: In 2008, the General Assembly appropriated funds for crisis services and Session Law 2008-107 provided support for the development of 30 community Mobile Crisis Management Teams. From July through December 2010, Mobile Crisis Management Teams provided 15,499[5] crisis responses. Of those, 4,759 dispositions (31%) were for admissions to state hospitals, state alcohol and drug abuse treatment centers, or community hospitals, and only 330 (2%) involved jail or detention. All of the other cases (67%) involved dispositions to non-inpatient community settings.

- 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 July 2010 through December 2010, these walk-in centers provided 142,604 services to consumers, 12.5% (17,851 services) of which were in response to crises. Among consumers who received services at walk-in centers, only 1.4% (2,038) required inpatient hospitalization, while in 93.4%of cases, individuals were connected to MH/DD/SAS providers in their communities.

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 on the next page, the number of adults served in CST increased during SFY 2009-10 and then declined to its lowest level at the end of

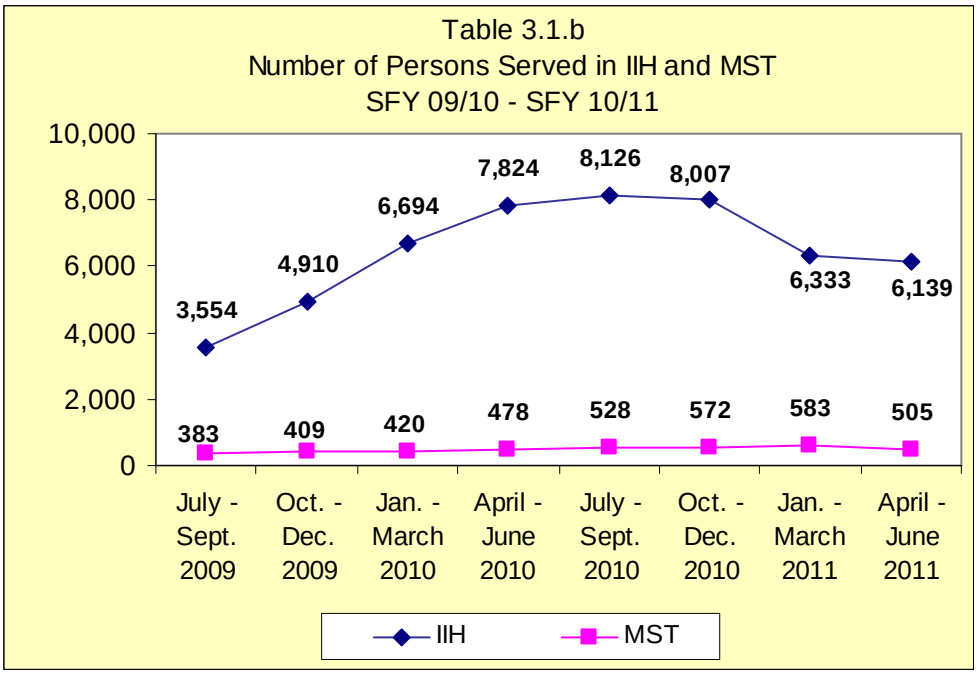
[5] These data reflect the services provided by Mobile Crisis Management Teams from all Local Management Entities except PBH.

SFY2010-11. 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 375% during the past two state fiscal years.



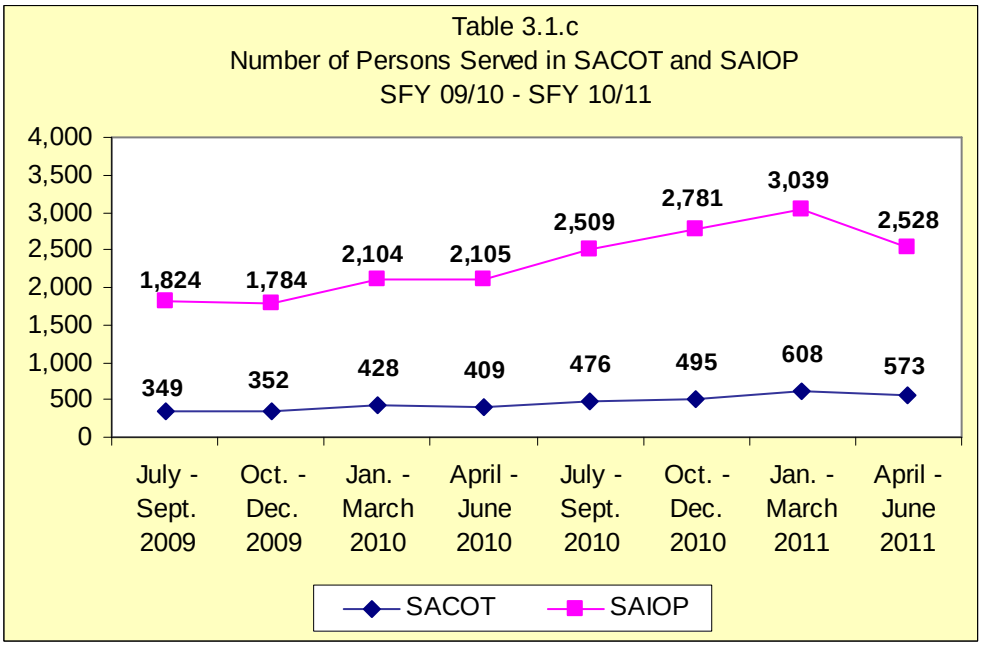
SOURCE: Medicaid and State Service Claims Data. July 1, 2009 - June 30, 2011.

Best practice services that support community living for children and adolescents with severe emotional disturbances and/or substance abuse problems require 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 increased just over 285% from the beginning of SFY 2009-10 until the first quarter of SFY 2010-2011 when this number began to decline and level off at the end of SFY 2010-2011. Similar to CST, 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 CABHAs which provide a continuum of care for a specified age disability group. Therefore, consumers receiving IIH received this service and were either transitioned to more intense or less intense services during their continuum of care. Conversely, MST increased 32% in the same time period.



SOURCE: Medicaid and State Service Claims Data. July 1, 2009 - June 30, 2011.

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 39% increase in the number of persons served since the beginning of SFY 2009-10 (see Table 3.1.c). SACOT services have remained relatively stable with only slight fluctuations in the last two years serving a low of 349 consumers in the first quarter of SFY 2009-10 to a high of 608 consumers in the third quarter of SFY 2010-11.



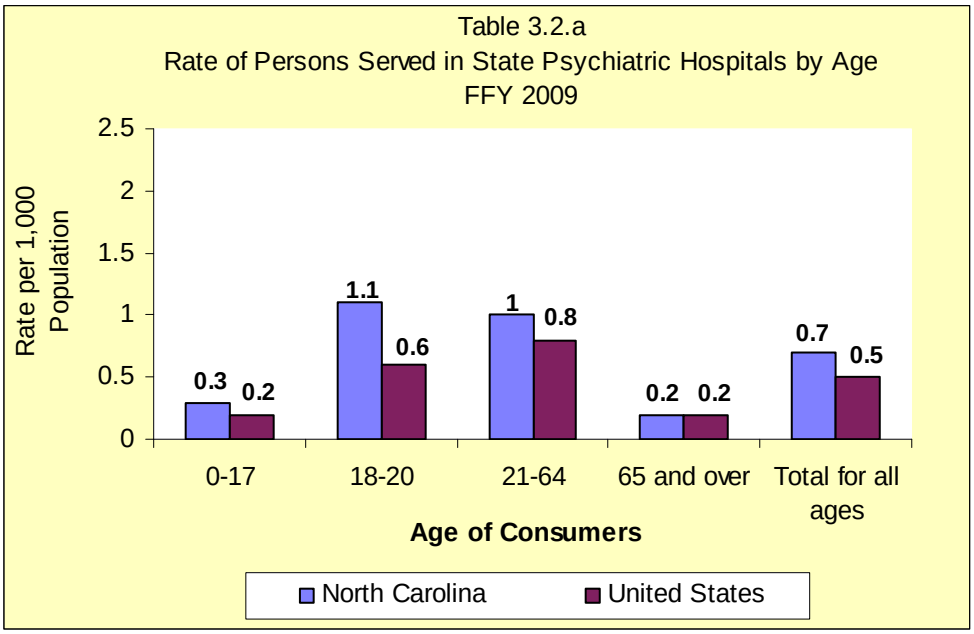
SOURCE: Medicaid and State Service Claims Data. July 1, 2009 - June 30, 2011.

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.

Table 3.2.a indicates North Carolina has continued to provide treatment for persons in its state psychiatric hospitals at a rate higher than the national rate across almost all ages, according to the most recent report (federal fiscal year (FFY) 2009) from the Center for Mental Health Services (CMHS).

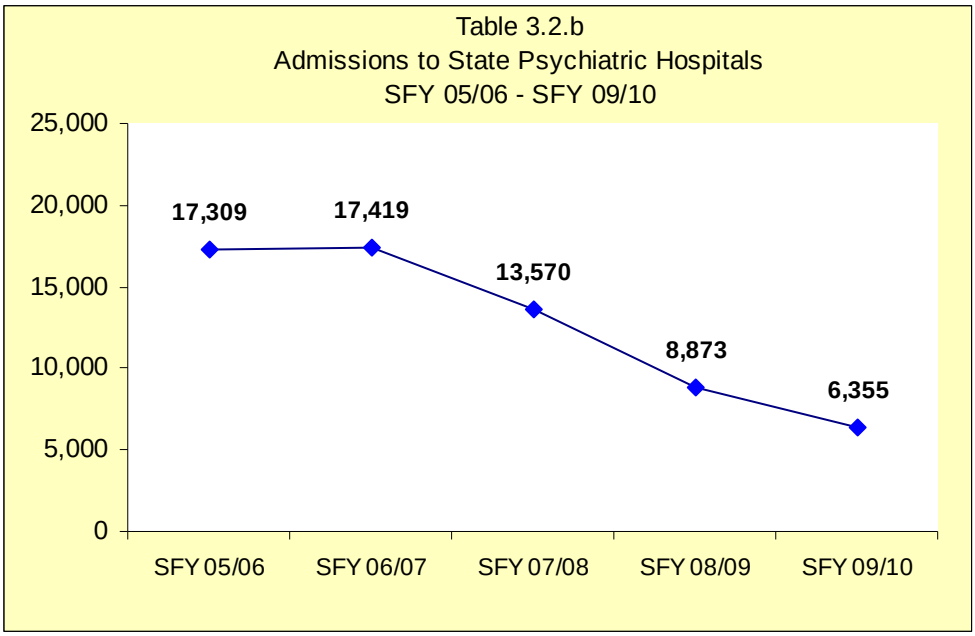


SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data as reported in the North Carolina Community Mental Health Block Grant report, FFY 2009.

Over the past five years, the number of admissions to the state psychiatric hospitals has been significantly reduced, as shown in Table 3.2.b on the next page. Since SFY 2005-06, the number of admissions to the state psychiatric hospitals decreased by almost two-thirds. Conversely, increases in the numbers served in community hospitals and county hospitals were seen from SFY 2009 to SFY 2011. Patients served in community hospitals[6] increased from 15,442 to 18,966 while patients served in three-way contracted psychiatric beds[7] in county hospitals increased from 1,460 to 5,238 during this time.

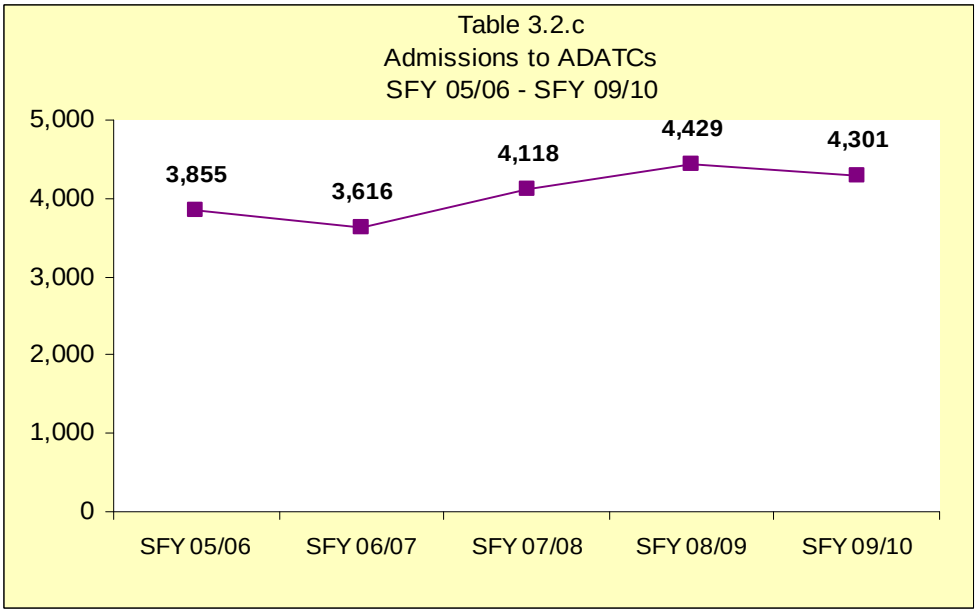
[6] This excludes state psychiatric hospitals.

[7] Three-way contracted beds are psychiatric beds in county hospitals that the Legislature appropriated funds for over the past several years to help reduce the use of state hospitals.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for state psychiatric hospital admissions during July 1, 2005 - June 30, 2010.

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 alcohol and drug treatment centers (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 substantially from 3,855 in SFY 2005-06 to 4,301 in SFY 2009-10 (a twelve percent increase).

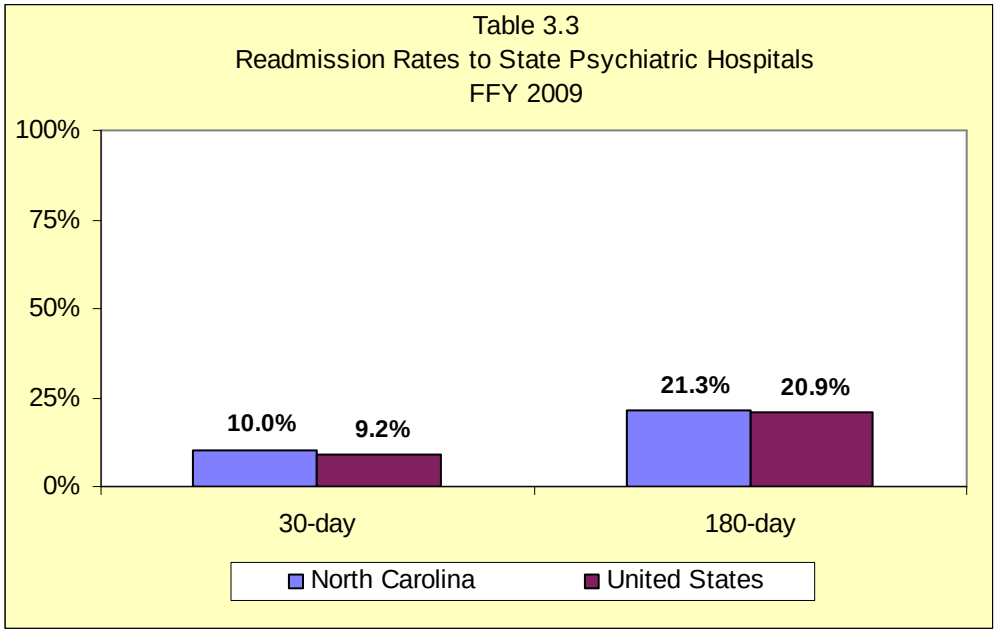


SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for ADATC admissions during July 1, 2005 - June 30, 2010.

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 the two Divisions with information on where more comprehensive services might be needed. This indicator measures the percent of persons discharged from state psychiatric hospitals during each quarter that fall within the responsibility of an LME to coordinate services[8], 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. In North Carolina as well as nationwide, the readmission rate is more than double when comparing the 30 day follow-up period to the 180 day follow-up period. Also, as seen in the table below, North Carolina state psychiatric hospital readmissions are in line with the nation for both the 30-day and 180-day time periods.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data as reported in the North Carolina Community Mental Health Block Grant report, FFY 2009.

[8] Discharge data has been modified to include only discharges coded as "direct" discharges or "program completion" to sources that fall within the responsibility of an LME to coordinate services (e.g. to other outpatient and residential non state facility, self/no referral, unknown, community agency, private physician, other health care, family friends, nonresidential treatment/habilitation program, other). Discharges for other reasons (e.g. transfers to other facilities, deaths, etc.); to other referral sources (e.g. court, correctional facilities, nursing homes, psychiatric service of general hospital, state facilities, VA); and out-of-state are not included in the numerator and denominator.

Measure 3.4: Transitions to Community from State Developmental Centers

The Division of State-Operated Healthcare Facilities 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.[9] 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 2011, a total of eleven individuals were discharged from the general population of the developmental centers to the community.[10] Table 3.4 shows the type of community setting to which the individuals moved.

Table 3.4.
Follow-Up Care for Consumers with Developmental Disabilities (DD) Discharged from the General Population of the State Developmental Centers
SFY 2011

Time Period	Number of Individuals Moved to Community	Type of Community Setting
July – September 2010	4	1 to ICF-MR group home 2 to supervised living home 1 to natural family
October – December 2010	5	2 to ICF-MR group home 1 to supervised living home 1 to alternative family living 1 to family home
January – March 2011	1	1 to ICF-MR group home
April – June 2011	1	1 to supervised living home

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

[9] 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.

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

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.

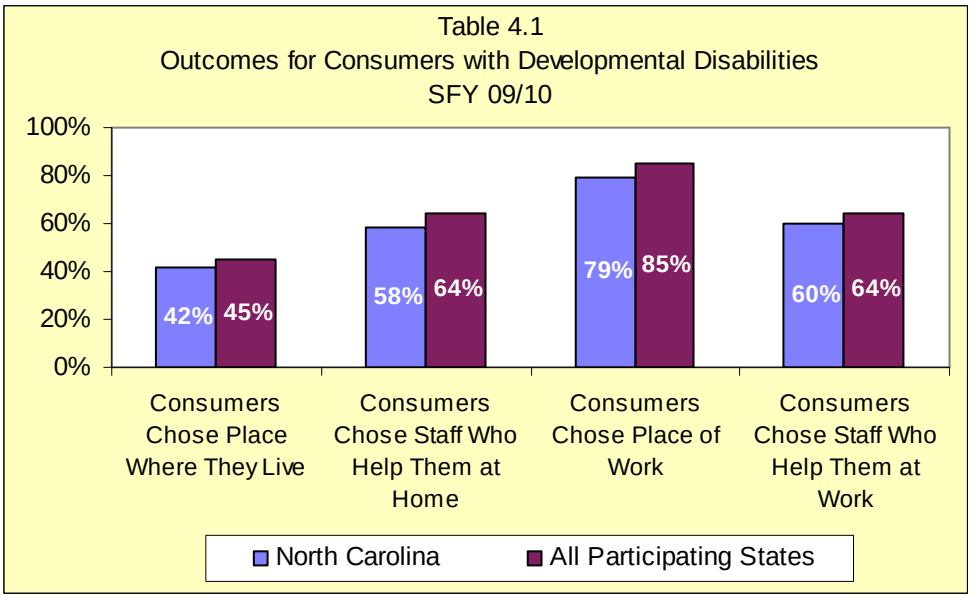
All persons – including those with disabilities – want to be safe, to engage in meaningful daily activities, to enjoy time with supportive friends and family, and to participate positively in the larger community. SAMHSA and CMS support the use of a wide variety of measures of consumers' perceptions 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 issues for SFY 2011-2012.

Measure 4.1: Outcomes for Persons with Developmental Disabilities

Table 4.1 on the next page, presents interview data from DD consumers collected during SFY 2009-10 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 (42%) of consumers with DD in North Carolina reported choosing where they live, 58% reported choosing the staff who help them in their home. Over three-fourths (79%) of the DD consumers in North Carolina reported choosing their place of work and 60% reported choosing the staff persons who assist them in their work.

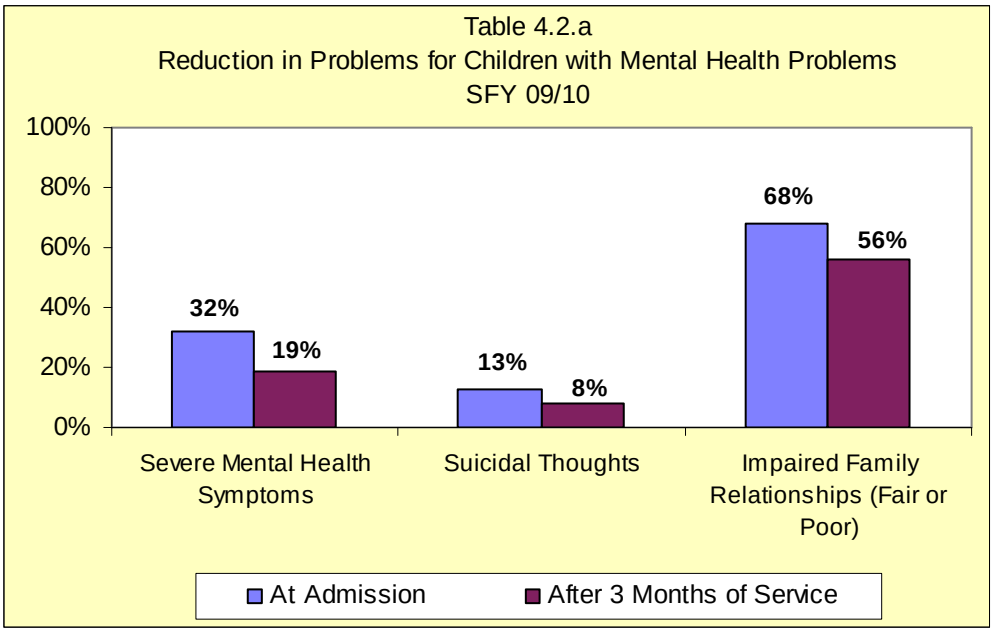


SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2009-10.

Measure 4.2: Outcomes for Persons with Mental Illness

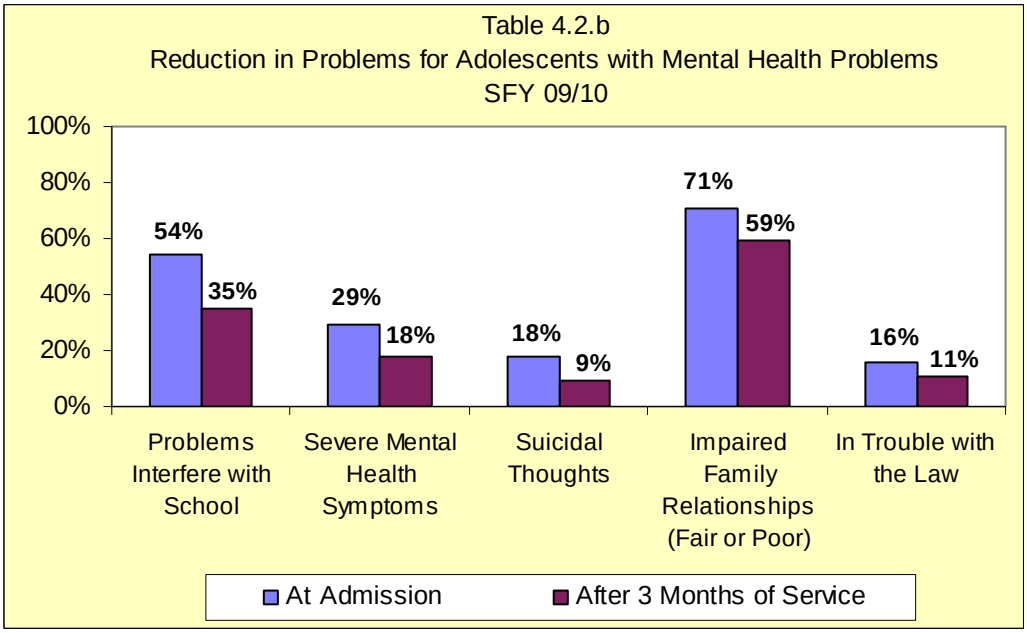
For persons with mental illness, SAMHSA is focusing on reducing symptoms that limit consumers' abilities to maintain positive, stable activities and relationships. Successful engagement in services for even three months can improve consumers' lives, as shown in data from NC-TOPPS consumer interviews. (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 (who received at least three months of treatment during SFY 2009-10). All of the areas below showed improvement after three months of treatment, the most noticeable being a thirteen percentage point drop in severe mental health symptoms.



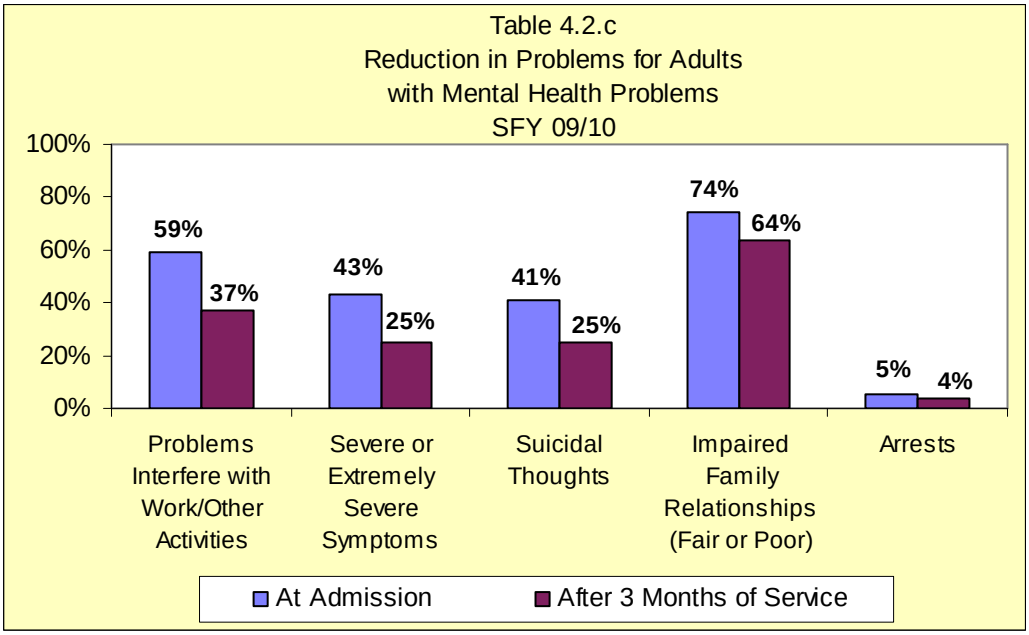
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2009 - June 30, 2010 matched to 3-Month Update Interviews.

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 2009-10 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 rate of suicidal thoughts was cut in 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 by approximately one third between the time of admission to after three months of treatment.



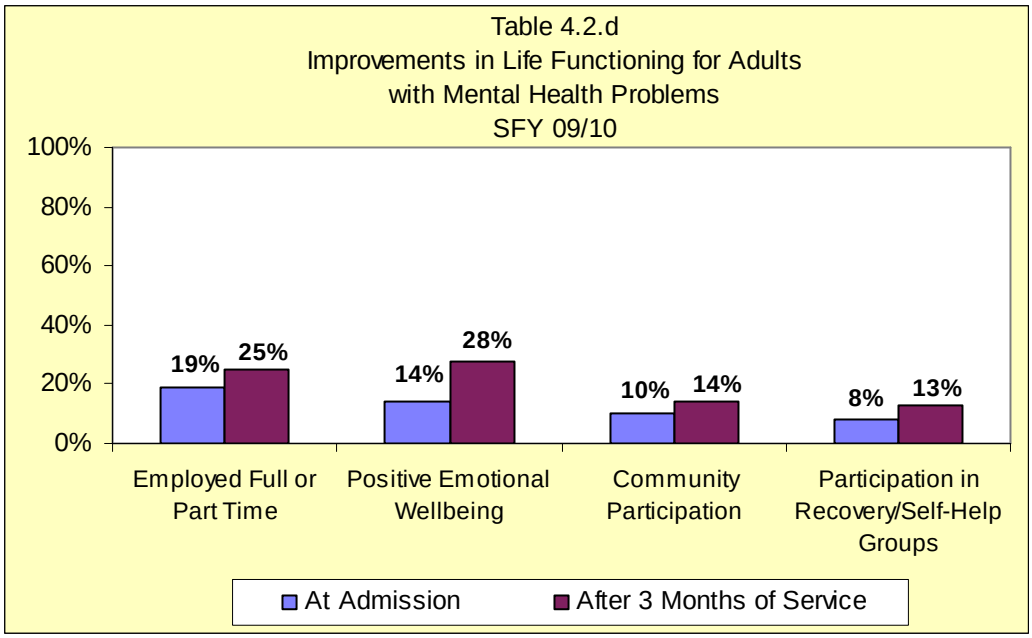
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2009 - June 30, 2010 matched to 3-Month Update Interviews.

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 problems with work or other activities (down 22 percentage points). Other noteworthy gains were made in reducing the severity of mental health symptoms (down 18 percentage points) and suicidal thoughts (down 16 percentage points). In addition, some improvements were made in family relationships as well as reducing arrests during treatment.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2009 - June 30, 2010 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 14 percentage points). Even in difficult economic times for the state, the percent of adults employed full or part-time increased six percentage points during treatment. In addition, the percent of adults participating in positive community activities and recovery or self-help groups increased slightly (four percent and five percent, respectively).

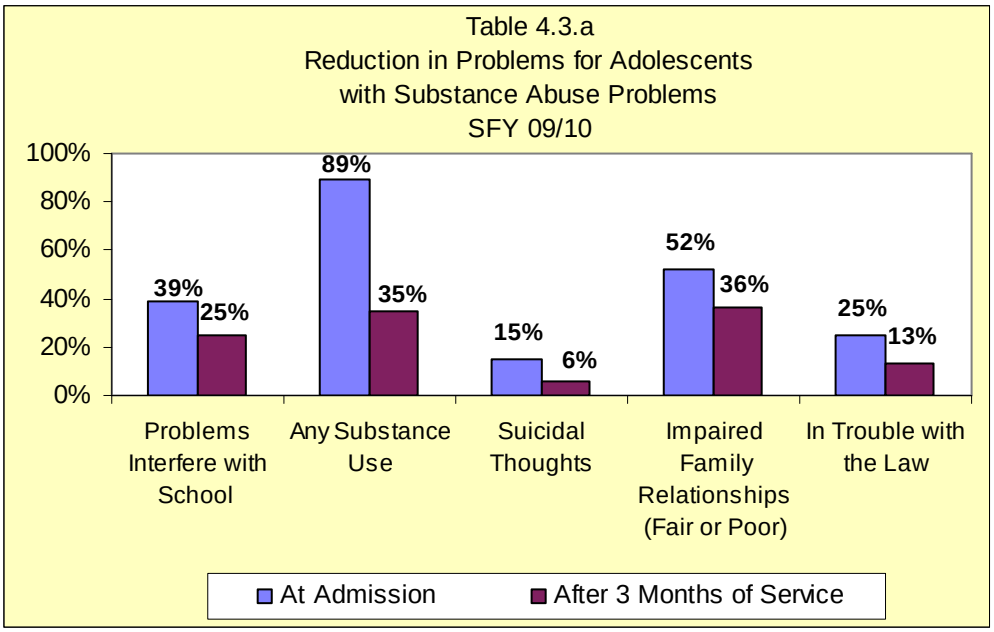


SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2009 - June 30, 2010 matched to 3-Month Update Interviews.

Measure 4.3: Outcomes for Persons with Substance Abuse Disorders

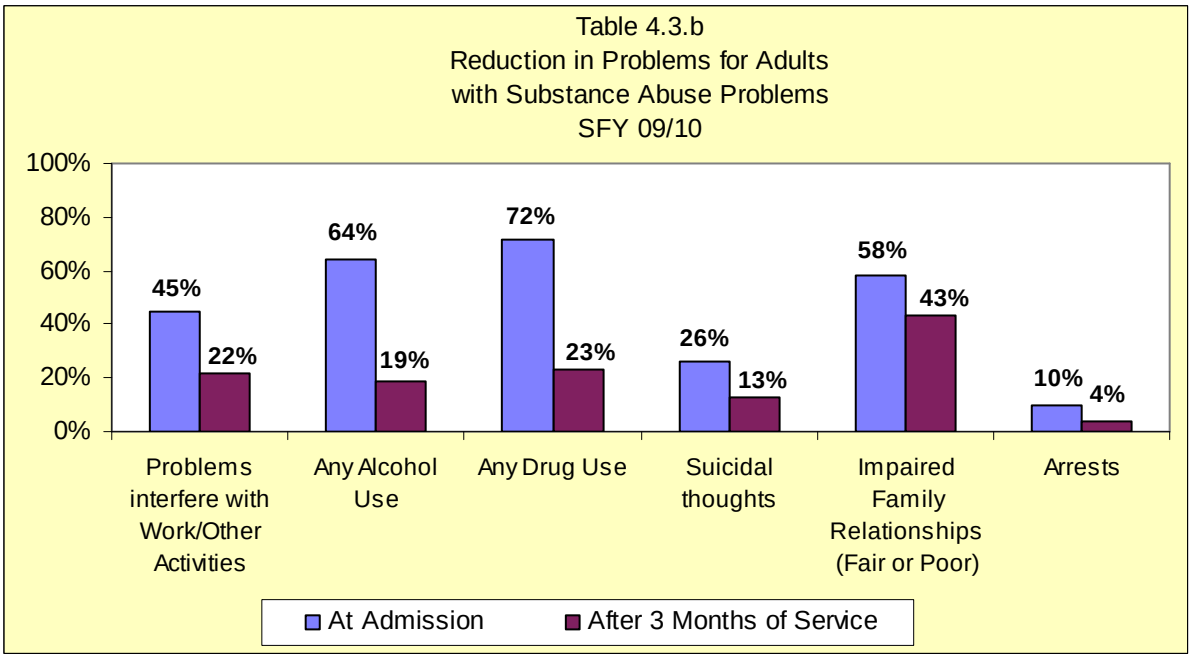
National measures for persons with substance abuse problems focus on eliminating the use of alcohol and other drugs in order to improve consumers' well-being, social relationships and activities. Successful initiation and engagement in services with this population can have very positive results in a 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 2009-10) showed meaningful improvement in a variety of areas of their lives. Most notably, the percent of youth who used substances decreased drastically (a drop of 54 percentage points) and those experiencing suicidal thoughts and in trouble with the law dropped by more than half. In addition, youth with impaired family relationships decreased by 16 percentage points and problems interfering with school saw a decrease of 14 percentage points.



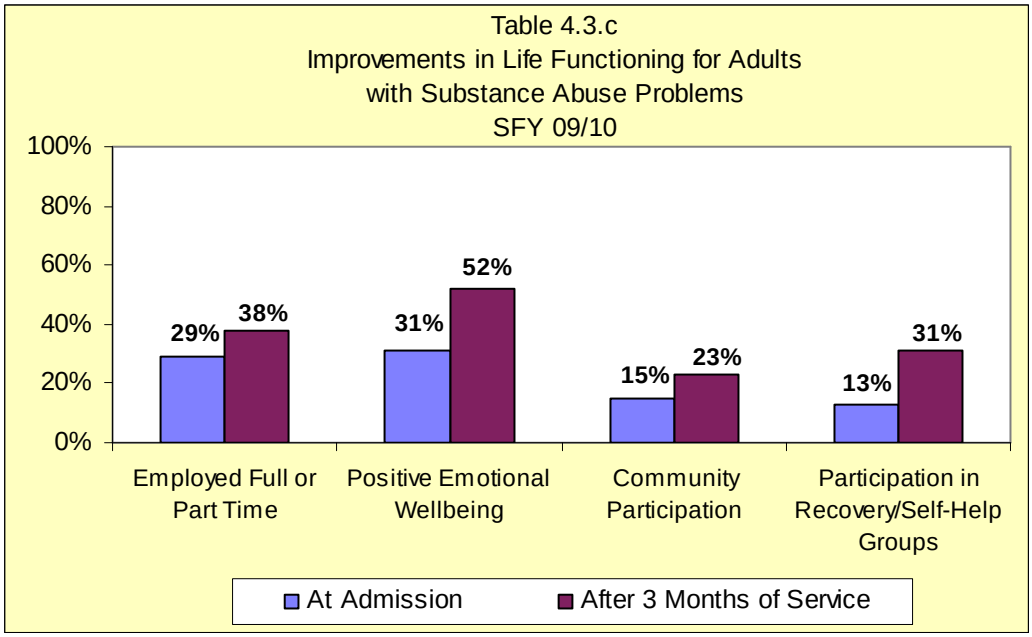
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2009 - June 30, 2010 matched to 3-Month Update Interviews.

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 49 percentage points and the decrease in the use of alcohol was 45 percentage points. In addition, the percent of adults that had problems interfere with their daily activities or had suicidal thoughts was roughly cut in half while the percent of adults arrested decreased by more than half.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2009 - June 30, 2010 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 29% to 38%). 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 (eight percentage points and 18 percentage points, respectively).



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2009 - June 30, 2010 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: Critical Access Behavioral Health Agency (CABHA) Monitoring

As discussed in the Fall 2009 report, the Department of Health and Human Services (DHHS) has implemented a new category of provider agency, a CABHA, for the delivery of mental health and substance abuse services. The implementation of CABHA requirements is designed to improve the quality of care and services. In order to ensure that CABHAs meet quality of care and consumer-outcome standards, regular local monitoring and CABHA monitoring will take place.

The Division will monitor certified CABHAs during August and September 2011 to ensure they are in compliance with the Medical Service and Certification and Staffing Requirements. Seventy-five CABHAs will be monitored which includes an initial random sample that was supplemented by provider agencies referred to the DHHS due to significant issues of concern. Monitoring includes four components:

- a data review by DHHS,
- an onsite review by LME staff,
- an onsite review by DHHS staff, and
- a telephone interview of a sample of consumers by LME staff.

The monitoring process has been informed by participation of consumer and family advocates, providers, LME staff, and staff members of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and Division of Medical Assistance. Every effort has been made to use available resources to gather information in order to eliminate duplication of monitoring efforts. Upon completion of the reviews, results will be generated and used to provide feedback to CABHAs for quality improvement purposes. These results will be reported in the next Semi-Annual Statewide System Performance Report (Spring 2012).

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

The Department is in the process of expanding the 1915 (b)/(c) Medicaid Waiver whereby the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders will be restructured. Local management entities (LMEs) will develop a managed care delivery system to serve such individuals in need of such services who are Medicaid eligible. The Division is preparing a strategic plan in coordination with the Division of Medical Assistance, LMEs, and stakeholders to define specific strategies and responsibilities, objectives and deadlines for implementation, as well as how the Division and DMA will monitor and evaluate this initiative.[11]

The main method used to monitor and evaluate the progress of the LMEs as they assume responsibilities of managed care organizations (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 innovations. LME/MCOs will report on these measures to the Division, permitting the evaluation of the impact of managed care on the existing service

[11] The Joint Legislative Oversight Committee on Health and Human Services will receive a copy of this Strategic Plan on October 1, 2011.

system. Additionally, results will be shared with providers, LMEs, partner agencies, and consumers and families.

In addition to the performance dashboard, DHHS 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 by an external quality review organization to verify 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 2012).

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.

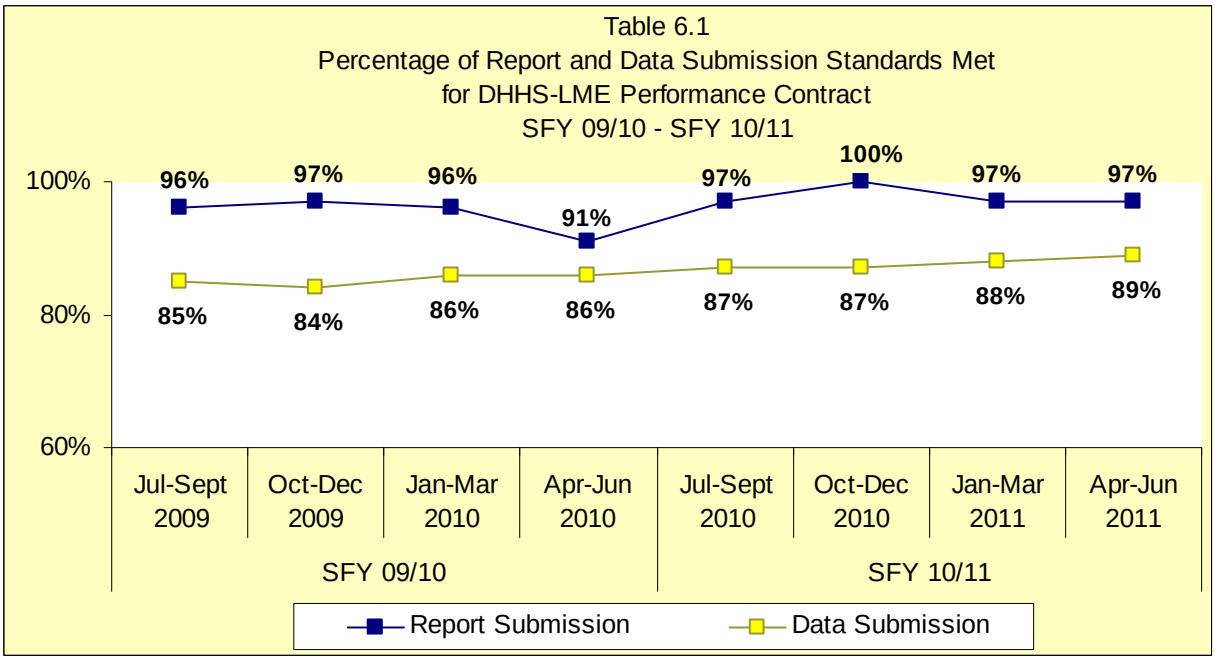
Making good decisions requires the ability to get accurate, useful information quickly, easily and regularly. It also requires efficient management of scarce resources. Staff at all levels need to know the status of their programs and resources in time to take advantage of opportunities, avoid potential 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 on the next page, LMEs' submission of timely and accurate information to the Division has fluctuated 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. Data submission has improved steadily over the past two years (an increase of four percentage points from first quarter of SFY 2009-10 to the fourth quarter of SFY 2010-11). While LMEs are doing better with submission of reports than with the submission of data, report submission has fluctuated over the course of the two years. These are meaningful improvements but will need continued attention.



SOURCE: Data from SFY 2009-10 and SFY 2010-11 Quarterly Performance Contract reports.

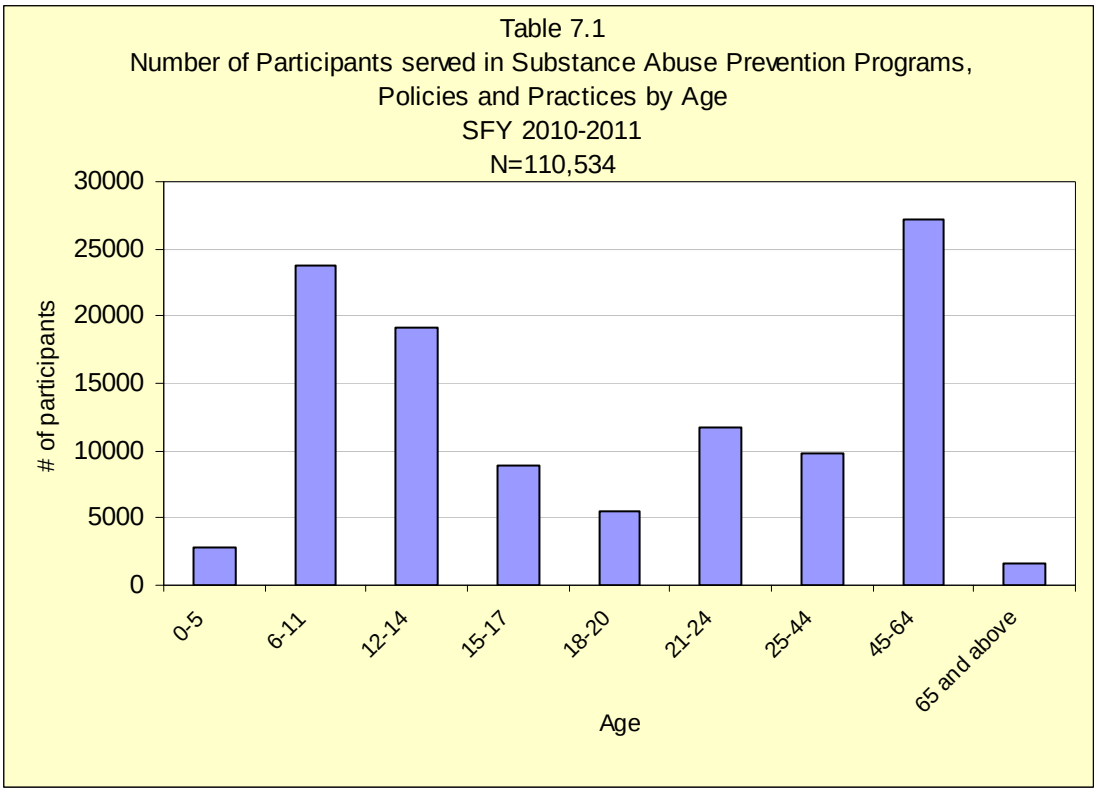
Domain 7: Prevention and Early Intervention

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: Substance Abuse Prevention and Treatment Block Grant

The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) 20% set-aside funds make up the largest portion of funding that target substance abuse prevention services in the Division. The SAPTBG provides services to address relevant programs, practices and policies identified through the "strategic prevention framework" process in local communities. In North Carolina, the SAPTBG prevention set-aside funds are used to support strategies (programs, practices and policies) implemented across the 100 counties and allocated to community providers based on a plan consistent with local needs. The Office of Prevention endorses the risk and protective factor model through implementation of evidence-based/informed strategies to universal, selective and indicated populations. A system of regionalized prevention centers supported by these funds helps with addressing local technical assistance needs.

In SFY 2010 strategies reached approximately 40,000 youth in evidence based curricula programs and over 100,000 participant strategies that included educational seminars, parent trainings and workshops (See Table 7.1 on the next page).



Source: Data from the North Carolina Prevention Outcomes Performance System (NC POPS), SFY 2010-2011.

Measure 7.2: Strategic Prevention Framework-State Prevention Enhancement (SPF-SPE) Cooperative Agreement

To build capacity for a state-wide infrastructure for prevention, the State of North Carolina applied for a Strategic Prevention Framework-State Prevention Enhancement (SPF-SPE) cooperative agreement to promote the adoption of evidence/practice-based strategies to address substance abuse prevention. This grant award from the USDHHS, Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP) will strengthen the state's current prevention infrastructure by developing a systematic, on-going monitoring system for substance abuse related consumption patterns and consequences, and to track progress on performance measures that address prevention priorities, trends, and outcomes. Competencies of prevention professionals will be addressed as well as standards of care for providers. The proposed SPF-SPE will align itself with SAMHSA's Strategic Initiative #1, focusing on its Goal #1: Prevention of Substance Abuse and Mental Illness. The accomplishment of the goals stated in the SPE will result in a trained prevention workforce, attention to cultural needs, relevant and consistent data systems for substance abuse prevention, and implementation of strategies to improve the health and well being of North Carolina citizens.

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 2008-09, 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 2005-06 through SFY 2009-10 comes from data in the Healthcare Enterprise Accounts Receivable Tracking System (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 2005-06 through SFY 2009-10 come from data in the Healthcare Enterprise Accounts Receivable Tracking System (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 2008 come 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 healthcare facilities.

Table 3.4 Follow-up Care for Consumers Discharged from State Developmental Centers: These data are for SFY 2009-10 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 North Carolina Treatment Outcomes and Program Performance System (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 The Number of Participants Served in Substance Abuse Prevention Programs, Policies, and Practices: This information comes from the North Carolina Prevention Outcomes Performance System (NC POPS). More information on this system can be found at http://kitusers.kithost.net/support/nc/Home/tabid/868/Default.aspx

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