



**FY2008**  
**Summary of State-Reported Outcomes**  
**for The Durham Center Area Board**

**April 3, 2008**

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# COMMUNITY SYSTEMS PROGRESS INDICATORS

The DMH/DD/SAS' Quality Management Team releases a quarterly report of Community Systems Progress Indicators for each LME in North Carolina. Although additional indicators were measured during FY07, only those which have continued through FY08 are included in this document. The tables and summaries presented over the next few pages present information for the Durham LME, comparing the data to other Urban LMEs (counties with an average of 200 or more persons living per square mile) and Statewide, which includes Urban, Rural and Mixed LMEs.

For some indicators, the SFY 2008 Performance Contract Standard differs from the specified SFY 2008 Target.

## **SERVICE DELIVERY** **Services to Person in Need**

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This indicator is measured by comparing the **prevalence**, or percent of the population estimated to have a particular condition in a given year, to the **treated prevalence**, or percent of the population in need who receive services for that condition within a year.

Estimated Persons In Need Of Services: These numbers were calculated by multiplying the most current available statewide prevalence rates for NC for MH, DD, and SA by the July 2007 county population projections for each relevant age group for each county in each LME's catchment area.

### Sources:

- ◆ Population Data: State Demographics Unit (<http://demog.state.nc.us>), July 2007 Population Projection (last update 6/5/07)
- ◆ Mental Health Prevalence Rates: Prepared by NRI/SDICC for CMHS, August 30, 2007 (for the MH Block Grant)
- ◆ Substance Abuse Prevalence Rates: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2004 and 2005
- ◆ Developmental Disability Prevalence Rates: Report by the US DHHS, Surgeon General (2001) based on data from the 1994 and 1995 National Health Interview Survey (NHIS) Disability Supplement, Phase I, Estimated Ages of People with MR/DD in US Non-Institutional Population.

*Treated prevalence rate is shown for each age group and disability population on the next page.*

# COMMUNITY SYSTEMS PROGRESS INDICATORS

## Services to Person in Need—Treated Prevalence Rate

Category	Quarter	SFY 2008 Target	Durham	Urban	State
Adult MH	2nd Qtr FY08	38%	39%	34%	38%
	1st Qtr FY08	38%	38%	33%	38%
	4th Qtr FY07	N/A	37%	33%	38%
Child & Adolescent MH	2nd Qtr FY08	38%	62%	36%	43%
	1st Qtr FY08	38%	58%	35%	41%
	4th Qtr FY07	N/A	55%	36%	40%
Adult DD	2nd Qtr FY08	36%	36%	33%	36%
	1st Qtr FY08	36%	35%	32%	36%
	4th Qtr FY07	N/A	40%	34%	36%
Child & Adolescent DD	2nd Qtr FY08	19%	22%	17%	19%
	1st Qtr FY08	19%	22%	17%	19%
	4th Qtr FY07	N/A	23%	18%	19%
Adult SA*	2nd Qtr FY08	10%	8%	7%	7%
	1st Qtr FY08	10%	8%	7%	7%
	4th Qtr FY07	N/A	10%	8%	8%
Adolescent SA*	2nd Qtr FY08	9%	9%	5%	6%
	1st Qtr FY08	9%	8%	5%	6%
	4th Qtr FY07	N/A	10%	6%	7%

*\*The substance abuse data used to generate these values does not include service data for County-funded services.*

# COMMUNITY SYSTEMS PROGRESS INDICATORS

## Timely Initiation and Engagement in Service

**Rationale:** Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.

Category	Quarter	Two Visits in 14 Days				Two More Visits in Next 30 Days			
		SFY 2008 Target	Durham	Urban	State	SFY 2008 Target	Durham	Urban	State
Mental Health	2nd Qtr FY08	42%	61%	37%	37%	25%	49%	25%	25%
	1st Qtr FY08	42%	59%	39%	39%	25%	48%	28%	27%
	4th Qtr FY07	N/A	55%	37%	36%	N/A	38%	25%	24%
Developmental Disabilities	2nd Qtr FY08	72%	44%	62%	62%	55%	33%	50%	51%
	1st Qtr FY08	72%	68%	66%	63%	55%	55%	53%	52%
	4th Qtr FY07	N/A	50%	61%	60%	N/A	38%	49%	48%
Substance Abuse	2nd Qtr FY08	71%	89%	68%	64%	50%	75%	52%	47%
	1st Qtr FY08	71%	82%	68%	64%	50%	58%	50%	47%
	4th Qtr FY07	N/A	80%	66%	64%	N/A	62%	49%	46%
Mental Health/ Developmental Disabilities	2nd Qtr FY08	None set	73%	51%	55%	None set	64%	40%	45%
	1st Qtr FY08	None set	89%	51%	55%	None set	84%	39%	46%
	4th Qtr FY07	—	—	—	—	—	—	—	—
Mental Health/ Substance Abuse	2nd Qtr FY08	None set	66%	51%	53%	None set	50%	40%	40%
	1st Qtr FY08	None set	70%	51%	53%	None set	48%	37%	39%
	4th Qtr FY07	—	—	—	—	—	—	—	—

SOURCE: Medicaid and State Service Claims Data. January 1-March 31, 2007 (first service received)

# COMMUNITY SYSTEMS PROGRESS INDICATORS

## Effective Use of State Psychiatric Hospitals

**Rationale:** State psychiatric hospitals provide a safety net for the community service system. An adequate community system can and should provide their residents with crisis services and short-term inpatient care close to home. This helps families stay in touch and reserves high-cost state facility beds for consumers with long-term care needs. *Reducing* the short-term use of state psychiatric hospitals is a goal that also allows more effective and efficient use of funds for community services.

	Short-Term Use (1-7 Days)			Longer-Term Use (8-30 Days) *			30+ Days*			
	SFY 2008 TARGET	Durham	Urban	State	Durham	Urban	State	Durham	Urban	State
2nd Qtr FY08	No more than 44%	53%	56%	54%	33%	30%	33%	14%	14%	14%
1st Qtr FY08	No more than 44%	54%	59%	56%	33%	28%	31%	14%	13%	13%
4th Qtr FY07	N/A	50%	56%	55%	34%	30%	32%	16%	14%	13%

*SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data on Discharges during April 1-September 30, 2007.*

*\*There is no SFY 2008 Target set for 8-30 Days of Care or 30+ Days of Care.*

The Durham Center has developed contracts with Duke and Holly Hill Hospital to provide short term acute inpatient mental health care for indigent adults as an alternative to state hospital admission. From FY07 to FY08 The Durham Center has more than doubled the number of private hospital admissions.

The implementation of Durham Center Access has reduced the volume of patients with mental health and substance abuse issues presenting directly to local hospital emergency rooms and provided an alternative referral source for law enforcement and other emergency responders for persons experiencing a mental health or substance induced crisis. From FY07 to FY08 there has been a 6% increase in the number of involuntary patients who presented at Durham Center Access for evaluation for hospitalization but a 3% decrease in the number of patients who have been diverted from State hospitalization. This may be largely a reflection of the fact that Durham Center Access is not currently licensed to accept involuntary patients for admission. When Durham Center Access moves to its new location in the summer of 2008, it is expected to admit involuntary as well as voluntary patients.

In spite of the development of new community based diversion options, from FY07 to FY08, there has been a 13% increase in the average number of involuntary Durham patients referred to the state hospital from private hospitals, and a 7% increase in the number of patients taken directly to the State hospital for involuntary admission. We would expect that the recent addition of care coordinators and a hospital liaison to focus on those consumers with the most serious problems and highest needs will help address these issues in the coming months.

# COMMUNITY SYSTEMS PROGRESS INDICATORS

## Timely Inpatient Follow-Up

**Rationale:** Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community services/ supports. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.

### Alcohol & Drug Addiction Treatment Center (ADATC)

	Follow-Up within 7 Days of Discharge				Follow-Up between 8 and 30 Days of Discharge*		
	SFY 2008 Target	Durham	Urban	State	Durham	Urban	State
2nd Qtr FY08	36%	24%	24%	26%	18%	11%	11%
1st Qtr FY08	36%	26%	27%	28%	11%	9%	12%
4th Qtr FY07	N/A	18%	22%	23%	5%	9%	11%

### Other Psychiatric Hospital Units

	Follow-Up within 7 Days of Discharge				Follow-Up between 8 and 30 Days of Discharge*		
	SFY 2008 Target	Durham	Urban	State	Durham	Urban	State
2nd Qtr FY08	42%	55%	37%	35%	9%	15%	15%
1st Qtr FY08	42%	28%	28%	29%	18%	14%	14%
4th Qtr FY07	N/A	39%	31%	31%	10%	14%	14%

*SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges January 1 -March 31, 2007); Medicaid and State Service Claims Data (for claims submitted January 1 - September 30, 2007).*

*\*There is no SFY 2008 Target set for Follow-Up between 8 and 30 Days of Discharge.*

# PERFORMANCE CONTRACT OUTCOMES

On a quarterly basis, the DMH/DD/SAS' Quality Management Team releases a report that includes data on the performance requirements specified under the Performance Contract. The requirements address three main areas, including: 1) Clinical Performance; 2) System Management Performance; and 3) Administrative Performance. On the following pages, each requirement and its standards are defined, and the Durham LME and Statewide results are displayed for the past three quarters (i.e., Fourth Quarter FY07 through Second Quarter FY08).

## **Fourth Quarter (April-June) FY07**

Durham met or exceeded 17 (78%) of the 22 performance standards that were applicable this quarter, including two of three Clinical Performance measures, five of six System Management Performance measures, and 10 of 13 Administrative Performance measures.

Statewide, LMEs met or exceeded 56% of the standards for Clinical Performance measures, 69% for System Management Performance measures, and 72% for Administrative Performance measures.

## **First Quarter (July-September) FY08**

Durham met or exceeded 11 (73%) of the 15 performance standards that were applicable this quarter, including one of three Clinical Performance measures, and 10 of 12 Administrative Performance measures.

Statewide, LMEs met or exceeded 54% of the standards for Clinical Performance measures, and 73% for Administrative Performance measures. There were no System Management Performance standards evaluated in this report.

## **Second Quarter (October-December) FY08**

Durham met or exceeded 10 (77%) of the 13 performance standards that were applicable this quarter, including one of three Clinical Performance measures, and nine of 10 Administrative Performance measures.

Statewide, LMEs met or exceeded 53% of the standards for Clinical Performance measures, and 74% for Administrative Performance measures. There were no System Management Performance standards evaluated in this report.

On page 12, the Administrative Performance grid directly from the original Performance Contract Outcomes report is displayed.

# PERFORMANCE CONTRACT OUTCOMES

## CLINICAL PERFORMANCE MEASURES

### Access, Triage & Referral-Access to Emergent, Urgent and Routine Care

*Performance Requirement:* LME maintains a log for each request for service and submits a quarterly report by the 20th day of the month following the end of the quarter. Reports shall be submitted on time and show the number of persons requesting services, the number and percent that are determined to need certain types of care, and the number and percent for which access was available within the applicable time limit.

**Best Practice Standard:** 100% of cases that are determined to need care are provided access within the applicable time limit.  
**SFY 2007 and SFY 2008 Standard:** 85% of cases.

For **emergent care**, qualified provider provides immediate care when consumer is available to receive care within 2 hours of request

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007
2nd Qtr FY08	100%-Met Best Practice Standard	96%	0%
1st Qtr FY08	100%-Met Best Practice Standard	96%	0%
4th Qtr FY07	100%-Met Best Practice Standard	97%	3%

For **urgent care**, access is defined as having a face-to-face service (assessment and/or treatment) provided within 48 hours of the request

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007
2nd Qtr FY08	45%-Did Not Meet Standard*	17%	29%
1st Qtr FY08	72%-Did Not Meet Standard*	25%	33%
4th Qtr FY07	94%-Met Standard	21%	38%

For **routine care**, a face-to-face service (assessment and/or treatment) is to be provided within 7 calendar days from the date/time of request

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007
2nd Qtr FY08	61%-Did Not Meet Standard	0%	13%
1st Qtr FY08	74%-Did Not Meet Standard	0%	8%
4th Qtr FY07	62%-Did Not Meet Standard	0%	10%

\* For first and second quarter reports, we changed the method for tracking and reporting emergent and urgent requests for service to more accurately reflect consumer flow. A large number of requests previously counted as Urgent requests are now counted as Emergent requests. Please note that 92-94% of consumers with Urgent requests were offered care within 48 hours, but some refused the timely appointment or did not show. Substance abuse consumers are counted as urgent or emergent, even if they do not choose to be seen within 48 hours.

# PERFORMANCE CONTRACT OUTCOMES

## SYSTEM MANAGEMENT PERFORMANCE MEASURES

### Service Management-Transition to Community Services (Psychiatric Hospital Bed-Day Allocation)

*Performance Requirement:* LMEs have the responsibility of authorizing inpatient and ADATC admissions and working with State-operated facilities to return consumers to appropriate community-based services as soon as practical following admission. The standards are measured at the end of each fiscal year, and thus, there is no separate data to report for first or second quarter of FY08.

**Best Practice Standard:** The LME uses 90% or less of its annual bed-day allocation per category.

**SFY 2007 and SFY 2008 Standard:** The LME uses 100% or less of its annual bed-day allocation per category (50% Allocation Used YTD).

*The table below is not based on the Performance Contract Outcomes report itself, but clearly reflects the bed day usage for the first six months of FY07 (June–December) compared to the same time period in FY08.*

State Hospital Bed Day Utilization, FY07 & FY08										
	June-December FY07			June-December FY08			Changes Between FY07 and FY08			
Type of Hospital Bed	Bed Days Used	Annual Allocation	% Used	Bed Days Used	Annual Allocation	% Used	Change in Annual Allocation	% Change Allocation	Change in Bed Days Used	Change in % Used
All Psychiatric Beds	6,389	16,764	38%	6,589	11,006	60%	-5,758	-34%	+200	3%
Adult Psychiatric	5,463	13,622	40%	5,624	9,406	60%	-4,216	-31%	+161	3%
Child/Adolescent Psych	926	3,142	29%	965	1,602	60%	-1,540	-49%	+39	4%

- ◆ Durham’s utilization of state hospital beds remained well under the state allocation throughout FY07.
- ◆ At the beginning of FY08, Durham’s overall state allocation of hospital beds decreased 34% compared to FY07, but the allocation for children and adolescents decreased by 49%.
- ◆ During the first six months of FY08, Durham’s use of state hospital beds has increased by only 3% compared to FY07, but is 10% over the state allocation year to date due to the decrease in the allocation.
- ◆ Utilization of child psychiatric beds is substantially higher than FY08 compared to the state allocation, but is only 4% higher in actual bed days used. The increase in youth bed days is driven by a small number of youth who had longer than average stays.
- ◆ Geriatric patients tend to have long hospital stays due to the lack of appropriate alternatives in the community

# PERFORMANCE CONTRACT OUTCOMES

## SYSTEM MANAGEMENT PERFORMANCE MEASURES (cont'd) Quality Management & Outcomes Evaluation-Quality Improvement Process

*Performance Requirement:* The LME shall submit an annual Quality Improvement report that describes how it has used its QI process to address service delivery system issues in at least one of the following areas: (a) building service capacity, (b) ensuring continuing of care and/or (c) ensuring the use of evidence-based practices. The following elements are addressed for each project: (1) the basis for choosing the issues targeted for improvement, (2) strategies developed to address identified issues, (3) actions taken, (4) an evaluation of results to date and (5) recommendations for next steps. This standard is only submitted once each fiscal year; therefore, no separate data can be reported for first or second quarter of FY08.

**Best Practice Standard:** At least 5 QI projects were undertaken. All 5 elements were addressed for each project.  
**SFY 2007 Standard:** At least 3 QI projects were undertaken. 3 elements were addressed for each project.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
4th Qtr FY07	100%-Met Best Practice Standard	45%	48%

## Quality Management & Outcomes Evaluation-Incident Reporting

*Performance Requirement:* The LME analyzes Level II and Level III incidents reported by providers, in accordance with 10A NCAC 27G .0600, to determine trends and take action to make system improvements. The LME shall submit quarterly reports [by the 20th of the month following the end of the quarter] summarizing Level II and Level III incidents reported by providers. The report will include summaries of (1) data analyses to identify patterns and trends, (2) strategies developed to address problems, (3) actions taken, (4) the evaluation of results and (5) next steps. DHHS will review the reports for evidence of an effective incident review process. This standard is fully evaluated at the end of each fiscal year; therefore, no standards are listed as met or unmet for first or second quarter of FY08.

**Best Practice Standard:** 100% of reports show clear evidence of an effective process containing all 5 elements (1-5 above).  
**SFY 2007 and SFY 2008 Standard:** 75% of reports show clear evidence of an effective process containing at least 4 elements.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
2nd Qtr FY08	100%-on track	92%-on track	8%-on track
1st Qtr FY08	100%-on track	88%-on track	13%-on track
4th Qtr FY07	100%-Met Best Practice Standard	76%	21%

# PERFORMANCE CONTRACT OUTCOMES

## Synopsis of Administration Performance Outcomes-Second Quarter FY08

LME	Qtr	Administration Percent Met <sup>2</sup> (* or **)	1.8.1. Quarterly Fiscal Monitoring Reports (Current Qtr)	1.8.1.4. SAPTBG Compliance Reports	1.8.1.5. SAJJ Initiative Quarterly Reports	1.8.1.6. Work First Initiative Quarterly Reports	1.8.2.0. CDW - Screening Record	1.8.2.2. CDW - Diagnosis	1.8.2.3. CDW - Unknown Data	1.8.2.4. CDW - Identifying and Demographic Records	1.8.2.5. CDW - Drug of Choice	1.8.2.6. CDW - Episode Completion Records	1.8.2.10. NC TOPPS (Update)	1.8.2.13. NC-SNAP
Alamance-Caswell-Rockingham	2	90.0%		**	**	*	*	*	**	*	*	*		**
Albemarle	2	30.0%		**	**	vw	*	*	*	*	*	*		*
Beacon Center	2	88.9%		**		vw	*	*	**	*	**	**		**
Burke-Catawba	2	88.9%		**		vw	*	*	*	*	**	**		**
CenterPoint	2	80.0%		**	**	vw	**	**	**	**	**	**		**
Crossroads	2	80.0%		**	**	vw	*	*	**	*	*	*		**
Cumberland	2	90.0%		**	**	*	**	*	*	**	*	*		**
Durham	2	90.0%		**	**	vw	**	*	**	**	**	**		**
East Carolina Behavioral Health	2	60.0%		**	**	vw	*	*	*	*	*	*		*
Eastpointe	2	80.0%		**	**	vw	**	*	*	*	*	*		*
Five County	2	70.0%		**	**	vw	*	**	**	*	*	**		**
Foothills	2	80.0%		**	**	vw	*	*	**	*	*	*		**
Guilford	2	90.0%		**	**	vw	**	*	*	**	*	*		**
Johnston	2	88.9%		**		vw	*	**	**	**	**	**		**
Mecklenburg	2	20.0%		**	**	vw								**
Onslow-Carteret	2	90.0%		**	**	vw	*	*	**	*	*	*		**
Orange-Person-Chatham	2	40.0%		**	**	vw			*	*	*	*		*
Pathways	2	50.0%		**	**	vw	**		*	*	*	*		*
Sandhills Center	2	90.0%		**	**	vw	*	**	**	*	**	**		**
Smoky Mountain	2	22.2%		*		vw			**					*
Southeastern Center	2	90.0%		**	**	vw	*	*	*	*	*	*		**
Southeastern Regional	2	90.0%		**	**	vw	**	**	**	**	**	**		**
Wake	2	80.0%		**	**	vw	*	*	*	*	*	*		*
Western Highlands	2	90.0%		**	**	vw	**	**	**	*	**	**		*
Met Best Practice Standard Q2: **	44.5%	0	21	20	22	8	6	13	6	7	9	0	15	
Met the SFY2008 Standard Q2: *	29.2%	0	1	0	2	11	12	9	13	11	10	0	2	
Total	73.7%	0	22	20	24	19	18	22	19	18	19	0	17	
		0.0%	91.7%	100.0%	100.0%	79.2%	75.0%	91.7%	79.2%	75.0%	79.2%	0.0%	70.8%	

2nd Qtr reports were due after the end of the quarter. Results will be reported next quarter.

Statewide average for the 10 measures that were applicable this quarter that met the current SFY or best practice standard.

- Notes:
- ★ = Met the Current State Fiscal Year Performance Contract Standard. ★★ = Met the Best Practice Standard.
  - vw = On track for meeting the annual Current State Fiscal Year Standard. vwv = On track for meeting the annual Best Practice Standard.
  - Measures that are shaded gray are not applicable this quarter.
  - The Percent Met column only includes measures where the performance standard is applicable this quarter.

# PERFORMANCE CONTRACT OUTCOMES

## ADMINISTRATION PERFORMANCE MEASURES (cont'd)

### Information Management, Analysis & Reporting: System Monitoring-Quarterly Fiscal Monitoring Report

*Performance Requirement:* LME submits all required system monitoring reports in acceptable format by the 20th day of the month following the end of the quarter. Reports are accurate and complete.

**Best Practice Standard:** 100% of reports are accurate, complete, and received by the due date.  
**SFY 2007 and SFY 2008 Standard:** Same as Best Practice Standard.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
2nd Qtr FY08	Rating Not Yet Available	N/A	N/A
1st Qtr FY08	100%-Met Best Practice Standard	100%	N/A
4th Qtr FY07	100%-Met Best Practice Standard	89%	N/A

### Information Management, Analysis & Reporting: System Monitoring-Semi-Annual SAPTBG Compliance Report

*Performance Requirement:* The LME shall submit a semi-annual SAPTBG Compliance Report by the 20th of the month following the end of the semi-annual period. Reports are accurate and complete and show at least 48 hours of Synar activity for the period. This standard is evaluated on a semi-annual basis.

**Best Practice Standard:** All reports are accurate and complete, show 48 hours of Synar activity, and are received by the due date.  
**SFY 2007 and SFY 2008 Standard:** All reports are accurate and complete, show 48 hours of Synar activity, and are received no later than 10 days after the due date.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
July-December FY08	100%-Met Best Practice Standard	88%	4%
January-June FY07	100%-Met Best Practice Standard	86%	3%

# PERFORMANCE CONTRACT OUTCOMES

## ADMINISTRATION PERFORMANCE MEASURES (cont'd)

### Information Management, Analysis & Reporting: System Monitoring-Substance Abuse/Juvenile Justice Initiative Reports

*Performance Requirement:* LME submits all quarterly Substance Abuse/Juvenile Justice Initiative Reports by the 20th of the month following the end of the quarter. Reports are accurate and complete.

**Best Practice Standard:** 100% of reports are accurate, complete, and received by the due date.

**SFY 2007 and SFY 2008 Standard:** 100% of reports are accurate, complete. 75% of reports are received on time, and 100% are received no later than 10 calendar days after the due date.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
2nd Qtr FY08	100%-Met Best Practice Standard	100%	0%
1st Qtr FY08	100%-Met Best Practice Standard	100%	0%
4th Qtr FY07	100%-Met Best Practice Standard	96%	0%

### Information Management, Analysis & Reporting: System Monitoring-Work First Initiative Quarterly Reports

*Performance Requirement:* LME submits a quarterly Work First Initiative Report by the 20th of the month following the end of the quarter. Reports are accurate and complete. This standard is fully evaluated at the end of each fiscal year; therefore, no standards are listed as met or unmet for first or second quarter of FY08.

**Best Practice Standard:** 100% of reports are accurate, complete, and received by the due date.

**SFY 2007 and SFY 2008 Standard:** 100% of reports are accurate, complete. 75% are received on-time and 100% of reports are received no later than 10 calendar days after the due date.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
2nd Qtr FY08	100%-on track	92%-on track	8%-on track
1st Qtr FY08	100%-on track	92%-on track	8%-on track
4th Qtr FY07	100%-Met Best Practice Standard	59%	14%

# PERFORMANCE CONTRACT OUTCOMES

## ADMINISTRATION PERFORMANCE MEASURES (cont'd)

### Information Management, Analysis & Reporting: Consumer Information-Client Data Warehouse (CDW)-Screening Records

*Performance Requirement:* LME submits required CDW record types by the 15th of each month. Consumers who are screened by the LMEs Access Unit and determined to have a MH/DD/SA problem will have a completed cross-reference to the Common Name Data Service (CNDS) in CDW within 30 days of the initial contact.

**Best Practice Standard:** 100% of consumers screened by the LMEs Access Unit who are determined to have a MH/DD/SA problem have a completed cross-reference to the CNDS within 30 days of initial contact.  
**SFY 2007 and SFY 2008 Standard:** 90% of consumers.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
2nd Qtr FY08	100%-Met Best Practice Standard	33%	46%
1st Qtr FY08	100%-Met Best Practice Standard	50%	29%
4th Qtr FY07	100%-Met Best Practice Standard	32%	50%

### Information Management, Analysis & Reporting: Consumer Information-Client Data Warehouse (CDW)-Diagnosis Records

*Performance Requirement:* LME submits required CDW record types by the 15th of each month. Open clients who are enrolled in a target population and receive a billable service will have a completed diagnosis in CDW within 30 days of the beginning date of service. A missing diagnosis is defined as DHHS not being able to secure a diagnosis from a service claim (IPRS or Medicaid) or a

**Best Practice Standard:** 100% of open clients who are enrolled in a target population and receive a billable service have a diagnosis in CDW within 30 days of beginning service.  
**SFY 2007 and 2008 Standard:** 90% of open clients.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
2nd Qtr FY08	99%-Met Standard	25%	50%
1st Qtr FY08	100%-Met Best Practice Standard	38%	54%
4th Qtr FY07	100%-Met Best Practice Standard	29%	61%

# PERFORMANCE CONTRACT OUTCOMES

## ADMINISTRATION PERFORMANCE MEASURES (cont'd)

### Information Management, Analysis & Reporting: Consumer Information - Client Data Warehouse (CDW) - "Unknown" Value

*Performance Requirement:* LME submits required CDW record types by the 15th of each month. Mandatory fields contain a value other than "unknown".

**Best Practice Standard:** 100% of all mandatory data fields for the prior quarter contain a value other than "unknown".  
**SFY 2007 and SFY 2008 Standard:** 90% of all mandatory data fields.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
2nd Qtr FY08	100%-Met Best Practice Standard	54%	38%
1st Qtr FY08	100%-Met Best Practice Standard	29%	63%
4th Qtr FY07	100%-Met Best Practice Standard	32%	61%

### Information Management, Analysis & Reporting: Consumer Information-Client Data Warehouse (CDW) Identifying & Demo. Records

*Performance Requirement:* LME submits required CDW record types by the 15th of each month. Open clients who are enrolled in a target population and receive a billable service will have a completed identifying record (record type 10) and a completed demographic record (record type 11) in CDW within 30 days of the beginning date of service on the paid claims record.

**Best Practice Standard:** 100% of open clients who are enrolled in a target population and receive a billable service have completed identifying and demographic records within 30 days of the beginning date of service.  
**SFY 2007 and SFY 2008 Standard:** 90% of open clients.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
2nd Qtr FY08	100%-Met Best Practice Standard	25%	54%
1st Qtr FY08	100%-Met Best Practice Standard	21%	58%
4th Qtr FY07	100%-Met Best Practice Standard	18%	68%

# PERFORMANCE CONTRACT OUTCOMES

## ADMINISTRATION PERFORMANCE MEASURES (cont'd)

### Information Management, Analysis & Reporting: Consumer Information - Client Data Warehouse (CDW) - Drug Of Choice Data

*Performance Requirement:* LME submits required CDW record types by the 15th of each month. A drug of choice record (record type 17) is completed within 60 days of the beginning date of service for clients enrolled in any of the following target populations: ASDHH, ASCDR, ASCJO, ASDSS, ASDWI, ASHMT, ASWOM, CSSAD, CSWOM, CSCJO, CSDWI, and CSMAJ.

**Best Practice Standard:** 100% of open clients in the designated target populations have a drug of choice record completed within 60 days.  
**SFY 2007 Standard:** 90% of open clients.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
2nd Qtr FY08	100%-Met Best Practice Standard	29%	46%
1st Qtr FY08	99%-Met Standard	13%	63%
4th Qtr FY07	99%-Met Standard	32%	46%

### Information Management, Analysis & Reporting: Consumer Information - Client Data Warehouse (CDW) Episode Completion (Discharge) Record

*Performance Requirement:* LME submits required CDW record types by the 15th of each month. An episode completion (discharge) record (Record Type 12) is completed for all consumers, except for members of the AMSRE target population, who have had no billable service or other administrative activity for at least 60 days.

**Best Practice Standard:** 100% of clients admitted since October 1, 2006 who meet the above conditions.  
**SFY 2007 Standard:** 90% of clients.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
2nd Qtr FY08	100%-Met Best Practice Standard	38%	42%
1st Qtr FY08	100%-Met Best Practice Standard	38%	58%
4th Qtr FY07	100%-Met Best Practice Standard	25%	61%

# PERFORMANCE CONTRACT OUTCOMES

## ADMINISTRATION PERFORMANCE MEASURES (cont'd)

### Information Management, Analysis & Reporting: Consumer Information NC Treatment Outcomes and Program Performance System (NC-TOPPS) Initial Assessments

*Performance Requirement:* The LME, through providers, will collect outcomes information on its consumers following sampling methods and reporting schedules for the instrument being used. The NC-TOPPS is required for all MH/SA consumers ages six and older and shall be entered in the web-based system within 30 days of completion of the assessment as specified in the NC-TOPPS Implementation Guidelines. The expected number of initial assessments will be based on the number of consumers in the relevant target populations for whom services are reimbursed through the IPRS or MMIS reimbursement systems during the time period under review.

**Best Practice Standard:** 100% of the expected initial forms are received on time.

**SFY 2007 Standard:** 90% of the expected initial forms.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
2nd Qtr FY08	This measure is being revised	This measure is being revised	This measure is being revised
1st Qtr FY08	42%-Did Not Meet Standard	0%	8%
4th Qtr FY07	60%-Did Not Meet Standard	0%	11%

### Information Management, Analysis & Reporting: Consumer Information NC Treatment Outcomes and Program Performance System (NC-TOPPS) Update Assessments

*Performance Requirement:* An update assessment must be completed within two weeks before or after the required update month (e.g. 3 months, 6 months, 12 months, 18 months, etc). All update assessments shall be complete and accurate. The DMH/DD/SAS shall annually sample consumers with initial assessments to determine the timeliness and accuracy of 3-month update assessments. The 3-month update assessments shall be administered between 76 and 104 days after the initial assessment.

**Best Practice Standard:** 100% of the expected update forms are received and are timely.

**SFY 2007 and SFY 2008 Standard:** 90% of the expected update forms.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
2nd Qtr FY08	81%-Did Not Meet Standard	0%	0%
1st Qtr FY08	76%-Did Not Meet Standard	0%	0%
4th Qtr FY07	72%-Did Not Meet Standard	0%	0%

# PERFORMANCE CONTRACT OUTCOMES

## ADMINISTRATION PERFORMANCE MEASURES (cont'd) Information Management, Analysis & Reporting: Consumer Information NC Support Needs Assessment Profile (NC-SNAP)

*Performance Requirement:* The LME, through providers, will submit to DMH/DD/SAS, by the 15th of each month, an electronically transmitted file (SQL or FTP) containing current assessment forms for all consumers receiving or requesting DD services.

**Best Practice Standard:** 95% of current assessments are no more than 15 months old.  
**SFY 2007 and SFY 2008 Standard:** 90% of current assessments.

Quarter	Durham Result	% of LMEs who Met Best Practice	% of LMEs who Met SFY2007-08
2nd Qtr FY08	100%-Met Best Practice Standard	63%	8%
1st Qtr FY08	94%-Met Standard	58%	8%
4th Qtr FY07	73%- Did Not Meet Standard	62%	8%

## Information Management, Analysis & Reporting-Consumer Information National Core Indicators (NCI) Consents and Pre-Surveys

This outcome is reported in the third quarter report to be published by DMH/DD/SAS on May 15th, 2008.

## Information Management, Analysis & Reporting-Consumer Information-Consumer Satisfaction Survey (CSS)

This outcome is reported in the third quarter report to be published by DMH/DD/SAS on May 15th, 2008.