



**FY 2010—FY 2011  
AREA BOARD REPORT  
Summary of State-Reported Outcomes  
First Quarter FY10 - First Quarter FY11**

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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. The tables and summaries presented over the next few pages present information for the Durham LME and Statewide averages. Any indicators of which we have concern are then shared with an internal committee for review and recommendation of how we can improve. SOURCE: Medicaid and State Service Claims Data (first service received) paid through April 30, 2010.

### Timely Access to Care

**Rationale:** Timely access to appropriate care is critical to protect consumer health and safety, minimize adverse consumer outcomes and promote consumer engagement in services.

For emergent care, qualified provider delivers immediate care when consumer is available to receive it (within 2 hours of request).

Quarter/FY	Standard	Goal	Durham	State
1st Qtr FY11	81%	100%	100%	98%
4th Qtr FY10	81%	100%	100%	98%
3rd Qtr FY10	81%	100%	100%	98%
2nd Qtr FY10	81%	100%	100%	98%
1st Qtr FY10	81%	100%	100%	99%

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

Quarter/FY	Standard	Goal	Durham	State
1st Qtr FY11	70%	88%	66%	86%
4th Qtr FY10	70%	88%	72%	84%
3rd Qtr FY10	70%	88%	79%	82%
2nd Qtr FY10	70%	88%	81%	86%
1st Qtr FY10	70%	88%	74%	85%

For routine care, a face-to-face service (assessment and/or treatment) is to be provided within 14 calendar days from the date/time of request; in second quarter, the standard was 7 calendar days. Decrease in 4th Q may be due to start of waitlist for services.

Quarter/FY	Standard	Goal	Durham	State
1st Qtr FY11	63%	88%	83%	80%
4th Qtr FY10	63%	88%	80%	77%
3rd Qtr FY10	63%	88%	84%	82%
2nd Qtr FY10	63%	88%	92%	80%
1st Qtr FY10	63%	88%	90%	76%

# COMMUNITY SYSTEMS PROGRESS INDICATORS

## Services to Persons in Need

Rationale: North Carolina 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 Mental Health issues, Developmental Disabilities, and Substance Abuse by the July 2008 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 2008 Population Projection (last update 6/9/08)
- ◆ Mental Health Prevalence Rates: Prepared by NRI/SDICC for CMHS, June 14, 2008 (for the MH Block Grant)
- ◆ Substance Abuse Prevalence Rates: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2004-05
- ◆ 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 Persons in Need — Treated Prevalence Rate

Category	Quarter	STANDARD	GOAL	Durham	State
Adult MH	1st Qtr FY11	37%	40%	<b>52%</b>	51%
	4th Qtr FY10	37%	40%	<b>53%</b>	51%
	3rd Qtr FY10	37%	40%	<b>52%</b>	49%
	2nd Qtr FY10	37%	40%	<b>52%</b>	48%
	1st Qtr FY10	37%	40%	<b>51%</b>	45%
Child MH	1st Qtr FY11	40%	40%	<b>68%</b>	55%
	4th Qtr FY10	40%	40%	<b>61%</b>	51%
	3rd Qtr FY10	40%	40%	<b>60%</b>	50%
	2nd Qtr FY10	40%	40%	<b>61%</b>	49%
	1st Qtr FY10	40%	40%	<b>59%</b>	48%
Adult DD	1st Qtr FY11	33%	38%	<b>39%</b>	40%
	4th Qtr FY10	33%	38%	<b>39%</b>	41%
	3rd Qtr FY10	33%	38%	<b>39%</b>	41%
	2nd Qtr FY10	33%	38%	<b>39%</b>	41%
	1st Qtr FY10	33%	38%	<b>40%</b>	39%
Child & Adolescent DD	1st Qtr FY11	18%	20%	<b>28%</b>	21%
	4th Qtr FY10	18%	20%	<b>29%</b>	22%
	3rd Qtr FY10	18%	20%	<b>27%</b>	21%
	2nd Qtr FY10	18%	20%	<b>27%</b>	21%
	1st Qtr FY10	18%	20%	<b>26%</b>	21%
Adult SA	1st Qtr FY11	8%	10%	<b>12%</b>	11%
	4th Qtr FY10	8%	10%	<b>12%</b>	10%
	3rd Qtr FY10	8%	10%	<b>11%</b>	10%
	2nd Qtr FY10	8%	10%	<b>11%</b>	10%
	1st Qtr FY10	8%	10%	<b>11%</b>	9%
Adolescent SA	1st Qtr FY11	6%	9%	<b>14%</b>	9%
	4th Qtr FY10	6%	9%	<b>11%</b>	9%
	3rd Qtr FY10	6%	9%	<b>12%</b>	8%
	2nd Qtr FY10	6%	9%	<b>13%</b>	8%
	1st Qtr FY10	6%	9%	<b>12%</b>	8%

# 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 two visits within the next 30 days (a total of four 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			
		STAN-DARD	GOAL	Durham	State	STAN-DARD	GOAL	Durham	State
Mental Health	1st Qtr FY11	34%	42%	<b>43%</b>	41%	23%	30%	<b>31%</b>	25%
	4th Qtr FY10	34%	42%	<b>46%</b>	42%	23%	30%	<b>34%</b>	26%
	3rd Qtr FY10	34%	42%	<b>47%</b>	40%	23%	30%	<b>34%</b>	25%
	2nd Qtr FY10	34%	42%	<b>53%</b>	42%	23%	30%	<b>38%</b>	27%
	1st Qtr FY10	34%	42%	<b>47%</b>	41%	23%	30%	<b>33%</b>	27%
Developmental Disabilities	1st Qtr FY11	55%	72%	<b>56%</b>	58%	44%	61%	<b>44%</b>	44%
	4th Qtr FY10	55%	72%	<b>59%</b>	61%	44%	61%	<b>44%</b>	45%
	3rd Qtr FY10	55%	72%	<b>52%</b>	63%	44%	61%	<b>30%</b>	47%
	2nd Qtr FY10	55%	72%	<b>56%</b>	65%	44%	61%	<b>33%</b>	52%
	1st Qtr FY10	55%	72%	<b>78%</b>	63%	44%	61%	<b>58%</b>	46%
Substance Abuse	1st Qtr FY11	52%	71%	<b>74%</b>	65%	39%	56%	<b>53%</b>	46%
	4th Qtr FY10	52%	71%	<b>77%</b>	62%	39%	56%	<b>60%</b>	44%
	3rd Qtr FY10	52%	71%	<b>73%</b>	59%	39%	56%	<b>62%</b>	41%
	2nd Qtr FY10	52%	71%	<b>72%</b>	58%	39%	56%	<b>47%</b>	43%
	1st Qtr FY10	52%	71%	<b>75%</b>	62%	39%	56%	<b>49%</b>	46%
Mental Health/ Developmental Disabilities	1st Qtr FY11	None set	None set	<b>54%</b>	52%	None set	None set	<b>44%</b>	39%
	4th Qtr FY10	None set	None set	<b>43%</b>	54%	None set	None set	<b>32%</b>	44%
	3rd Qtr FY10	None set	None set	<b>31%</b>	47%	None set	None set	<b>20%</b>	37%
	2nd Qtr FY10	None set	None set	<b>46%</b>	55%	None set	None set	<b>30%</b>	41%
	1st Qtr FY10	None set	None set	<b>47%</b>	54%	None set	None set	<b>30%</b>	39%
Mental Health/ Substance Abuse	1st Qtr FY11	None set	None set	<b>60%</b>	60%	None set	None set	<b>49%</b>	44%
	4th Qtr FY10	None set	None set	<b>64%</b>	61%	None set	None set	<b>52%</b>	45%
	3rd Qtr FY10	None set	None set	<b>62%</b>	58%	None set	None set	<b>49%</b>	42%
	2nd Qtr FY10	None set	None set	<b>70%</b>	59%	None set	None set	<b>50%</b>	44%
	1st Qtr FY10	None set	None set	<b>66%</b>	60%	None set	None set	<b>55%</b>	46%

# 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)			
	STANDARD	GOAL	Durham	State	STANDARD	GOAL	Durham	State
1st Qtr FY11	No more than 46%	No more than 44%	27%	32%	None set	None set	45%	44%
4th Qtr FY10	No more than 46%	No more than 44%	23%	34%	None set	None set	43%	39%
3rd Qtr FY10	No more than 46%	No more than 44%	41%	35%	None set	None set	41%	40%
2nd Qtr FY10	No more than 46%	No more than 44%	36%	38%	None set	None set	38%	39%
1st Qtr FY10	No more than 46%	No more than 44%	32%	39%	None set	None set	51%	41%

SOURCE for fourth quarter: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data on Discharges .

## State Psychiatric Hospital Readmissions\*

**Rationale:** Successful community living, without repeated admissions to inpatient psychiatric care, requires effective coordination and ongoing appropriate levels of community care after hospitalization. A low psychiatric hospital readmission rate is a nationally accepted standard of care that indicates how well a community is assisting individuals at risk for repeated hospitalizations.

SOURCE for fourth quarter: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data on Discharges .

	Within 30 Days of Discharge				Within 180 Days of Discharge			
	STANDARD	GOAL	Durham	State	STANDARD	GOAL	Durham	State
1st Qtr FY11	No more than 10%	No more than 10%	14%	7%	No more than 23%	No more than 22%	26%	17%
4th Qtr FY10	No more than 10%	No more than 10%	7%	7%	No more than 23%	No more than 22%	19%	18%
3rd Qtr FY10	No more than 10%	No more than 10%	9%	8%	No more than 23%	No more than 22%	20%	18%
2nd Qtr FY10	No more than 10%	No more than 10%	10%	10%	No more than 23%	No more than 22%	20%	20%
1st Qtr FY10	No more than 10%	No more than 10%	16%	9%	No more than 23%	No more than 22%	30%	21%

# 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*	
	STANDARD	GOAL	Durham	State	Durham	State
1st Qtr FY11	27%	70%	<b>78%</b>	40%	17%	13%
4th Qtr FY10	27%	70%	<b>44%</b>	44%	12%	13%
3rd Qtr FY10	27%	70%	<b>44%</b>	34%	6%	15%
2nd Qtr FY10	27%	70%	<b>56%</b>	34%	13%	16%
1st Qtr FY10	27%	70%	<b>48%</b>	32%	0%	11%

### Other Psychiatric Hospital Units

	Follow-Up within 7 Days of Discharge				Follow-Up between 8 and 30 Days of Discharge*	
	STANDARD	GOAL	Durham	State	Durham	State
1st Qtr FY11	41%	70%	<b>65%</b>	52%	13%	14%
4th Qtr FY10	35%	70%	<b>59%</b>	53%	19%	13%
3rd Qtr FY10	35%	70%	<b>59%</b>	47%	12%	17%
2nd Qtr FY10	35%	70%	<b>58%</b>	49%	14%	17%
1st Qtr FY10	35%	70%	<b>66%</b>	49%	11%	15%

# COMMUNITY SYSTEMS PROGRESS INDICATORS

## Child Services in Non-Family Settings\*

Rationale: Children and adolescents served in the most natural and least restrictive community settings appropriate to their needs are more likely to maintain or develop positive family and community connections and to achieve other lasting, positive outcomes.

	STANDARD	GOAL	Durham	State
1st Qtr FY11	No more than 4%	No more than 4%	1%	2%
4th Qtr	No more than 4%	No more than 4%	1%	2%
3rd Qtr	No more than 4%	No more than 4%	2%	3%
2nd Qtr	No more than 4%	No more than 4%	3%	4%
1st Qtr	No more than 4%	No more than 4%	3%	4%

\*Non-Family Settings Include: Level 2 (Program Type), Level 3, and Level 4 Residential Treatment Services.

## Overall Performance on Community Systems Progress Indicators

The Durham Center met or exceeded 18 of the 21 Performance Standards (86%) set in the contract with the state for the 1st Quarter of FY 2011, which are used to determine continued eligibility for Single Stream funding. The Durham Center greatly improved performance in ensuring consumers discharged from ADATC (state alcohol and treatment centers) are seen in the community within 7 days of discharge. Standards not met include readmissions to state psychiatric facilities and consumers showing for urgent appointments more than 48 hours after initial call for services.

## 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 four quarters.

### First Quarter (July—September 2010) FY11:

Durham met 12 of 13 (92%) applicable performance standards. Statewide, the LMEs met 90% of the standards. The only unmet area was the timeliness of NC-TOPPS Update Assessments (only two of the LMEs met this performance standard).

### Fourth Quarter (April—June 2010) FY10:

Durham met 13 of 15 (87%) applicable performance standards. Statewide, the LMEs met 88% of the standards. The unmet area was NC-TOPPS Update Assessments (only one of the LMEs met this performance standard) and the JJSAMHP report due to an error in the report. The report will be fixed and re-submitted.

### Third Quarter (January—March 2010) FY10:

Durham met 13 of 14 (93%) applicable performance standards. Statewide, the LMEs met 95% of the standards. The unmet area was NC-TOPPS Update Assessments. Only one of the LMEs met this performance standard.

### Second Quarter (October—December 2009) FY10:

Durham met 13 of 14 (93%) applicable performance standards. Statewide, the LMEs met 89% of the standards. The unmet area was NC-TOPPS Update Assessments. No LME met this performance standard.

### First Quarter (July-September 2009) FY10:

Durham met 14 of 15 (93%) applicable performance standards in the 1st quarter. Statewide, the LMEs met 89% of the standards. The unmet area was NC-TOPPS Update Assessments. Only one of the LMEs met this performance standard.

## PERFORMANCE CONTRACT OUTCOMES

### 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.

*SFY 2011 Standard:* Each report shows clear evidence of an effective process containing all 5 elements (1-5 above).

Quarter	Durham Result	% of LMEs who Met Standard
1st Qtr FY11	This measure is being revised	This measure is being revised
4th Qtr FY10	<b>100% - Met Standard</b>	96%
3rd Qtr FY10	<b>100% - Met Standard</b>	100%
2nd Qtr FY10	<b>100% - Met Standard</b>	100%
1st Qtr FY10	<b>100% - Met Standard</b>	100%

# PERFORMANCE CONTRACT OUTCOMES

## Quarterly Fiscal Monitoring Report

*Performance Requirement: Performance Requirement: Performance Requirement:* LME submits all required fiscal monitoring reports in acceptable format by the following due dates:

- First quarter report = Oct 20.
- Second quarter report = Feb 20.
- Third quarter report = Apr 20.
- Fourth quarter report = Aug 31.

*SFY 2011 Standard:* Reports are accurate, complete, and received by the due date.

Quarter	Durham Result	% of LMEs who Met Standard
1st Qtr FY11	100% - Met Standard	91.3%
4th Qtr	100% - Met Standard	95.7%
3rd Qtr	100% - Met Standard	100%
2nd Qtr	100% - Met Standard	100%
1st Qtr	100% - Met Standard	100%

# PERFORMANCE CONTRACT OUTCOMES

## 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.

*SFY 2011 Standard:* Reports are accurate, complete, and are received no later than 10 days after the due date.

Quarter	Durham Result	% of LMEs who Met Standard
1st Qtr FY11	100% - Met Standard	100%
4th Qtr	0% - Did Not Meet Standard	72.7%
3rd Qtr	100% - Met Standard	71.4%
2nd Qtr	100% - Met Standard	95.2%
1st Qtr	100% - Met Standard	100%

## 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.

*SFY2011 Standard:* All reports are accurate and complete and are received no later than 10 days after the due date.

Quarter	Durham Result	% of LMEs who Met Standard
1st Qtr FY11	100% - Met Standard	100%
4th Qtr	100% - Met Standard	100%
3rd Qtr	100% - Met Standard	100%
2nd Qtr	100% - Met Standard	100%
1st Qtr	100% - Met Standard	100%

# PERFORMANCE CONTRACT OUTCOMES

## 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.

*SFY 2011 Standard:* 90% 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.

Quarter	Durham Result	% of LMEs who Met Standard
1st Qtr FY11	100% - Met Standard	100%
4th Qtr	100% - Met Standard	100%
3rd Qtr	100% - Met Standard	87.5%
2nd Qtr	100% - Met Standard	100%
1st Qtr	100% - Met Standard	95.8%

## 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 Record Type 13.

*SFY 2011 Standard:* 90% 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.

Quarter	Durham Result	% of LMEs who Met Standard
1st Qtr FY11	100% - Met Standard	100%
4th Qtr	100% - Met Standard	100%
3rd Qtr	100% - Met Standard	100%
2nd Qtr	100% - Met Standard	95.8%
1st Qtr	100% - Met Standard	91.7%

## PERFORMANCE CONTRACT OUTCOMES

### Client Data Warehouse (CDW) - "Unknown" Value (Admissions)

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

*SFY 2011 Standard:* 90% of all mandatory data fields for the prior quarter contain a value other than "unknown".

Quarter	Durham Result	% of LMEs who Met Standard
1st Qtr FY11	<b>100% - Met Standard</b>	100%
4th Qtr	<b>100% - Met Standard</b>	100%
3rd Qtr	<b>100% - Met Standard</b>	100%
2nd Qtr	<b>100% - Met Standard</b>	100%
1st Qtr	<b>100% - Met Standard</b>	95.8%

### Client Data Warehouse (CDW) - "Unknown" Value (Discharges)

Quarter	Durham Result	% of LMEs who Met Standard
1st Qtr FY11	<b>100% - Met Standard</b>	100%
4th Qtr	<b>100% - Met Standard</b>	91.7%
3rd Qtr	<b>100% - Met Standard</b>	95.8%
2nd Qtr	<b>100% - Met Standard</b>	95.8%
1st Qtr	<b>100% - Met Standard</b>	95.8%

## PERFORMANCE CONTRACT OUTCOMES

### Client Data Warehouse (CDW) - Identifying & Demographic 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 Record Type 13.

*SFY 2011 Standard:* 90% 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.

Quarter	Durham Result	% of LMEs who Met Standard
1st Qtr FY11	<b>100% - Met Standard</b>	91.3%
4th Qtr	<b>100% - Met Standard</b>	95.8%
3rd Qtr	<b>100% - Met Standard</b>	91.7%
2nd Qtr	<b>98% - Met Standard</b>	91.7%
1st Qtr	<b>99% - Met Standard</b>	95.8%

## PERFORMANCE CONTRACT OUTCOMES

### 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, ASTER, ASWOM, CSSAD, CSWOM, CSCJO, CSDWI, and CSMAJ.

*SFY 2011 Standard:* 90% of open clients in the designated target populations have a drug of choice record completed within 60

Quarter	Durham Result	% of LMEs who Met Standard
1st Qtr FY11	<b>100% - Met Standard</b>	100%
4th Qtr	<b>100% - Met Standard</b>	100%
3rd Qtr	<b>100% - Met Standard</b>	100%
2nd Qtr	<b>100% - Met Standard</b>	91.7%
1st Qtr	<b>100% - Met Standard</b>	95.8%

### 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.

*SFY 2011 Standard:* 90% of clients admitted since October 1, 2006 who meet the above conditions.

Quarter	Durham Result	% of LMEs who Met Standard
1st Qtr FY11	<b>99% - Met Standard</b>	87%
4th Qtr	<b>100% - Met Standard</b>	91.7%
3rd Qtr	<b>100% - Met Standard</b>	87.5%
2nd Qtr	<b>99% - Met Standard</b>	87.5%
1st Qtr	<b>95% - Met Standard</b>	83.3%

# PERFORMANCE CONTRACT OUTCOMES

## 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.

*SFY 2011 Standard:* 90% of the expected initial forms are received on time

Quarter	Durham Result	% of LMEs who Met Standard
1st Qtr FY11	This measure is being revised	This measure is being revised
4th Qtr	This measure is being revised	This measure is being revised
3rd Qtr	This measure is being revised	This measure is being revised
2nd Qtr	This measure is being revised	This measure is being revised
1st Qtr	This measure is being revised	This measure is being revised

## 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.

*SFY 2011 Standard:* 90% of the expected update forms are received and are timely.

Quarter	Receipt—% Received		Timeliness—% Received on Time	
	Durham Result	% of LMEs who Met Standard	Durham Result	% of LMEs who Met Standard
1st Qtr FY11	<b>99.9% - Met Standard</b>	<b>96%</b>	<b>83.9% - Did Not Meet Standard</b>	8.7%
4th Qtr	<b>99.8% - Met Standard</b>	<b>96%</b>	<b>78.5% - Did Not Meet Standard</b>	4.2%
3rd Qtr	<b>97.7% - Met Standard</b>	<b>83.3%</b>	<b>67.6% - Did Not Meet Standard</b>	4.2%
2nd Qtr	<b>93.3% - Met Standard</b>	<b>83.3%</b>	<b>57.8% - Did Not Meet Standard</b>	0%
1st Qtr	<b>80% - Did Not Meet Standard</b>	<b>83.3%</b>	<b>51.5% - Did Not Meet Standard</b>	4.2%

## PERFORMANCE CONTRACT OUTCOMES

### 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.

*SFY 2011 Standard:* 90% of current assessments are no more than 15 months old.

Quarter	Durham Result	% of LMEs who Met Standard
1st Qtr FY11	100% - Met Standard	95.7%
4th Qtr	100% - Met Standard	91.7%
3rd Qtr	100% - Met Standard	95.8%
2nd Qtr	100% - Met Standard	95.8%
1st Qtr	99.9% - Met Standard	95.8%