Semi-Annual Report to the
Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services

on

Mental Health, Developmental Disabilities and Substance Abuse Services
Statewide System Performance Report
SFY 2006-07: Fall Report

Session Law 2006-142

House Bill 2077

Section 2.(a)(c)

October 1, 2006

North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Executive Summary

Legislation in 2006 requires that the Division report to the Legislative Oversight Committee (LOC) every six months progress on performance domains. The Division has accomplished a number of projects in the past several years that lay the foundation for an effective quality management system and provide the data for this and future reports. These measures will be refined with the assistance of a consultant and reported on in future reports.

Highlights

- **Domain 1: Access to Services** – The overall number of persons served through the public system has increased in the past five years. However, a downward trend in services to adults with substance abuse problems is an area of significant concern.
- **Domain 2: Individualized Planning and Supports** – Over 4,000 agencies across the state have enrolled as qualified providers to facilitate consumers' opportunities to choose who services them. While over two-thirds of consumers with developmental disabilities and over three-quarters of mental health and substance abuse consumers report involvement in choosing their service goals, the Division expects this to increase due to the new Person-Centered Plan format and training in person-centered thinking skills initiated this year.
- **Domain 3: Promotion of Best Practice**s – The state has enrolled almost 3,000 agencies to provide Enhanced Benefit services through which evidence-based practices (EBP) models can be reimbursed. Over-use of state hospitals continues to be a major concern.
- **Domain 4: Consumer-Friendly Outcomes** – The Division is following national consensus on measuring improvements in consumers' quality of life as a result of services. Overall, North Carolina performs as well as or better than other states in measures for consumers with developmental disabilities' participation in community life and meaningful activities. Mental health and substance abuse consumers show marked improvement in a variety of areas after three months of treatment.
- **Domain 5: Quality Management System** – Local management entities (LMEs) are increasing their monitoring of service providers, and an increasing number of issues for improvement have been identified and resolved quickly.
- **Domain 6: System Efficiency and Effectiveness** – The Division has been working over the past few years to ensure compliance for submitting consumer demographic and disability data to the Division's information/data systems. As a result, compliance has been increasing. This is a trend that will affect positively the Division's ability to design and develop strategies for improving efficiency and effectiveness.
- **Domain 7: Prevention and Early Intervention** – Approximately 11,500 people across twenty-five LMEs have participated in EBP programs last year to increase awareness and understanding of substance abuse issues. In addition, the Division collaborated with the Department of Public Instruction in a federal pilot project to inform the public about the stigma associated with mental illness. Involvement in projects like these are increasing.

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Mental Health, Developmental Disabilities and Substance Abuse Services
Statewide System Performance Report
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Introduction

Session Law 2006-142 House Bill 2077 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, NC G.S. 122C-102(c) was revised 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 mental health, developmental disabilities and substance abuse services, on the State's progress in these performance areas*."

The following is the first in this new series of reports. It provides background information on each of the domains of performance listed in the legislation above. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services, with the help of the consultant(s) funded by the General Assembly through Senate Bill 1741, will use this information to set targets to be achieved in the next three fiscal years, according to goals developed in the strategic planning process that will occur during the remainder of this fiscal year. Future semi-annual reports will provide baseline information and progress on each of the selected goals.

Creating a Quality Management System

In 2001, the North Carolina General Assembly, through Session Law 2001-437, House Bill 381, mandated the Division to transform the way that publicly-funded mental health, developmental

disabilities, and substance abuse services are provided in order to ensure effective and efficient services to North Carolinians with chronic and severe disabilities. As part of that effort, the Division began developing strategies to track progress on implementing and achieving the goals of system reform.

The Division has undertaken a number of initiatives over the past several years to create a foundation for quality management to ensure the effective service implementation. Since the reform legislation, the Division has:

- Refined and expanded the Division's primary data information systems and created a web-based query capacity.
- Created a Quality Management Team that is responsible for developing systems and mechanisms to track, evaluate and improve the quality of the service system.
- Designed and is implementing a comprehensive approach to quality management based on the Quality Framework for Home & Community Based Services promoted by the federal Centers for Medicare and Medicaid Services (CMS).
- Implemented a performance-based contract with local management entities (LMEs) that includes thirty standardized measures of performance that are tracked and published quarterly.
- Implemented a comprehensive strategy for local monitoring of service providers in coordination with the Division of Facility Services (DFS).
- Implemented statewide incident and complaint reporting and response systems that link to state and local quality assurance and improvement activities.
- Expanded statewide information systems, such the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS), to collect information on each consumer's mental health and substance abuse service needs, services received, service outcomes and perceptions of care in keeping with the National Outcomes Measures (NOMS) being developed by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

These accomplishments have been achieved with the support of funding and technical assistance from CMS and SAMHSA. Specifically the Division has received grants and technical assistance over the past few years including:

- CMS Quality Assurance/Quality improvement Real Choice Systems Change Grant.
- SAMHSA Mental Health Data Infrastructure Grants (2).
- SAMHSA Substance Abuse State Data Infrastructure Grant.
- SAMHSA State Outcomes Measurement and Management System Grant.
- SAMHSA Network for the Improvement of Addiction Treatment pilot state.
- SAMHSA Strategic Prevention Framework State Incentive Grant.
- SAMHSA Washington Circle Public Sector Performance Work Group pilot state.

The Division's accomplishments in improving its information and quality management systems are necessary foundations for the data included below. While some of the systems have been in place long enough to provide meaningful information in this first report, others are relatively new and will provide information for future reports.

Measuring Statewide System Performance

The domains of performance written into legislation reflect the goals of the President's New Freedom Initiative and national consensus on goals all states should be working toward, specifically to provide support for individuals with disabilities to be able to live productive and personally fulfilling lives in communities of their choice. The Division is in the process of developing a set of standard performance measures that can be used to evaluate the implementation of system reform efforts and its impact on system performance and consumers' lives. The Division is choosing measures that relate to:

- The goals of the State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services.
- SAMHSA National Outcome Measures (NOMS) (See Appendix A for details).
- Areas of quality recommended in the CMS Quality Framework (See Appendix B for details).

In addition, the Division is aligning measures of statewide performance with local critical performance indicators, where applicable, so that each LME can evaluate its own progress in relation to other areas of the state. The critical performance indicators chosen for this first report to the Joint Legislative Oversight Committee are a result of work to date in this effort.

For each performance area, the following sections include:

- A definition of the domain.
- A description of each indicator of performance for that domain, which includes:
    - Its relevance to system reform efforts and importance in a high-quality system.
    - Baseline data or a description of plans to collect the needed information.
    - Division expectations about future trends and plans for addressing problem areas.
- Appendices at the end of this report provide information on the data sources for the information included in each domain.

Domain 1: Access to Services

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 disabilities who request help. Timely access is essential for helping to engage people in treatment long enough to repair or improve control over their lives, to prevent crises and to minimize the

negative impact of their disabilities on their lives. Both the SAMHSA National Outcome Measures and CMS Quality Framework include measures of consumers' access to services.

National research estimates the occurrence of chronic and serious mental health, developmental disabilities and substance abuse problems in the population. (See Appendix C for sources.) Based on those estimates, each year:

- Approximately 5.8% of adults and 6.6% of children (ages 6-11) face serious mental health problems.
- Approximately 7.8% of adolescents (ages 12-17) and adults (age 18 and above) face serious substance abuse problems.
- Approximately 2.5% of children and 0.5% of adults have developmental disabilities.

Measure 1.1: Persons Receiving Community 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. Tracking the number of persons that the LMEs serve in communities provides a barometer of progress on that goal.

The number of persons served is determined from data submitted to the Client Data Warehouse (CDW) by the LMEs. In state fiscal year (SFY) 05-06 the Division began requiring LMEs to complete a discharge record on consumers who had not received any service for sixty days (or 365 days for adult mental health consumers in recovery). The intent of this requirement is to produce a more accurate count of persons who are receiving active care. This requirement will have no impact on LME or provider ability to admit new persons into care or to re-admit inactive consumers who require new services. As a result of these two changes, the Division expects the numbers of persons on the LMEs' active caseloads to decrease somewhat over the next year. The preliminary number of persons served for SFY 05-06 (in Table 1.1.a) suggests that this change may already be happening.

Measure 1.1 includes information on the number of persons that the state's mental health, developmental disabilities and substance abuse system has served over the past five years. The Spring SFY 06-07 report will compare the number served in SFY 05-06 to the number of North Carolinians estimated to need publicly funded services. This comparison will help to evaluate the need for additional changes to current fiscal or programmatic policies.

In the following tables, SFY 05-06 numbers are based on preliminary data submitted by LMEs to the CDW and may slightly underestimate total persons served. These numbers will be updated in future reports.

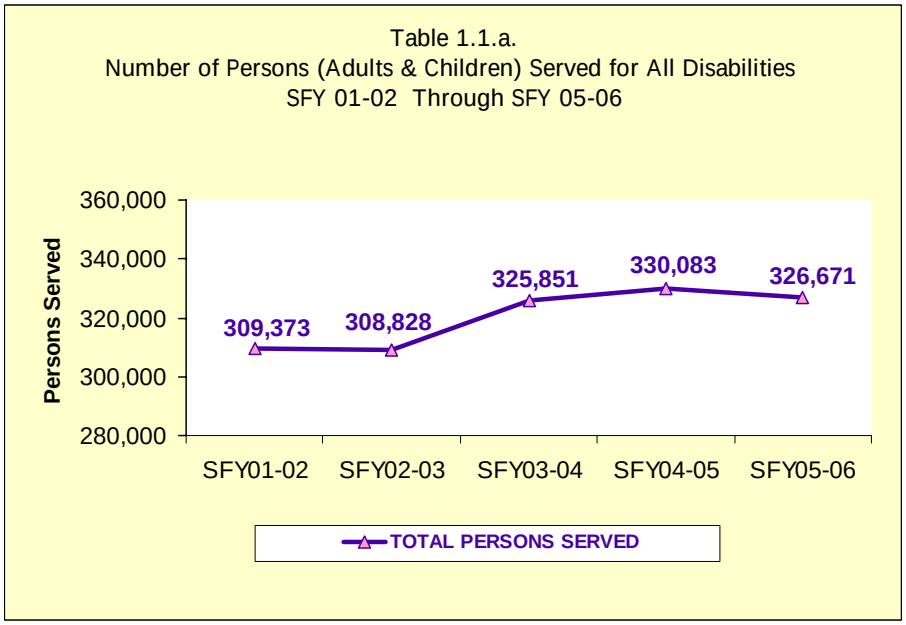


Table 1.1.a. shows an increase of almost 6% in the total number of adults and children who have been served in the community over the past five state fiscal years. Following a substantial increase between SFY 02-03 and SFY 03-04, the number of persons served has leveled off. This may be due in part to LME mergers, divestiture of services, and data system re-structuring that are part of North Carolina's reform activities.

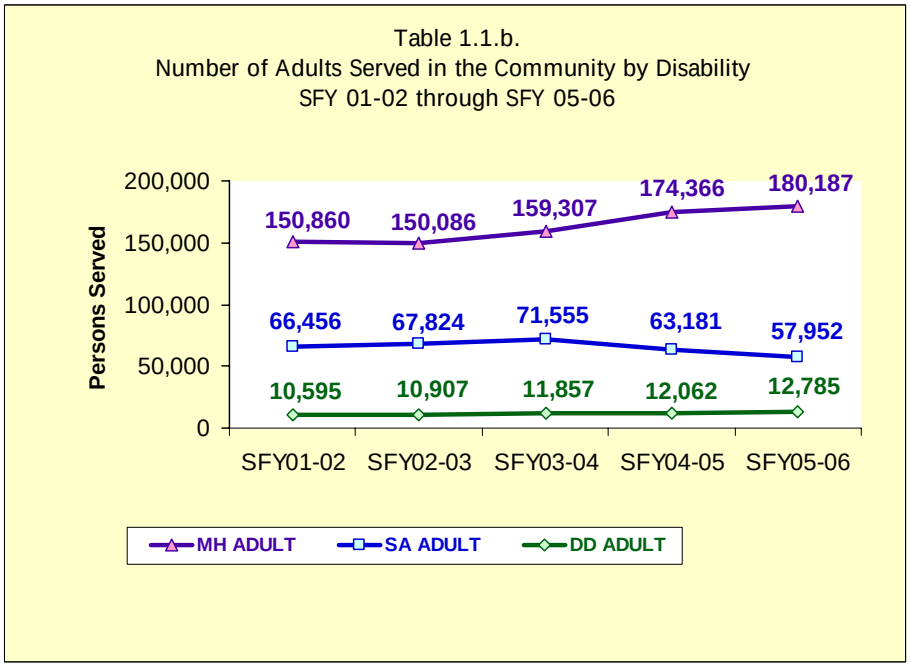


Table 1.1.b. shows differing patterns by disability for the number of adults who have been served in the community over the past five state fiscal years.

- **Adults with a primary mental health diagnosis:** The number of adults served in the community over the past five years has increased by 19%.
- **Adults with a primary substance abuse diagnosis:** The number of persons served in the community over the past five years has decreased by 13%.
- **Adults with a primary developmental disability diagnosis:** The number of adults served in the community over the past five years has increased by 21%.

While the increase in services to mental health consumers and consumers with developmental disabilities is encouraging, the downward trend in services to adults with substance abuse is an area of significant concern. The Division continues to work with the LMEs and providers to design and implement new strategies to better identify and engage individuals in this critical population.

Measure 1.2: Timeliness of Initial Service

A system that can respond quickly to a request for help supports an individual's efforts to enter and remain in services long enough to have a positive impact on his or her disability.

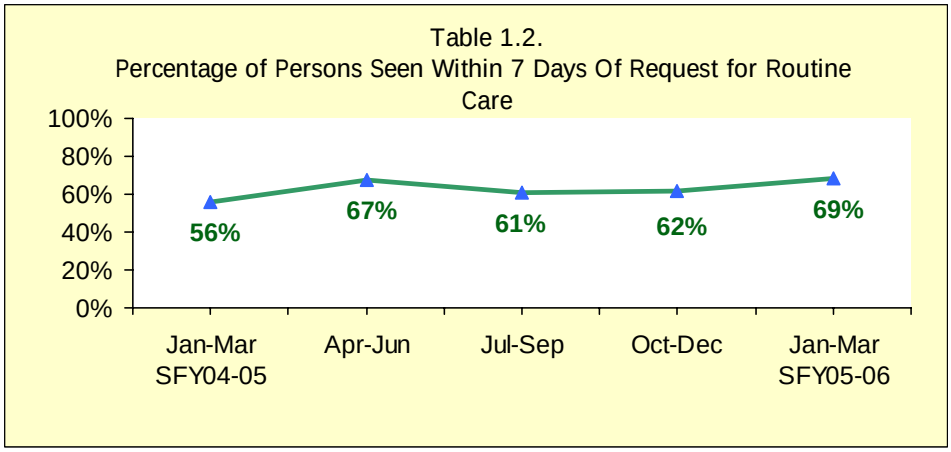


Table 1.2 shows that the percentage of all consumers who were actually seen by a provider within seven days of requesting services has increased by 13% in the fifteen months since the Division began tracking this nationally accepted measure in January 2005.

The Division has also implemented a uniform *Consumer Screening/Triage/Referral Interview and Registration Form* that should improve performance in this area. The Division continues to work with LMEs to reach the established goal of having 85% of consumers receive their first services within 7 days of their request.

Domain 2: Individualized Planning and Supports

This domain measures the extent to which services are tailored to fit the needs of the individual rather than simply providing a standard service package. It includes an individual's and/or family's involvement in planning for the delivery of appropriate services.

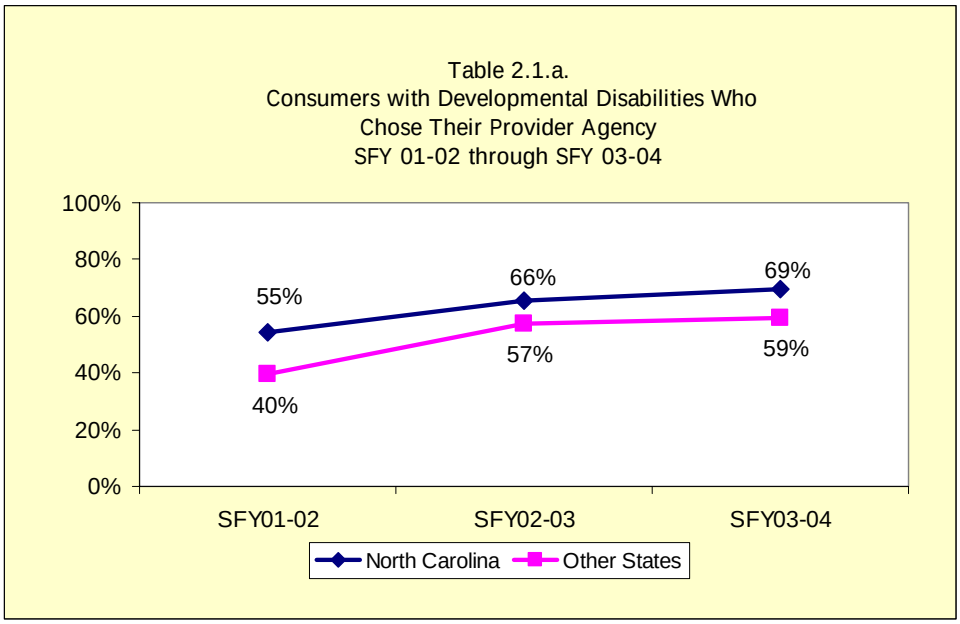
The CMS Quality Framework includes a focus on the extent to which consumers are involved in developing their service plans, have a choice among providers and receive assistance in obtaining and moving between services when necessary.

Measure 2.1: Consumer Choice of Providers

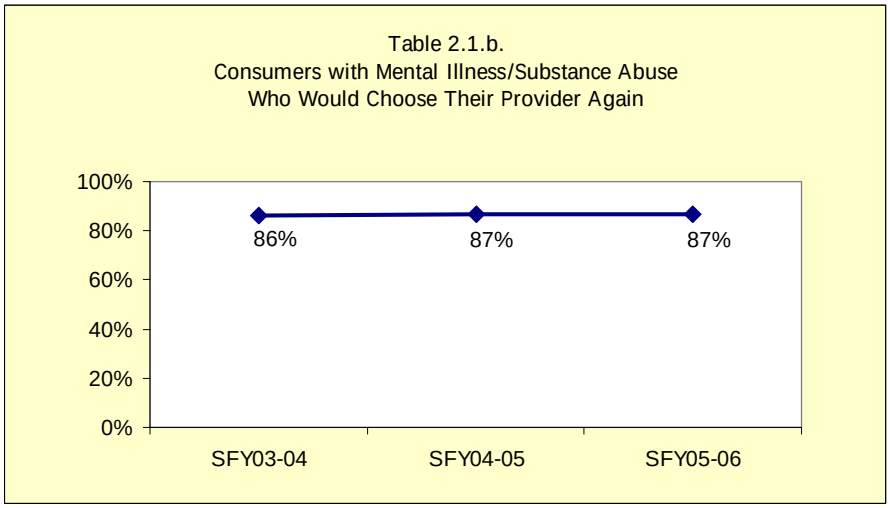
Having a choice among providers is the initial step in honoring the individualized needs of persons with disabilities. The ability of a consumer to exercise a meaningful choice of providers depends first and foremost on having a sufficient number of qualified providers to serve those requesting help. The identification of qualified providers began in earnest with the implementation of new service definitions on March 20, 2006. As of July 2006 the system had made excellent progress in enrolling agencies in every region of the state, including:

- 1,049 Community Support providers.
- 646 Diagnostic Assessment providers.
- 596 CAP-MR/DD Waiver service providers.
- 690 Child Residential Service providers.
- 439 Intensive In-home providers.
- 408 Targeted Case Management providers.
- 76 Psychosocial Rehabilitation providers.
- 63 Mobile Crisis providers.
- 61 Substance Abuse Intensive Outpatient Treatment Program providers.
- 60 Assertive Community Treatment Team providers.
- 59 Day Treatment providers.
- 50 Substance Abuse Comprehensive Outpatient Treatment Program providers.
- 14 Opioid Treatment Program providers.
- 12 Facility-based Crisis Centers.
- 7 Multi-Systemic Therapy providers.

Finding the right provider can mean the difference between willing engagement in services or discontinuation of services before recovery can be achieved. With sufficient provider capacity, consumers have an opportunity to select services from agencies that can meet their individual scheduling and transportation requirements, address their individual needs effectively and encourage their recovery in a way that feels comfortable and supportive to the consumer. The following tables address the extent to which individuals report having a choice in who serves them.



Consumers with Developmental Disabilities: Table 2.1.a. shows that in annual surveys of parents and guardians of persons with developmental disabilities who live at home, over two-thirds report that they are able to choose the agencies that work with their families. (See Appendix C for more information on this survey.) This is a steady improvement over the last three years of available data. In addition, more North Carolina families report having a choice than families from the other states participating in the project.



Consumers with Mental Health and Substance Abuse Disabilities: Table 2.1.b. shows that a significant majority of adult mental health and substance abuse consumers have positive feelings towards their providers. This trend has remained fairly stable over the last three years.

Five percent of adult mental health and substance abuse consumers participate in the Division's annual consumer survey each year used for Table 2.1.b. (See Appendix C for more information on this survey.) In July 2006, the Division began asking all mental health and substance abuse consumers about their opportunities to choose their primary provider. This ongoing data collection will allow more timely analysis of consumer choice. Future reports will include the results of analysis on this measure.

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.

The Division requires a PCP for each person who receives Enhanced Benefit Services[2]. In the spring of 2006, providers and LMEs received state-sponsored training and a standardized PCP format. The LMEs will provide technical assistance to providers to ensure consistent and thorough individualized planning for all consumers. The Division is currently developing mechanisms to measure the implementation and quality of this important foundation of a consumer-centered system and will be working with a consultant to refine those mechanisms.

[2] "*The enhanced benefit service definition package is for persons with complicated service needs." State MH/DD/SAS Plan 2005, p. 58.*

The data in the following tables come from annual surveys of a sample of consumers prior to the implementation of the standardized PCP requirements.

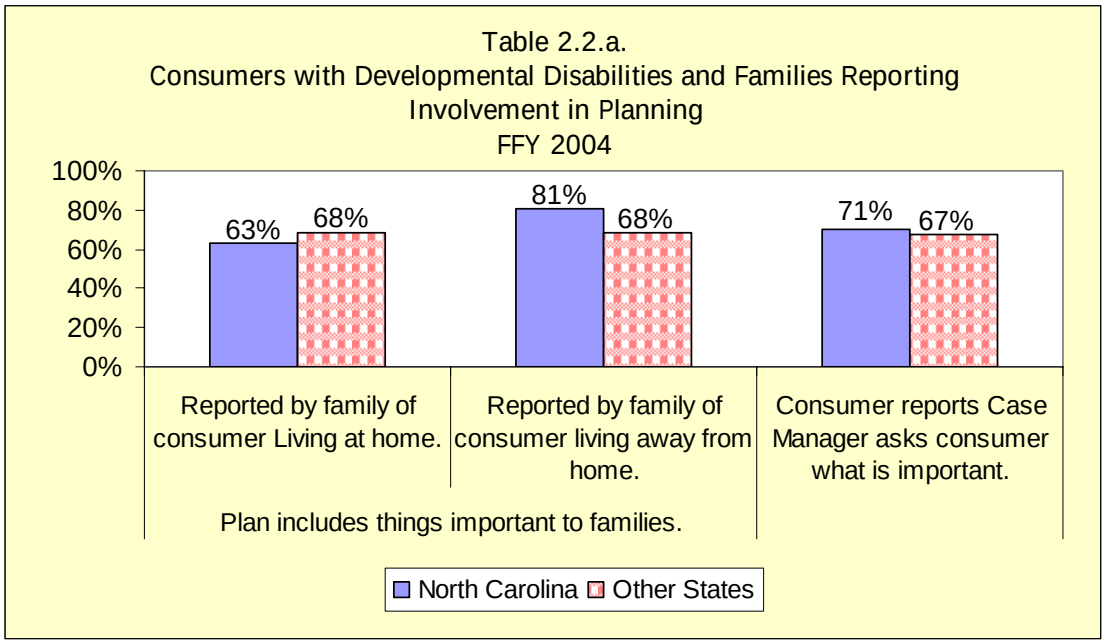
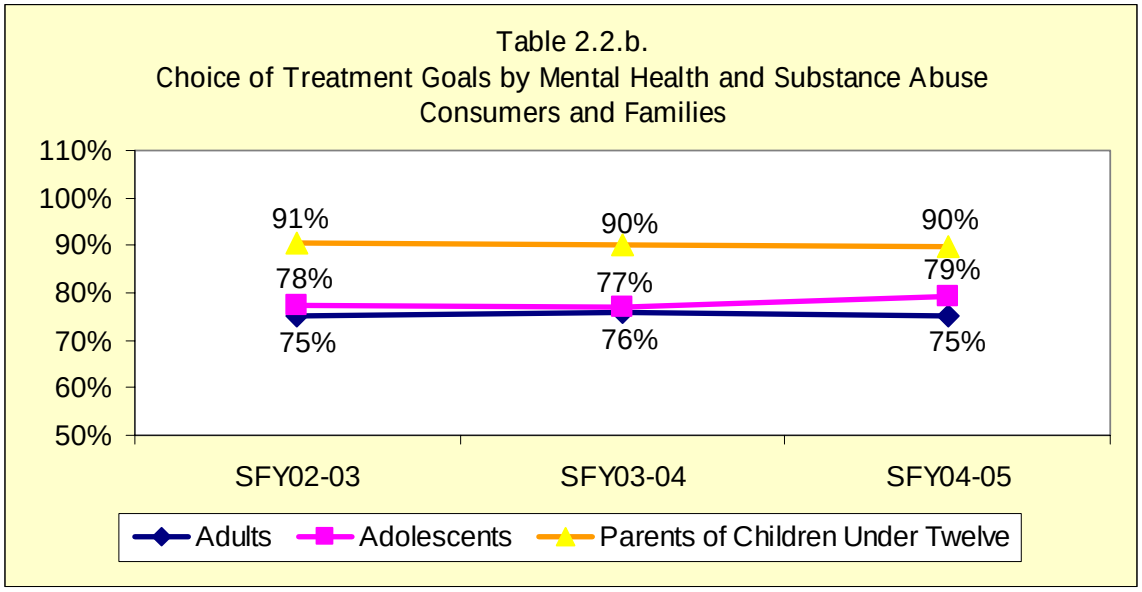


Table 2.2.a. shows that, in three key areas related to service planning, a majority of consumers with developmental disabilities report receiving attention and assistance from providers in reaching their personal goals addressed in the plan. In addition, North Carolina consumers' responses are similar to those of consumers in other states using this survey.

While these reports are encouraging, the Division, LMEs and providers must continue to incorporate person-centered thinking into all aspects of the service system. This is a major shift in philosophy that will require time, diligence and collaboration to achieve fully.



As shown in Table 2.2.b, over three-fourths of mental health and substance abuse consumers surveyed report that they choose their treatment goals. These responses have remained stable over the last three years, with parents of pre-adolescent children reporting substantially more involvement than older age groups. The greater involvement of parents of young children may reflect the state's efforts to institute a system of care that strongly encourages family ownership of the service planning process. As person-centered planning and thinking take hold across the state, the Division expects to see similar improvements in other age groups' involvement in setting personally meaningful goals.

Domain 3: Promotion of Best Practices

This domain refers to adopting and supporting those models of service that give individuals the best chance to live full lives in their chosen communities. It includes system support for community-based programs and practice models that scientific research has shown to improve the attitudes, behaviors and/or functioning of persons with disabilities. SAMHSA includes the availability of such evidence-based practices in its National Outcome Measures.

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; reimbursing providers who adopt those practices and providing oversight and technical assistance to ensure the quality of those services. The Division is committed to creating an effective service system based on best practices, as described in the *2005 State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services,* and as indicated by the adoption of new service definitions that reimburse providers for using evidence-based models of practice. The Division is currently providing grant funds to four LMEs (Durham, CenterPoint, Wake and Catawba) to develop the infrastructure within each LME that will promote and sustain the local use of best practices.

Measure 3.1: Availability of Evidence-Based Practices

As noted in Measure 2.1 (Consumer Choice of Providers), the state has enrolled almost 3,000 agencies to provide Enhanced Benefit services through which many evidence-based practice (EBP) models can be reimbursed.

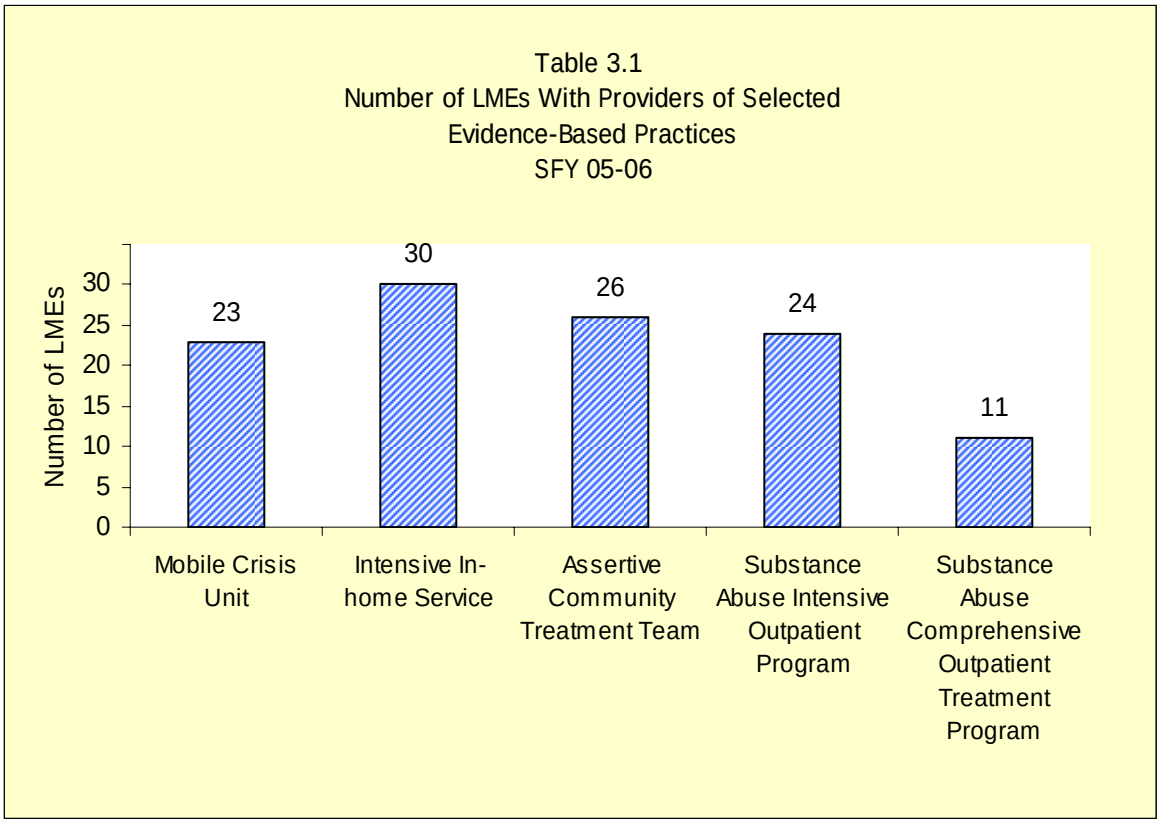


Table 3.1 shows that most of the thirty LMEs have enrolled providers for at least four evidence-based practices.

The Division will continue to work with LMEs to increase the availability of EBPs in all areas of the state. The Division is currently working on strategies to ensure that providers deliver EBPs in accordance with quality standards. For consumers with developmental disabilities, the state currently has about 596 providers to provide services for up to 10,000 individuals through the Community Alternatives Program for Mental Retardation and Developmental Disabilities (CAP-MR/DD), a Home & Community Based Waiver granted by CMS. Waiver services are designed to be flexible enough to fit an individual's changing needs, and as such, represent a best-practice approach to supporting individuals with developmental disabilities.

Measure 3.2: Management of State Hospital Usage

North Carolina is committed to developing a service system in which individuals receive the services and supports they need in their home communities whenever possible. A community-

based service system allows an individual to maintain contact with and receive support from loved ones. This is a particularly critical component of recovery in times of crisis. Service systems that concentrate on preventing crises and providing community-based crisis response services can help individuals stay connected to their family and friends, while reducing the use of state-operated psychiatric hospitals in times of acute crisis.

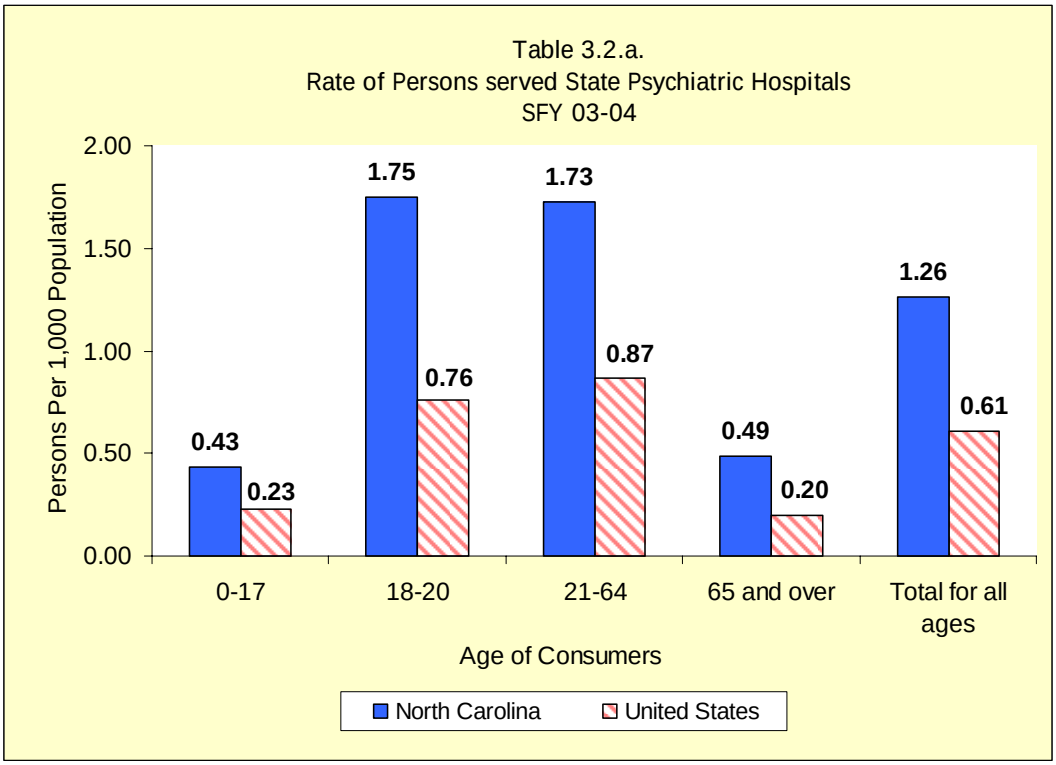
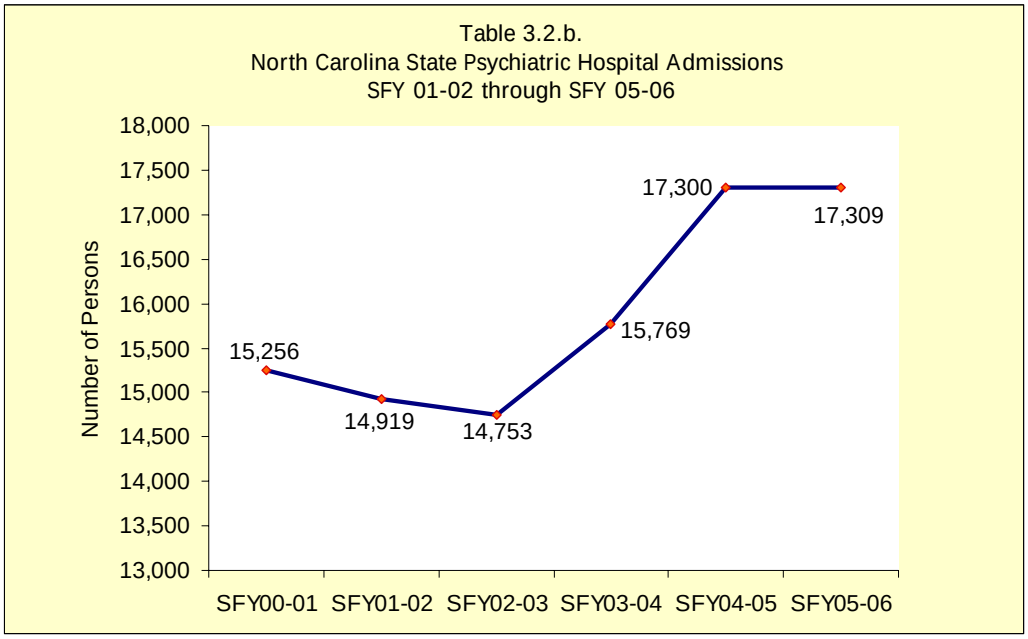


Table 3.2.a.shows that North Carolina provides treatment for persons in its state psychiatric hospitals at approximately twice the national rate, according to the most recent report federal fiscal year (FFY) 2004 from the Center for Mental Health Services (CMHS). This elevated use of the state hospitals occurs across all age groups. Reducing short-term use of state hospitals is a major goal of the state's system reform efforts.

The development and implementation of crisis plans by all LMEs in SFY 06-07 and a careful analysis of the gaps identified by the Long Range Plan to be finalized this fall should positively impact this measure.



In addition to serving more people in state psychiatric hospitals than the national average, Table 3.2.b. shows that there has been a significant increase in admissions over the past five years. The greatest increase occurred between SFY 02-03 and SFY 04-05, when admissions rose by 17%. Between SFY 04-05 and SFY 05-06, the number of admissions appears to have stabilized. The increases are the result of many factors, such as insufficient community service capacity (especially crisis and substance abuse services) and higher severity of need of consumers entering the hospitals. External factors, such as the state's growing population and loss of jobs that provide mental health benefits, compound these problems. The Division, LMEs and providers are addressing this critical issue through efforts to develop strong local community service systems.

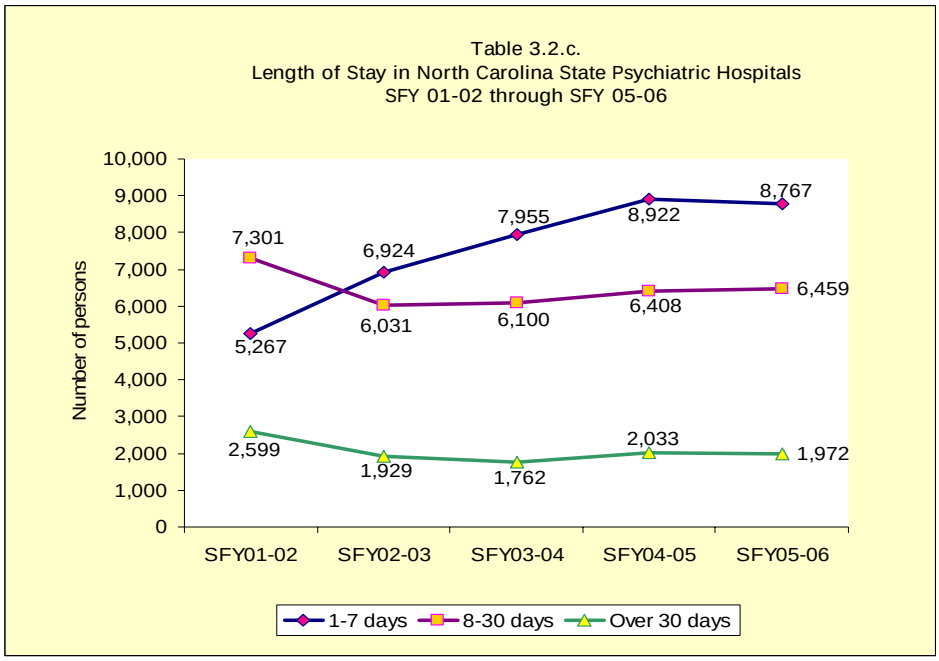
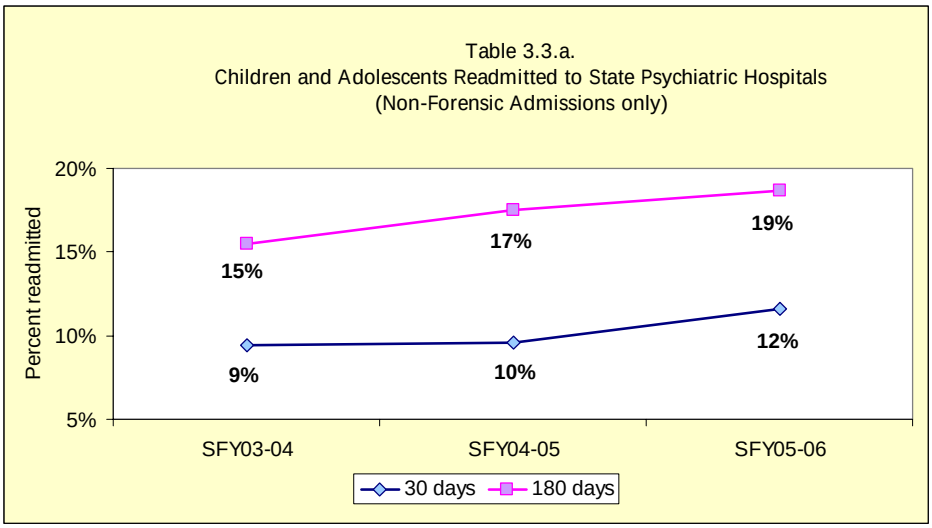


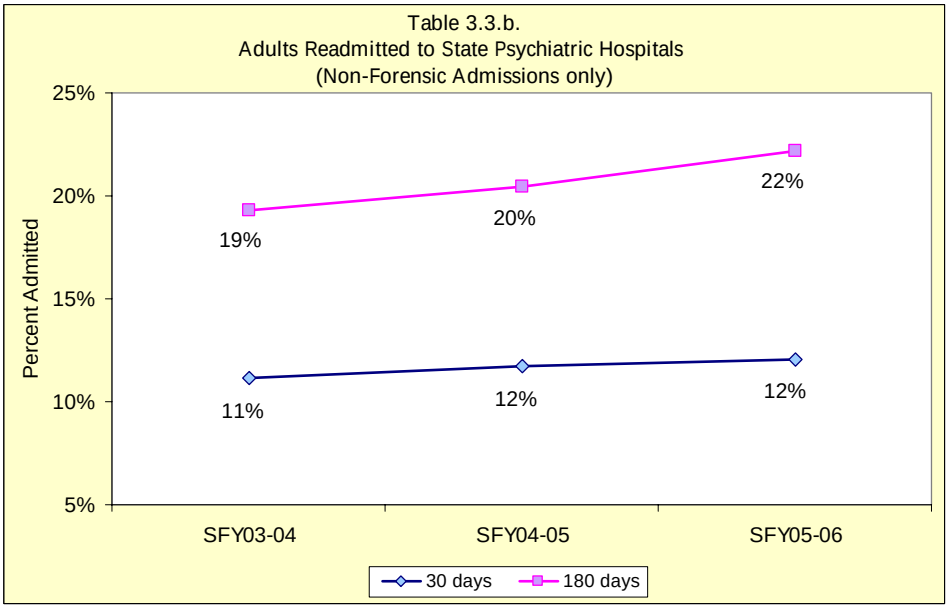
Table 3.2.c.shows an overall increase in short term (1-7 days) and long term (over 30 days) stays in state psychiatric hospitals. These trends most likely reflect increased demand for services coupled with insufficient local service capacity that can help individuals with complex, chronic disabilities to minimize crises and maintain stable lives in their home communities. In particular, services such as intensive outpatient substance abuse treatment, ACT teams and providers who specialize in working with individuals who have both mental retardation and mental illness are needed. In addition, more step-down services such as partial hospitalization, acute treatment units and crisis stabilization services must be developed.

The Division is currently working with the hospitals, LMEs and providers to design and implement effective strategies for decreasing state psychiatric hospitalizations, particularly by providing crisis services to persons with acute needs in their home communities. Success in this area will depend on building sufficient community crisis services and developing comprehensive crisis plans within each individual's PCP, both of which are current emphases of Division efforts. As a result of these initiatives, the Division expects future reports to show a decrease in short-term (1-7 day) hospital stays.

Measure 3.3 State Psychiatric Hospital Recidivism

An effective service system provides enough support to help prevent consumer crises and minimizes their negative impact through appropriate planning and treatment. Recurring hospitalization for those persons who are likely to experience frequent crises is a signal that additional supports are needed. Tracking hospital readmissions within 30 days and 180 days of discharge is a critical measure of consumer care that has been adopted by SAMHSA's Center for Mental Health Services. It provides the Division with information on where more comprehensive services might be needed.





Tables 3.3.a and 3.3.b show a gradual increase between SFY 03-04 and SFY 05-06 in child and adult consumers requiring re-admission to state hospitals within 30-days of discharge and within 180-days of discharge. In addition, the state's rates of readmission are slightly higher than the national average. These trends are of great concern. As part of the crisis planning effort mandated by the General Assembly, in SFY 06-07, the Division will be requiring LMEs to develop strategies, with the assistance of consultants, to reverse these trends.

Domain 4: Consumer-Friendly Outcomes

Consumer Outcomes measure the impact of services on the lives of the individuals who receive care. One of the primary goals of system reform is building a recovery-oriented service system. Recovery for persons with disabilities means having 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 people – 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. The SAMHSA National Outcome Measures and the CMS Quality Framework include measures of consumers' perceptions of service outcomes and measures of functioning in a variety of areas, including:

- Symptom reduction, abstinence, and/or behavioral improvements.
- Housing stability and independence.
- Employment and education.
- Social connectedness.
- Reduction in criminal involvement.

The Division is currently working to ensure that individual progress on these consumer outcomes is considered as a regular part of developing person-centered plans for every consumer. In addition, the Division and local agencies will continue to analyze consumer outcomes data to identify problems areas that require policy development or targeting of additional funds for training and technical assistance in clinical practice and other service system enhancements.

Measure 4.1: Outcomes for Persons with Developmental Disabilities

Community inclusion and meaningful activities are two of the broad national goals emphasized by CMS for persons with developmental disabilities.

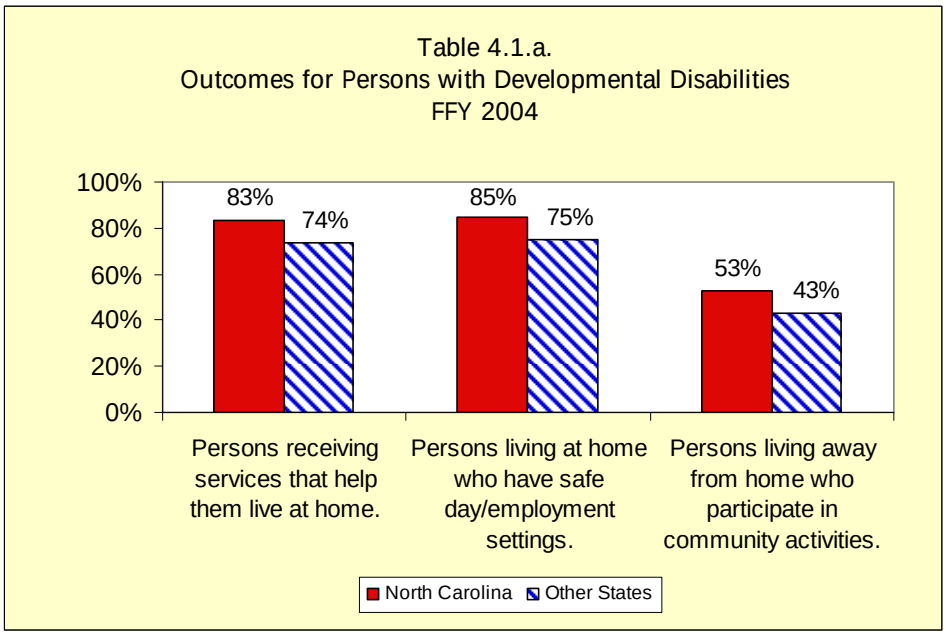


Table 4.1.a. shows that, in the 2004 annual survey (the latest available), more parents and guardians of individuals in North Carolina with developmental disabilities reported progress on these goals than parents and guardians in other states. (See Appendix C for details on this survey.)

- 83% of consumers received supports and services that helped them remain at home compared to 74% in other states.
- 85% of consumers living at home received employment/day activity supports in a safe and healthy environment compared to 75% in other states.
- 53% of consumers living away from home participated in community activities compared to 43% in other states.

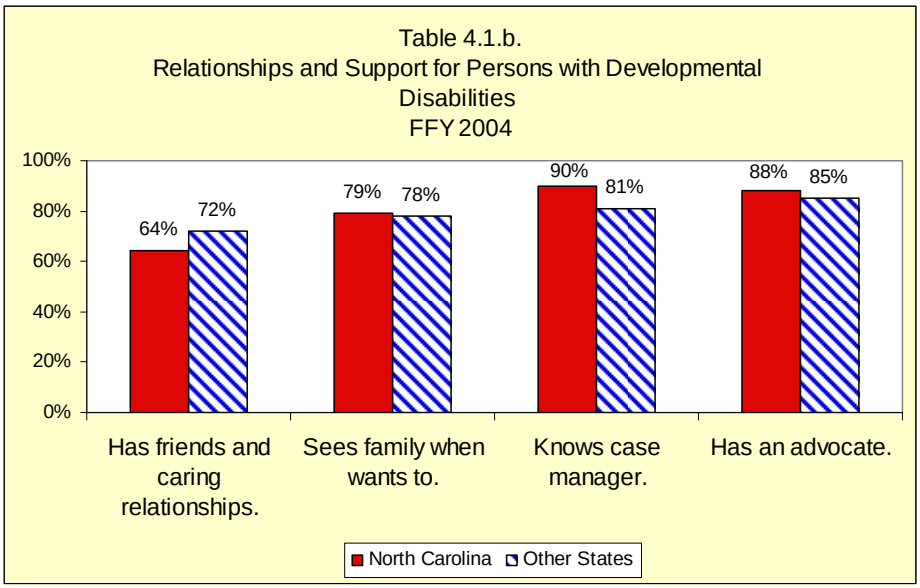


Table 4.1.b shows that North Carolina also compares favorable to other states according to a face-to-face survey of consumers with developmental disabilities. A majority of them report that they have supportive relationships with families and others.

The lower percentages for NC consumers who report having friends (Table 4.1.b) and participating in community activities (Table 4.1.a) indicate the need for increased opportunities for consumers to become involved in community life in more meaningful and regular ways. The Division will work with LMEs, providers, and consumers to develop strategies to increase opportunities for meaningful participation in activities readily available to local citizens.

The Division is also developing outcome measures for consumers with developmental disabilities that will be included in the outcomes system currently used with all mental health and substance abuse consumers. This will allow more comprehensive tracking of life outcome changes for the developmental disability population on an ongoing basis and incorporation of that information into the person-centered planning process.

Measure 4.2: Outcomes for Persons with Mental Health Disabilities

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

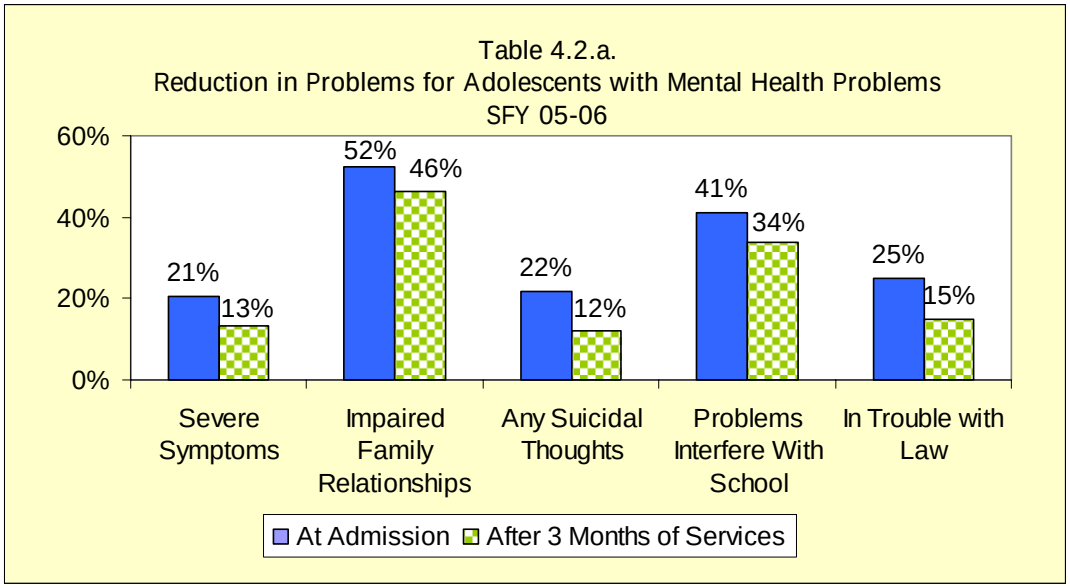


Table 4.2.a. shows improvement in the lives of adolescents with mental health problems who received three months of treatment during SFY 05-06 in the following areas:

- The percent of adolescents with severe or extremely severe symptoms and percent of those with impaired family relationships were reduced somewhat.
- The percent of adolescents with suicidal thoughts was cut almost in half.
- The percent of adolescents whose problems interfered with school or other activities decreased slightly.
- The percent of adolescents in trouble with the law was reduced by one-third.

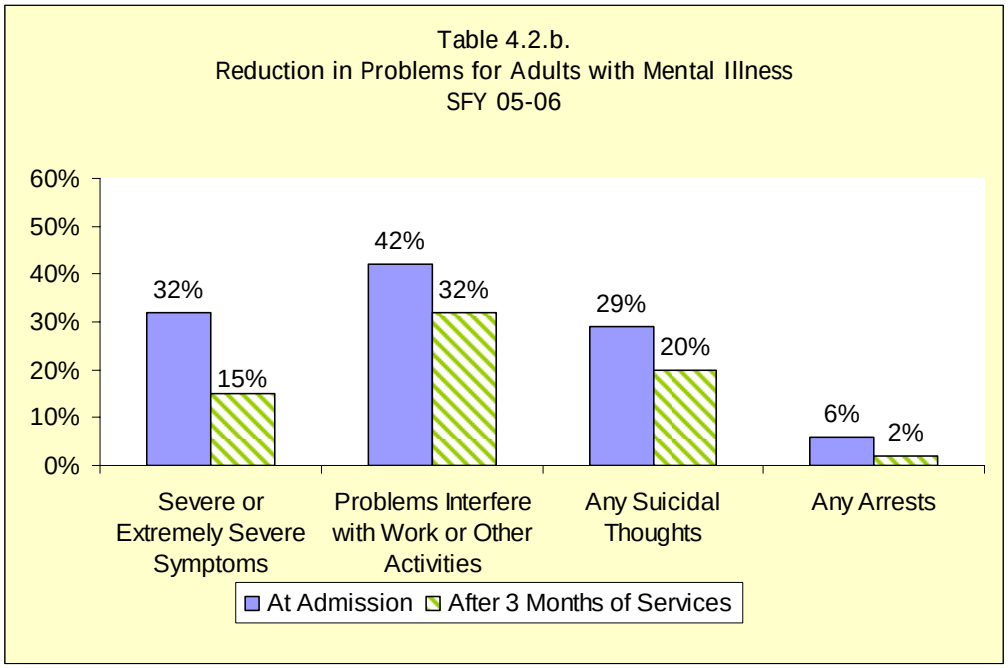


Table 4.2.b. shows the progress of adults with mental illness in reducing symptoms and the problems associated with those symptoms after three only months of treatment.

- The percent of adults who reported severe or extremely severe symptoms was cut in half.
- The percent of adults whose problems interfered with work and other activities decreased by almost one-fourth.
- The percent of adults who reported suicidal thoughts decreased almost one-third.
- The percent of adults arrested decreased by one-third.

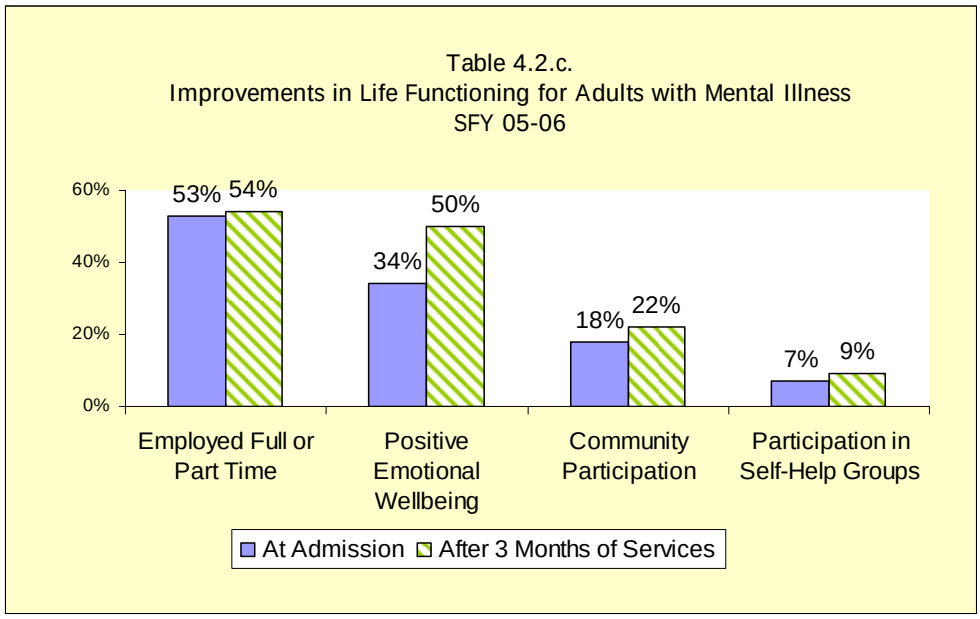


Table 4.2.c. shows that three months of service made a positive difference in the quality of life for adults with mental illness.

- The percent of adults employed full or part-time remained stable.
- The percent of adults reporting positive emotional wellbeing was increased by almost half.
- The percent of adults participating in positive community activities increased by nearly one-fourth.
- The percent of adults participating in self-help or recovery groups increased slightly.

While outcomes for adult mental health consumers are all positive, room for improvement remains, especially in the areas of employment and participation in self-help groups and other community activities. Adults and adolescents who remain engaged in services for more than the three months reported here can be expected to continue improving in all of the areas shown above.

Measure 4.3: Outcomes for Persons with Substance Abuse Disabilities

SAMHSA National Outcome 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 is critical for this population and can have very positive results in a short time, as shown in the data from consumer interviews below. (See Appendix C for details on the NC-TOPPS system used to collect this data.)

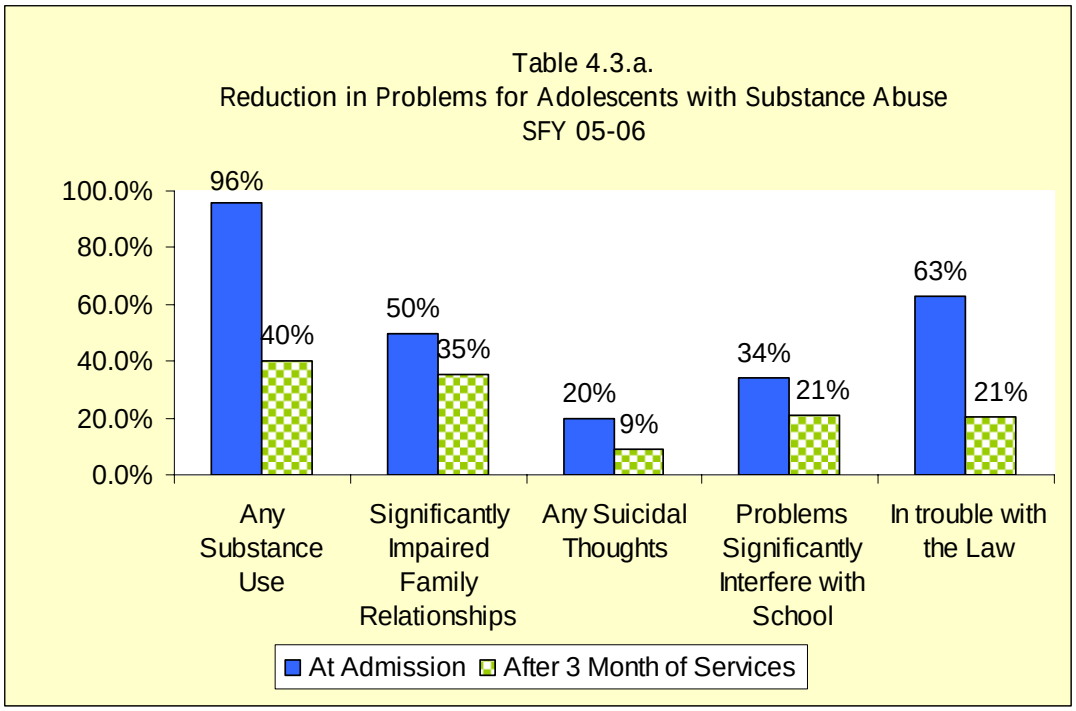


Table 4.3.a. shows that the lives of adolescents with substance abuse problems who received three months of treatment during SFY 05-06 improved meaningfully in a variety of areas.

- The percent of adolescents actively abusing substances and percent of those with suicidal thoughts were cut by well over half.
- The percent of adolescents with impaired family relationships and percent whose problems interfere with school were reduced by about one-third.
- The percent of adolescents in trouble with the law decreased by over two-thirds.

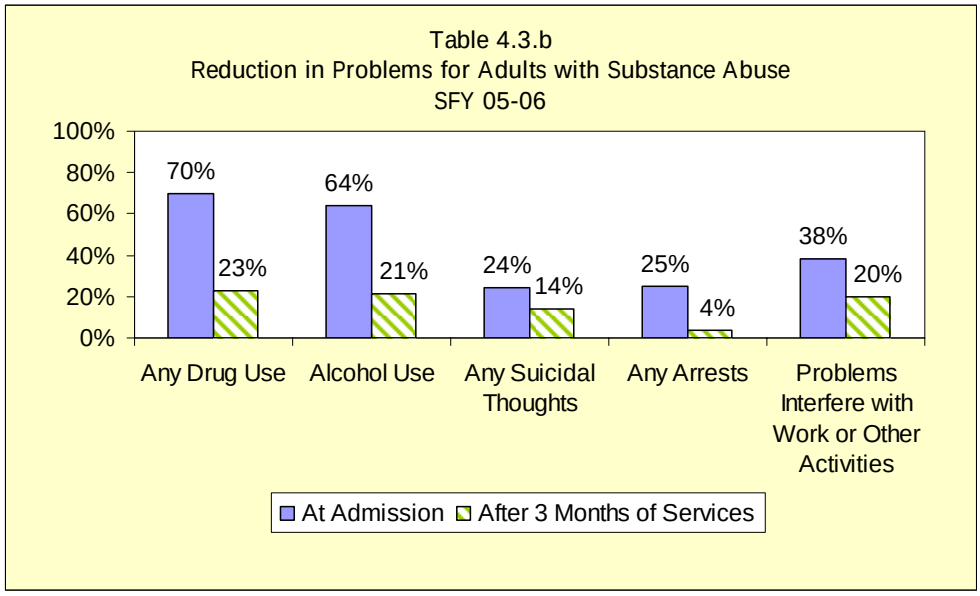


Table 4.3.b. shows the progress of adult substance abuse consumers in reducing substance use and related problems.

- The percent of adults using drugs and the percent of those using alcohol were cut by two-thirds.
- The percent of adults who reported suicidal thoughts decreased by more than one-third.
- The percent of adults arrested decreased by over three-fourths.
- The percent of adults whose problems interfere with work or other activities decreased by almost half.

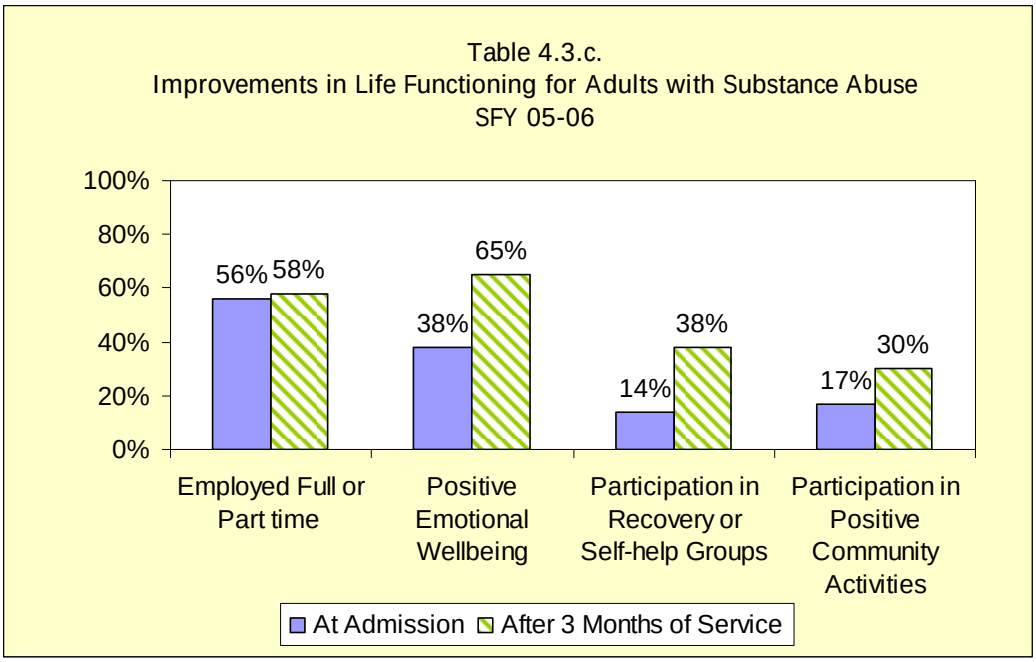


Table 4.3.c. shows that services also had a positive impact on the quality of life of adult substance abuse consumers.

- The percent of adults employed full or part-time increased slightly.
- The percent of adults reporting positive emotional wellbeing increased by almost three-fourths.
- The percent of adults participating in recovery or self-help groups almost tripled.
- The percent of adults participating in positive community activities almost doubled.

As was seen for mental health consumers, helping adult substance abuse consumers maintain and improve their employment situation is an area with room for improvement. The Division expects those who remain engaged in services for more than three months to continue improving in this and other areas of their lives.

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:

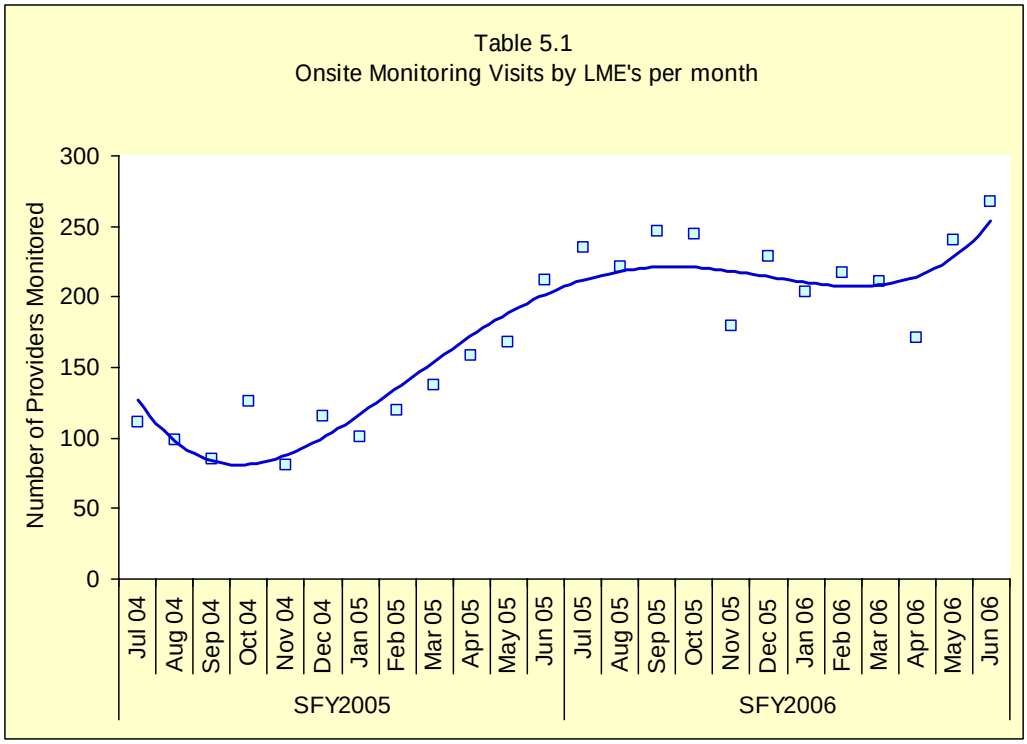
- **Design**, or building into the system the resources and mechanisms to support quality.
- **Discovery**, or adopting technological and other systems to gather information on system performance and effectiveness.
- **Remediation**, or developing procedures to ensure prompt correction of problems and 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 seek and 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: Assurance of Basic Service Quality

A major goal of system reform has been the separation of service provision from service oversight. The LMEs are responsible for monitoring the quality of services provided by private agencies and assisting those agencies to resolve problems quickly and effectively. The Division set a performance requirement in the *DHHS-LME Performance Contract* to promote regular monitoring and resolution of problems in provider agencies.



As Table 5.1 shows, oversight of provider agencies has increased substantially since the inception of the *DHHS-LME Performance Contract*, which requires LMEs to monitor providers in their catchment areas (1,513 monitoring visits in SFY 04-05 compared to 2,663 visits in SFY 05-06). As a result, the number of issues that LMEs have identified as requiring improvement has also increased. In SFY 05-06, three-fourths of LMEs' monitoring visits found issues that

required improvement and 94% of these met the Division's performance standard of being resolved or referred to DHHS for further action within four months.

Measure 5.2: Quality Improvement Efforts

The *DHHS-LME Performance Contract* also requires LMEs to conduct improvement projects to build service capacity and quality. For SFY 05-06, LMEs reported an average of five projects each with some LMEs undertaking as many as twelve. Topics varied according to local issues, with many showing very positive results. The most frequent quality improvement topics were:

Table 5.2

Most Frequent Quality Improvement Initiatives

TOPIC	Number of LMEs
Improving the Screening/Triage/Referral Process	14
Reducing out-of-home placements	13
Increasing provider and consumer satisfaction	11
Improving Continuity of Care	11
Increasing use of Evidence-Based Practices	9

In addition to quality improvement projects, the *DHHS-LME Performance Contract* requires LMEs to analyze patterns in adverse events involving consumers, which are reported through the statewide Incident and Death Reporting System instituted in SFY 02-03, and to undertake efforts to minimize future incidents. While LMEs focused initially on improving provider reporting compliance, local improvement projects have more recently addressed reducing consumer incidents, many with positive and even unexpected results. For instance, New River LME found that their rate of consumer injuries due to trips and falls was higher than the state average, according to the quarterly *Critical Incident Report* published by the Division. In response, the LME developed an exercise program and a checklist to measure changes in the occurrence of these injuries. As hoped, the project resulted in a reduction in falls. In addition, consumers' moods and morale improved, and they needed fewer medications for pain. This is the kind of quality improvement project that has a direct positive impact on consumers' safety and well-being.

The Division continues to encourage LME improvement efforts through public reporting of local trends and projects to reduce adverse events. Future reports will include performance measures related to trends in consumer incidents and complaints and efforts to address them.

Domain 6: System Efficiency and Effectiveness

This domain 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 careful information management.

The *DHHS-LME Performance Contract* serves as the Division's vehicle for evaluating LME efficiency and effectiveness. The scope of work of the contract is each LME's Local Business Plan (LBP), which lays out the requirements and local plan for fulfilling each function. In addition, the contract contains thirty statewide performance measures that the Division tracks and reports on its website quarterly. The Division is currently developing new Local Business Plan (LBP) guidelines and processes for evaluating LME performance of their functions. The current *DHHS-LME Performance Contract* requirements and measures will be revised for SFY 07-08 to reflect these changes, and results will be incorporated into future reports.

Measure 6.1: Business and 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 current *DHHS-LME Performance Contract* includes a number of requirements for timely and accurate submission of financial and consumer information. Together the measures for these requirements provide an indication of local systems' capacity for efficient and effective system management.

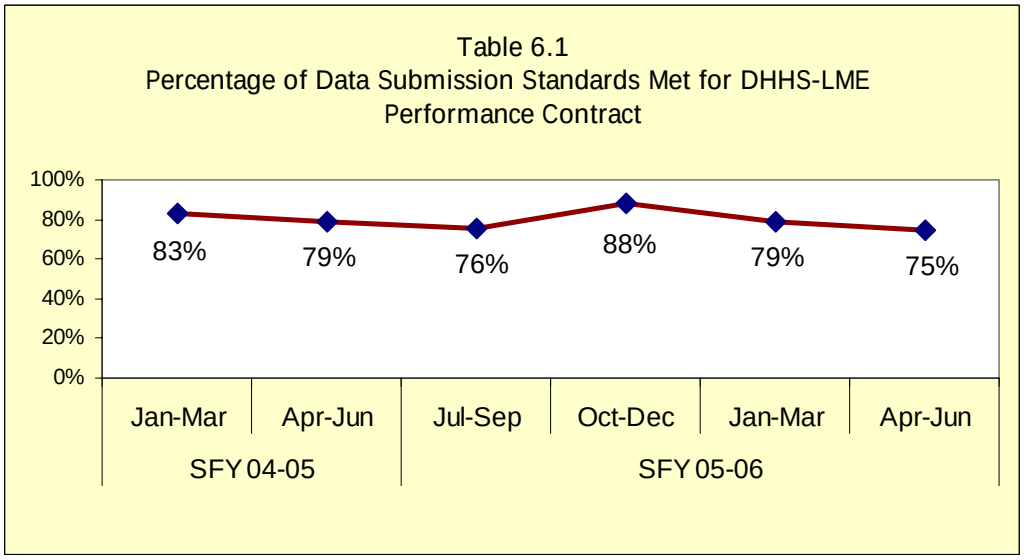


Table 6.1 shows that over the past eighteen months, LMEs have met or exceeded the *DHHS-LME Performance Contract* standard for over three-quarters of the requirements regarding submission of consumer demographic, outcome, satisfaction, and service utilization data. The current standards are based on expectations for timeliness, accuracy and completeness of the data submitted.

The Division has worked diligently in the past few years to ensure compliance with requirements for submitting consumer demographic and disability data to the Client Data Warehouse (CDW), the Division's primary data system. That effort has resulted in nearly all LMEs meeting the compliance standard on a regular basis. The Division is currently working to achieve similar compliance rates on data submission requirements begun in July 2005 for consumer outcomes data in the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS). In the first year of this initiative, compliance rates reached 55% statewide for providers' submission of initial NC-TOPPS data and 67% for follow-up data. The Division has implemented tracking and feedback systems to help LMEs work with providers to continue improving these rates in the future. By the April report, the Division expects compliance to have increased substantially as a result of current efforts.

Measure 6.2: Review of Persons Served in Cost-Bands

The Division is developing a measure to profile expenditure of public funds by age/disability groups in order to analyze the efficient and effective use of funds. This is a SAMHSA National Outcome Measure that will provide regular tracking of high-cost and low-cost service usage. Analysis of consumer groups who are receiving either excessive or insufficient amounts of service across the state will allow the Division to identify areas for improvement in service management, so that policies, technical assistance, and resources can be directed appropriately and effectively. The Division is currently designing the model for this analysis and will report the data in subsequent reports.

Domain 7: Prevention and Early Intervention

This domain refers to activities designed to minimize the occurrence of mental illness, developmental disabilities, and substance abuse whenever possible and to minimize the negative impact on persons' lives when a disability cannot be prevented. It includes efforts to educate the general public and persons at-risk about the nature of disabilities and how to prevent, recognize and address them appropriately.

Measure 7.1: Education for Youth At-Risk for Substance Abuse

Preventing problems from a disability is much more effective – both clinically and financially – than treating a disability that has already caused major impairments in an individual's or family's life. The SAMHSA National Outcome Measures emphasize the use of evidence-based programs to educate the public, parents, and especially at-risk youth on the problems associated with substance abuse and how to prevent such abuse.

- In SFY 05-06, twenty different evidence-based programs and strategies were used to increase awareness and change attitudes and behavior. Approximately 11,500 people across twenty-five LMEs were served through these programs.
- In SFY 04-05, over 2,600 young adults who were convicted of first-time drug offenses attended Drug Education Schools. Through these classes they received fifteen hours of instruction to help them monitor and modify their own behavior to prevent future drug use and its consequences. Ninety percent of those students passed the class and over 80% then became eligible to have their legal charges expunged.

The Division is committed to continuing to increase the number of people who are served through these important prevention programs.

Measure 7.2: Public Awareness Programs

LMEs are responsible for reaching out to the people in their communities to educate them about disabilities. Such efforts do more than help to identify persons at-risk for problems and those in need of services. Public education efforts also help the community at large to become more accepting of persons with disabilities who live in their neighborhoods. Reducing the stigma associated with disabilities from mental illness, developmental delays, and substance abuse is an

integral component of fostering recovery for mental health, developmental disabilities, and substance abuse consumers and a supportive community-based service system.

In 2003, the Division and North Carolina Department of Public Instruction, along with seven other pilot states, began a SAMHSA-sponsored initiative in eight high schools and six LMEs across the state to inform the public about the realities of mental illness and to educate teachers and school staff on how to identify and work with students with behavioral health problems. Through this initiative, the Division distributed 75 public service announcement kits in English and Spanish and made over 20 presentations to local groups on reducing the stigma associated with mental illness. As a result, the Division received a 2005 Voice Award from SAMHSA for outstanding efforts in this initiative. Although this initiative has ended, the Division will continue efforts to reduce stigma by distributing resource kits to additional state and local agencies on how to implement similar programs and by participating in the new national Anti-Stigma Campaign that was developed as a successor to the initial project.

The Division is seeking help from a consultant on other ways to measure progress on this important front. Once appropriate measures are developed, they will be included in future reports.

Conclusion

This report represents the first comprehensive assessment of the performance of the public mental health, developmental disabilities and substance abuse service system since the initiation of system transformation efforts. The Division will continue to strengthen the measurement strategies and mechanisms needed to track the progress and performance of the system. In addition, the Division will be working to find timely and user-friendly ways to communicate changes that are occurring, in addition to producing this report each fall and spring. One such effort initiated in July 2006 is the Division's "Quality Quick Facts" series. These simple graphs are posted on the homepage of the Division's website (http://www.ncdhhs.gov/mhddsas/) and give information on the public mental health, developmental disabilities and substance abuse services system each month.

The North Carolina mental health, developmental disabilities and substance abuse services system has changed in fundamental and significant ways over the past five years. The extensive nature of these changes has created periods of uncertainty and some unexpected problems have arisen. In the midst of attending to the consequences of a massive system transformation, many of the intended goals of reform have quietly moved forward. In addition, the day-to-day activities that were in place prior to reform efforts and that underpin any mental health, developmental disabilities and substance abuse services system have continued steadily despite the fluid environment around them. The Division will continue to work with consumers and families, providers, LMEs and other stakeholders to reach the lofty, and laudable, goals of the transformation effort.

Appendix A: SAMHSA National Outcome Measures

Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs)

DOMAIN	OUTCOME	MEASURES		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ▶	30-day substance use (non-use/reduction in use) ▶ Perceived risk/ harm of use ▶ Age of first use ▶ Perception of disapproval/attitude
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/ Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ▶	Increase in/no change in number of employed or in school at date of last service compared to first service ▶	Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ▶	Alcohol-related car crashes and injuries; alcohol and drug-related crime
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ▶	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ▶	NOT APPLICABLE
Social Connectedness	Increased Social Supports/Social Connectedness[1]	Under Development	Under Development	Family communication around drug use
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ▶	Unduplicated count of persons served; penetration rate-numbers served compared to those in need ▶	Number of persons served by age, gender, race and ethnicity
Retention	Increased Retention in Treatment - Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ▶ Unduplicated count of persons served ▶	Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message
	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ▶	NOT APPLICABLE	NOT APPLICABLE
Perception of Care	Client Perception of Care[2]	Clients reporting positively about outcomes ▶	Under Development	NOT APPLICABLE
Cost Effectiveness	Cost Effectiveness (Average Cost)[2]	Number of persons receiving evidence-based services/number of evidence-based practices provided by the State	Number of States providing substance abuse treatment services within approved cost per person bands by the type of treatment	Services provided within cost bands
Use of Evidence-Based Practices	Use of Evidence-Based Practices[2]		Under Development	Total number of evidence-based programs and strategies

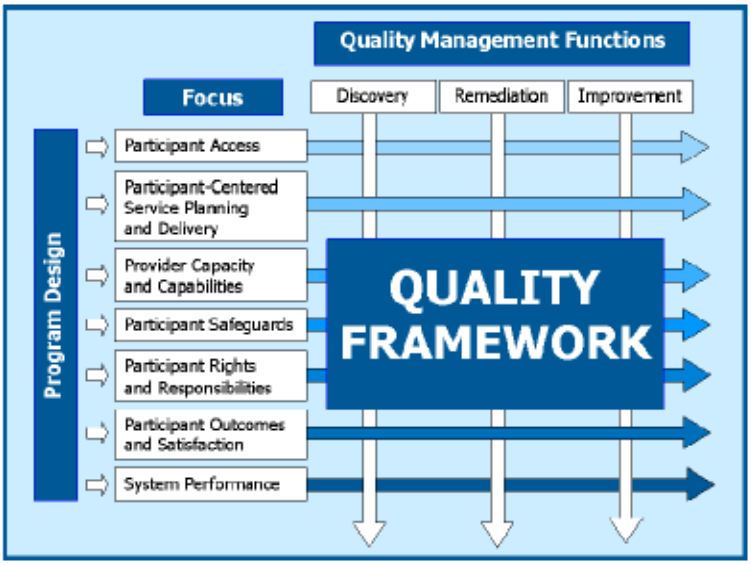
[1] For ATR, "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.
[2] Required by 2003 OMB PART Review.

Appendix B: CMS Quality Framework

HCBS QUALITY FRAMEWORK

The Home and Community-Based Services (HCBS) Quality Framework provides a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of community services and supports for older persons and individuals with disabilities. The Framework focuses attention on participant-centered **desired outcomes** along seven dimensions.

Program design sets the stage for achieving these desired outcomes. Program design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring participant health and welfare, and critical safeguards (e.g., incident reporting and management systems).



Quality management encompasses three functions:

- **Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
- **Remediation:** Taking action to remedy specific problems or concerns that arise.
- **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

Focus	Desired Outcome
Participant Access	*Individuals have access to home and community-based services and supports in their communities.*
Participant-Centered Service Planning and Delivery	*Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community*
Provider Capacity and Capabilities	*There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
Participant Safeguards	*Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
Participant Rights and Responsibilities	*Participants receive support to exercise their rights and in accepting personal responsibilities.*
Participant Outcomes and Satisfaction	*Participants are satisfied with their services and achieve desired outcomes.*
System Performance	*The system supports participants efficiently and effectively and constantly strives to improve quality.*

Quality management gauges the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Program design features and quality management strategies will vary from program to program, depending on the nature of the program's target population, the program's size and the services that it offers, its relationship to other public programs, and additional factors.

The Framework was developed in partnership with the National Associations of State Directors of Developmental Disabilities Services, State Units on Aging, and State Medicaid Directors.

CMS CENTERS for MEDICARE & MEDICAID SERVICES · NASDDDS National Association of State Directors of Developmental Disabilities Services · NASUA · APHSA American Public Human Services Association

Appendix C: Description of Data Sources

Domain 1: Access To Services

Estimates Of Mental Health, Developmental Disabilities And Substance Abuse Problems: The estimates of the occurrence of disabilities among North Carolinians come from the following sources:

- Mental illness – SAMHSA Center for Mental Health Services' annual estimates
- Substance abuse –SAMHSA's National Survey of Drug Use and Health
- Developmental Disabilities – U.S. Public Health Service (National Health Interview Disability Supplement, Phase I)

Tables 1.1.a. – 1.1.b. 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 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 Seven Days of Request: This information comes from LME reports to the Division that are included in the quarterly *DHHS-LME Performance Contract Reports* . The Division verifies the accuracy of the information annually. More information on the *Performance Contract*, including the quarterly reports, can be found on the web at:

http://www.ncdhhs.gov/mhddsas/performanceagreement/.

In January 2006, LMEs began submitting data on individuals who request services to the Division as part of their CDW data. Future information on timeliness of services will be reported from this system.

Domain 2: Individualized Planning and Supports

Enrolled Qualified Providers: The Division of Medical Assistance (DMA) maintains the data on agencies qualified and enrolled to provide enhanced services. The Division and DMA have worked closely to ensure that provider endorsement and enrollment information is up-to-date and shared on a regular schedule.

Tables 2.1.a. and 2.2.a. Perceptions Of Persons With Developmental Disabilities: The National Core Indicators Project (NCIP) provides data on the perceptions of individuals with developmental disabilities and their parents and guardians. Approximately 400 in-person interviews with consumers are conducted each year. In addition, over 2,000 mail surveys are sent out each year to parents and guardians of individuals receiving developmental disability services and supports. 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 sixteen other participating states, can be found at: http://www.hsri.org/nci/index.asp?id=reports.

Tables 2.1.b. and 2.2.b. Perceptions Of Adults And Parents Of Children With Mental Health And Substance Abuse Disabilities: The SAMHSA-sponsored Mental Health Statistical Improvement Project's Consumer Survey (MHSIP-CS) provides this data. Each LME surveys five percent of its active consumers each year. This anonymous 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.ncdhhs.gov/mhddsas/manuals/.

Domain 3: Promotion of Best Practices

Table 3.1. Providers Of Evidence-Based Practices: For information on providers qualified to provide evidence-based practices, see Domain 2 above.

Tables 3.2.a – 3.3.b. Individuals' Use Of State-Operated Facilities: The Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) provides this data. It includes demographic, diagnostic, length of stay and treatment information on all consumers who are served in State-operated facilities.

Domain 4: Consumer Outcomes

Tables 4.1.a – 4.1.b. Service Outcomes For Persons With Developmental Disabilities: This information comes from the National Core Indicators Project (NCIP), described in Domain 2 above. Through this project, the Division collects information concerning adults with developmental disabilities. Similar information on children with developmental disabilities is not yet gathered. In SFY 06-07 the Division is developing measures to allow inclusion of consumers with developmental disabilities in the NC-TOPPS system described below.

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 mental health and substance abuse services. More information on NC-TOPPS, including annual reports on each age-disability group, can be found at http://nctopps.ncdmh.net/.

Domain 5: Quality Management

Tables 5.1.– 5.2. LME Provider Monitoring And Quality Improvement Initiatives: This information comes from LME reports to the Division that are included in the quarterly *DHHS-LME Performance Contract Reports*, which the Division verifies annually. More information on the Contract can be found under Domain 1 above.

The information on LMEs' improvement activities regarding critical incidents comes from quarterly reports submitted to the Division by LMEs. Information from these reports is compiled and published as *Quarterly Critical Incident Reports* on the Division website at: http://www.ncdhhs.gov/mhddsas/manuals/.

Domain 6: Efficiency and Effectiveness

Table 6.1. Business And Information Management: The *DHHS-LME Performance Contract* includes measures on LME submission of consumer data to the CDW, NC-TOPPS, NCIP and MHSIP-CS and submission of reports detailing use of state and federal funds, which are reported in Table 6.1. The Division is currently revising the existing performance measures and expectations for SFY 07-08 implementation. More information on the *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. Tracking Individuals Trained And Served: Information on each of the programs included in this section is summarized in an annual or semi-annual report that is submitted by the LMEs to the Division on the use of state and federal funds. More information can be found on the Division website: http://www.ncdhhs.gov/mhddsas/.

Table 7.2. Public Awareness Programs: Information on the Eliminating Barriers Initiative (EBI) and Anti-Stigma Campaign comes from the final report for the EBI federal initiative. This report can be found on the Division website: http://www.ncdhhs.gov/mhddsas/.