NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Third Quarter SFY 2008-2009

January 1 – March 31, 2009

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"You don't just wander in the wilderness, you set specific goals and specific benchmarks, and then you measure your success on achieving those goals and benchmarks."

-- DHHS Secretary Lanier Cansler, February10, 2009.

Highlights of Third Quarter SFY 2008-2009

Timely Access to Care

- According to data reported to the Division from the Local Management Entities (LMEs), almost all of the individuals (99%) determined to need emergent care were provided a face-to-face service (assessment and/or treatment) within two hours from the time of the request. Another one percent had a provider on-site within two hours ready to give care when the individual was available. This represents an improvement over the prior quarter, but fell short of the SFY 2009 target of 100%.
- LMEs reported that 82% of individuals determined to need urgent care were provided a face-to-face service within 48 hours from the time of the request (an improvement over the prior quarter, but failed to meet the SFY 2009 target of 88%).
- Almost three-quarters Two-thirds (72%) of individuals determined to need routine care were provided a face-to-face service within 14 calendar days from the time of the request (an improvement over the prior quarter, but failed to meet the SFY 2009 target of 88%).

Services to Persons in Need

- The percentage of persons estimated to be in need of mental health services that were provided services in their communities paid with federal or state funds **exceeded the SFY 2009 target for adults** (43% served compared to the target of 40%) and **exceeded the target set for children** with 48% served compared to the target of 40%.
- The percentage of persons estimated to be in need of developmental disability services that were provided services in their communities paid with federal or state funds **met the SFY 2009 target for adults** (38% served compared to the target of 38%) and **exceeded the target set for children** (21% served compared to the target of 20%).
- The percentage of persons estimated to be in need of substance abuse services that were provided services in their communities paid with federal or state funds have not yet reached the higher SFY2009 targets of 10% for adults and 9% for children. This quarter the number of consumers receiving substance abuse services continued to increase, but the percentages remained the same as last quarter at 8% for adults and 7% for children.

Timely Initiation and Engagement in Service

- Statewide, the SFY 2009 target for initiation into care of consumers receiving mental health services was not met this quarter with 41% of consumers receiving a 2nd visit within 14 days of the first visit compared to the target of 42%. The SFY 2009 target for engagement of these consumers was not met this quarter with only 27% of consumers receiving 2 additional visits within 30 days after meeting the initiation measure, compared to the target of 30%. This represents no change from last quarter for both measures.
- Statewide, the SFY 2009 target for initiation into care of consumers of developmental disability services was not met this quarter with 64% of consumers receiving a 2nd visit within 14 days of the first visit compared to the target of 72%. Similarly, 51% of consumers of developmental disability services had 4 visits within 45 days of beginning care compared to the SFY 2009 target for engagement of 61%. This represents a decrease over the prior quarter's 70% for initiation and 59% for engagement.

- The SFY 2009 target for initiation into care of consumers of substance abuse services was not met this quarter. Almost two-thirds (62%) of these consumers received 2 visits within the first 14 days of care compared to the target of 71%. Almost half (46%) of consumers of substance abuse services received 4 visits within 45 days of care, which did not meet the SFY 2009 target of 56% for engagement in care. The percentages for both measures remained the same as the prior two quarters.

Effective Use of State Psychiatric Hospitals

- Consumers receiving short term care (7 days or less) in state psychiatric hospitals did not meet the SFY 2009 target this quarter -- 46% of consumers had stays of 7 days or less compared to the SFY 2009 target of 44% or fewer consumers admitted to state psychiatric hospitals with stays of 7 days or less. This represents no change from last quarter.

State Psychiatric Hospital Readmissions

- Across the state, fewer than 9% of consumers discharged from a state psychiatric hospital were readmitted within 1 to 30 days. This is **better than the SFY 2009 target** of 11% or less. Within 1 to 180 days, 20% of consumers were readmitted, which is **better than the SFY2009 target** of 23% or less. Both readmission rates this quarter represent further improvement over the prior quarter.

Timely Follow-Up after Inpatient Care

- The SFY 2009 targets for follow-up care for consumers discharged from ADATCs and state psychiatric hospitals were significantly increased to 70% of consumers seen within 1 to 7 days following discharge. This increase reflects the great importance and high priority given to the achievement of this measure this year. Statewide, 28% of consumers discharged from ADATCs and 42% of consumers discharged from state psychiatric hospitals were seen within 1 to 7 days following discharge this quarter. These numbers represent a two percent increase over last quarter's 26% seen within 7 days of discharge from an ADATC and a seven percent increase over last quarter's 35% seen within 7 days of discharge from a state psychiatric hospital.

Child Services in Non-Family Settings

- Like previous reports, only four percent of children and adolescents receiving mental health and/or substance abuse services were served in non-family settings (Level 2 Program, Level 3, or Level 4 residential treatment) this quarter, which is **better than the SFY09 target** of five percent or less.

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Introduction

This is the third year in which the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) has been tracking the effectiveness of community systems through statewide performance indicators.[1] These indicators provide a means for the public and General Assembly to hold DMH/DD/SAS, the Local Management Entities (LMEs), and provider agencies accountable for progress toward the goals of the Mental Health System Reform. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities.

Each topic covered by these indicators involves substantial "behind-the-scenes" activity by service providers, LME and state staff, consumers, and family members. These indicators do not purport to cover all of those efforts. Instead, they address the desired results of those activities as a way to guide decisions about more detailed analysis by system stakeholders into issues that affect progress toward the goals of MH/DD/SAS system transformation. The indicators were chosen to reflect:

- accepted standards of care,
- fair and reliable measures, and
- readily available data sources.

The following pages present graphs showing the progress of each LME on the selected indicators for the most recent time period available.[2] The source information below each graph provides details on the data systems and time periods used.

Each indicator includes a statewide target to be achieved by the end of the fiscal year. These targets are indicated by a red line across the graphs on the following pages. The Division has set higher targets for areas of greatest concern, notably seeking the greatest improvements in substance abuse services and in decreased use of state psychiatric hospitals.

Appendices for MH/DD/SAS Community Systems Progress Report, a separate document, contains the formulas for calculating the indicators and tables showing the data for each LME on all indicators. *Critical Measures at a Glance*, a new one-page summary of the report, as well as the full report and appendices, are available on the Division website at:

http://www.ncdhhs.gov/mhddsas/statspublications/reports

The indicators and targets in this report mirror requirements of the SFY 2008-2009 *DHHS-LME Performance Contract*. Performance standards required by the Contract are noted at the bottom of each graph. However, the emphasis of the *Community Systems Progress Reports* remains on highlighting gains made toward desired results rather than compliance with basic requirements. For this reason, a text box below each graph highlights the number of LMEs that achieved the fiscal year target during the reporting period.

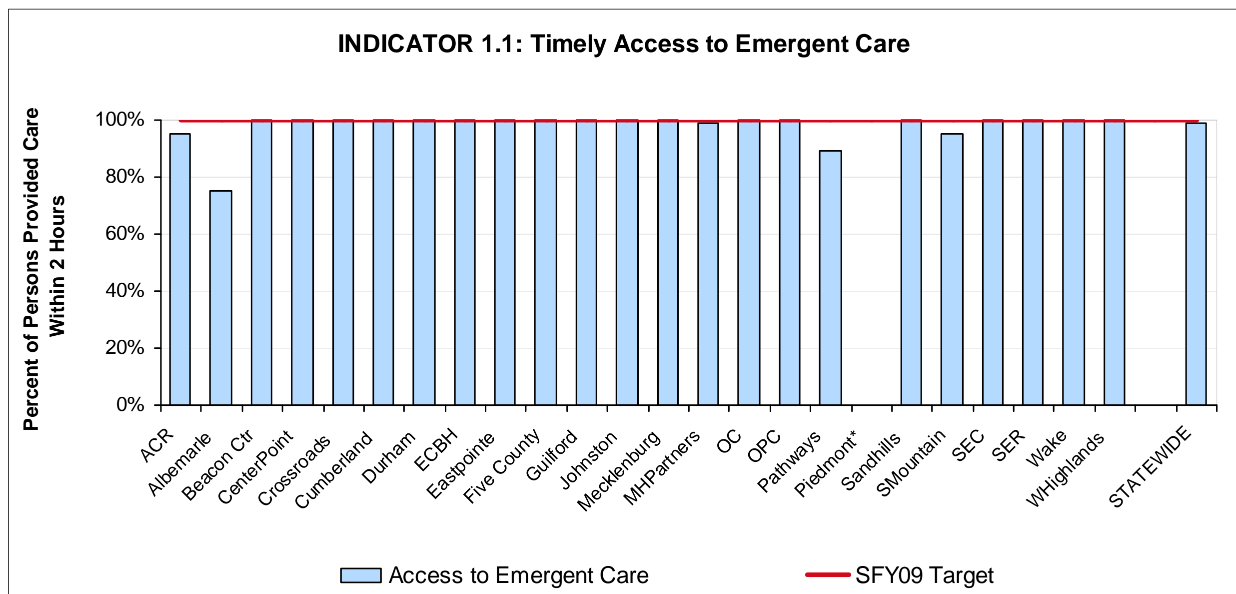
[1] This report fulfills the requirements of S.L. 2006-142 (HB 2077) that directs the Department of Health and Human Services to develop critical indicators of LME performance. Measures reflect the goals of the NC State Plans 2007-2010, the President's New Freedom Initiative, CMS' Quality Framework for Home and Community Based Services, and SAMHSA's Federal Action Agenda and National Outcome Measures.

[2] Measures relying on service claims data are delayed by 90 to 180 days to allow time for claims to be processed. Data on service claims for Piedmont LME, which is operating under a Medicaid waiver, were not available.

Indicator 1: Timely Access to Care

1.1 Emergent 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. The timely access measures are based on Healthcare Enterprise Data Information System (HEDIS ©) measures, supported by the federal Centers for Medicaid and Medicare.



SOURCE: LME data reported to DMH/DD/SAS, January 1 - March 31, 2009; N=8,277 persons in need

Statewide, according to LME self-report data, almost 100% of persons determined to need emergent care had a provider on-site within two hours of the time of the request, ready to give care once the individual was available. 99% of persons determined to need emergent care were provided federal or state funded services through our community service system within that time frame (see Appendix for details).

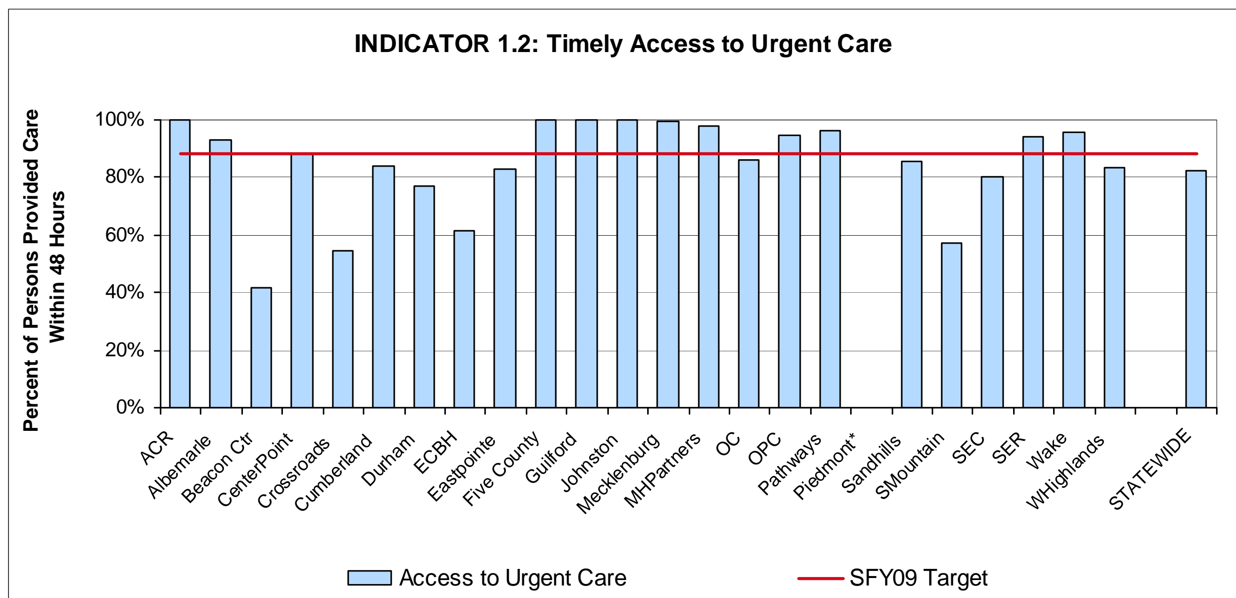
The established SFY 2009 target for access to emergent care is 100%, as indicated by the red line in the graph above[3]. Of the 23 LMEs reporting, almost four-fifths (18 LMEs) met the target.

[3] The SFY 2009 DHHS-LME Performance Contract requirement is 100%.

Indicator 1: Timely Access to Care

1.2 Urgent 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. The timely access measures are based on Healthcare Enterprise Data Information System (HEDIS ©) measures, supported by the federal Centers for Medicaid and Medicare.



SOURCE: LME data reported to DMH/DD/SAS, January 1 - March 31, 2009; N=7,870 persons in need

Statewide, according to LME self-report data, 82% of persons determined to need urgent care were provided federal or state funded services through our community service system within 48 hours from the time of the request (an improvement over the prior quarter). The rate of persons who were served within the 48-hour period varied among LMEs from a low of 42% (Beacon Center) to a high of 100% (Alamance-Caswell-Rockingham, Five County, Guilford, Johnston, and Mecklenburg).

The established SFY 2009 target for access to urgent care is 88%, as indicated by the red line in the graph above[4]. Of the 23 LMEs reporting, slightly more than half (12 LMEs) met or exceeded the target.

[4] The SFY 2009 DHHS-LME Performance Contract requirement is 80% or above.

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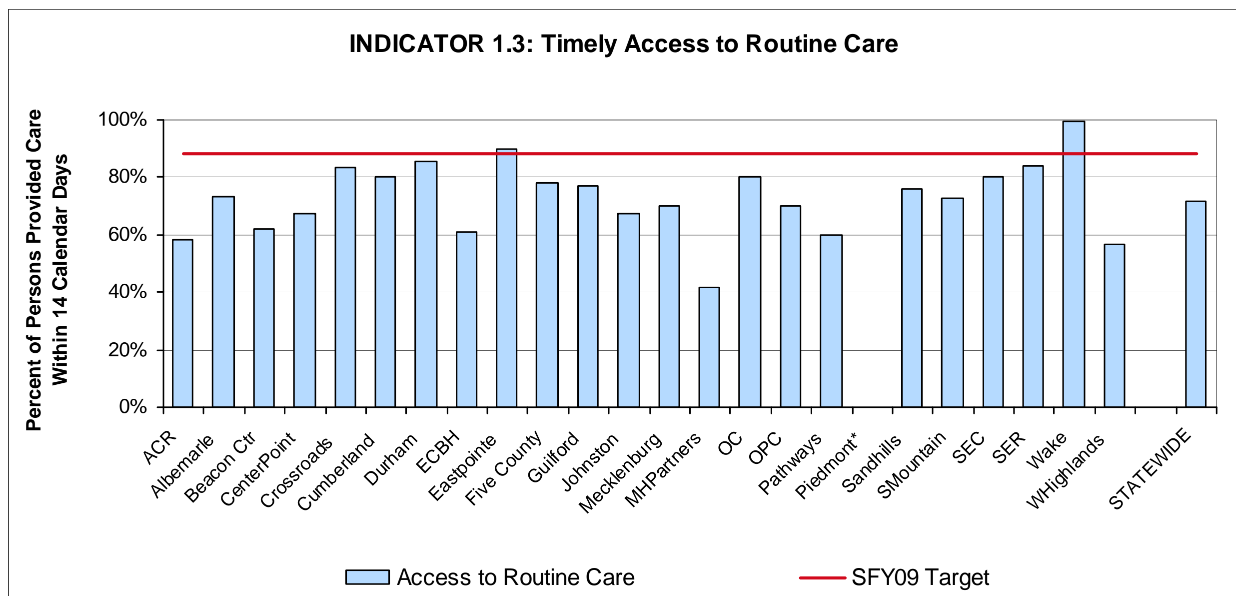
Indicator 1: Timely Access to Care

1.3 Routine 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. The timely access measures are based on Healthcare Enterprise Data Information System (HEDIS ©) measures, supported by the federal Centers for Medicaid and Medicare.



SOURCE: LME data reported to DMH/DD/SAS, January 1 - March 31, 2009; N=27,429 persons in need

Almost three-quarters (72%) of persons determined to need routine care were provided federal or state funded services through our community service system within 14 calendar days from the time of the request (an improvement over the prior quarter). The rate of persons who were served within the 14-day period varied among LMEs from a low of 42% (Mental Health Partners) to a high of 100% (Wake).

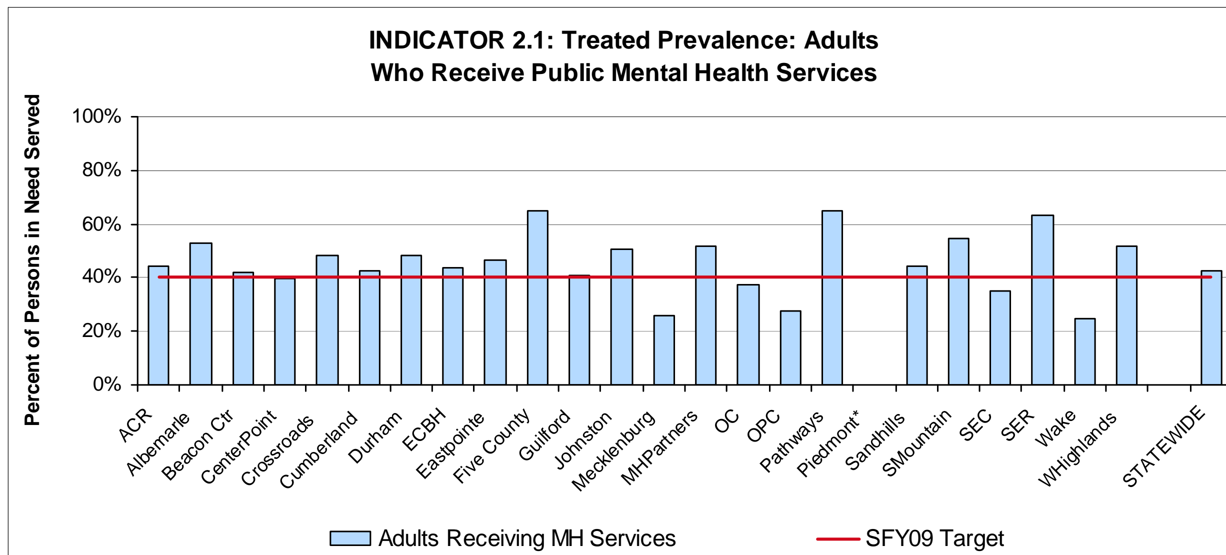
The established SFY 2009 target for access to routine care is 88%, as indicated by the red line in the graph above[5]. Of the 23 LMEs reporting, only two LMEs met or exceeded the target.

[5] The SFY 2009 DHHS-LME Performance Contract requirement is 80% or above.

Indicator 2: Services to Persons in Need

2.1 Adult Mental Health Services

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



SOURCE: Medicaid and State Service Claims Data, January 1, 2008 to December 31, 2008; N=349,824 adults in need

Statewide, 149,747 adults (43% of those in need of services[6]) received federal or state funded MH services through our community service system from January 2008 through December 2008.[7] This is an improvement over the prior quarter. The rate of adults who were served varied among LMEs from a low of 25% (Wake) to a high of 65% (Five County, Pathways).

The established SFY 2009 target for persons receiving adult mental health services is 40% or higher, as indicated by the red line in the graph above[8]. Of the 23 LMEs with service claims data, almost four-fifths of the LMEs (18 LMEs) met or exceeded the target.

[6] URS Table 1: Number of Persons with Serious Mental Illness [*sic*], age 18 and older, by State, 2007, Civilian Population with SMI (5.4%). Prepared by NRI/SDICC for CMHS: June 14, 2008. Estimates applied to county population as of July 2008.

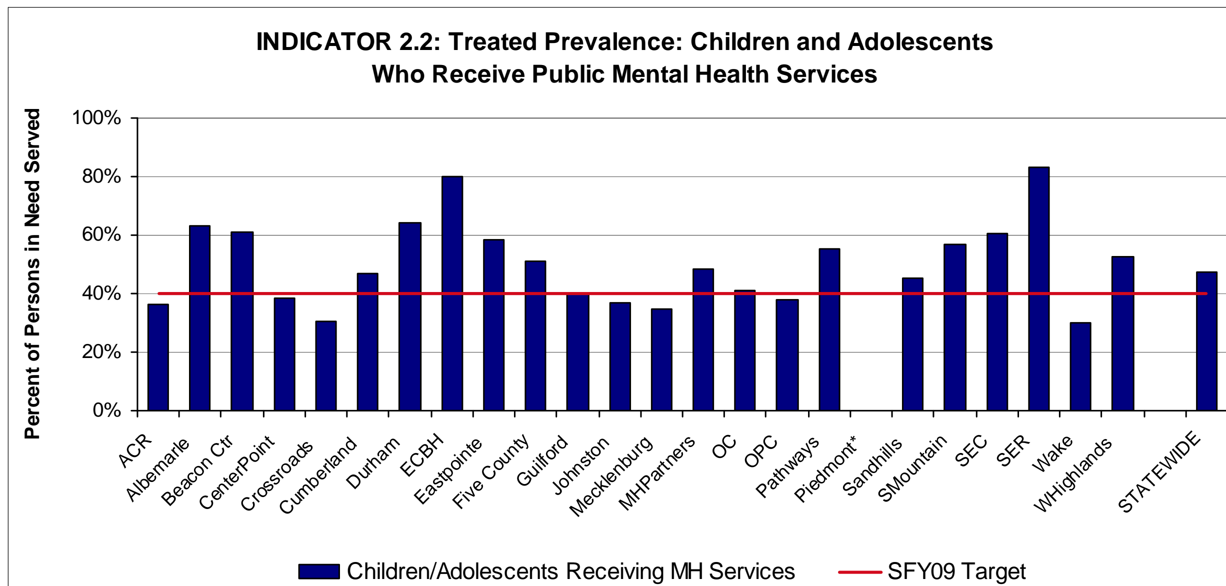
[7] The numbers served reflect adults, ages 18 and over, who received any MH services (including assessments) in the community system, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, Tri-Care, county funds, other federal, state, and local agencies, private insurance, and private funds. Therefore 100% of the population is not expected to be served by the public community system.

[8] The SFY 2009 DHHS-LME Performance Contract requirement is 38% or above.

Indicator 2: Services to Persons in Need

2.2 Child and Adolescent Mental Health Services

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



SOURCE: Medicaid and State Service Claims Data, January 1, 2008 to December 31, 2008; N=204,432 children and adolescents in need

Statewide, 97,294 children and adolescents (48% of those in need of services[9]) received federal or state funded MH services through our community service system from January 2008 through December 2008.[10] This is an improvement over the prior quarter. The rate of those served varied from a low of 30% (Wake) to a high of 83% (Southeastern Regional).

The established SFY 2009 target for persons receiving child mental health services is 40%, as indicated by the red line in the graph above[11]. Of the 23 LMEs with service claims data, seven-tenths (16 LMEs) met or exceeded the target.

[9] URS Table 1: Number of Children with Serious Emotional Disturbances [*sic*], age 9 to 17, by State, 2007, Level of functioning score=60, midpoint of range between lower and upper limits of estimates (12%). Prepared by NRI/SDICC for CMHS: June 14, 2008. The Division applies the estimates established by CMHS for children ages 9-17 to those under the age of 9, since no established estimates exist for younger children. Estimates applied to county population as of July 2008.

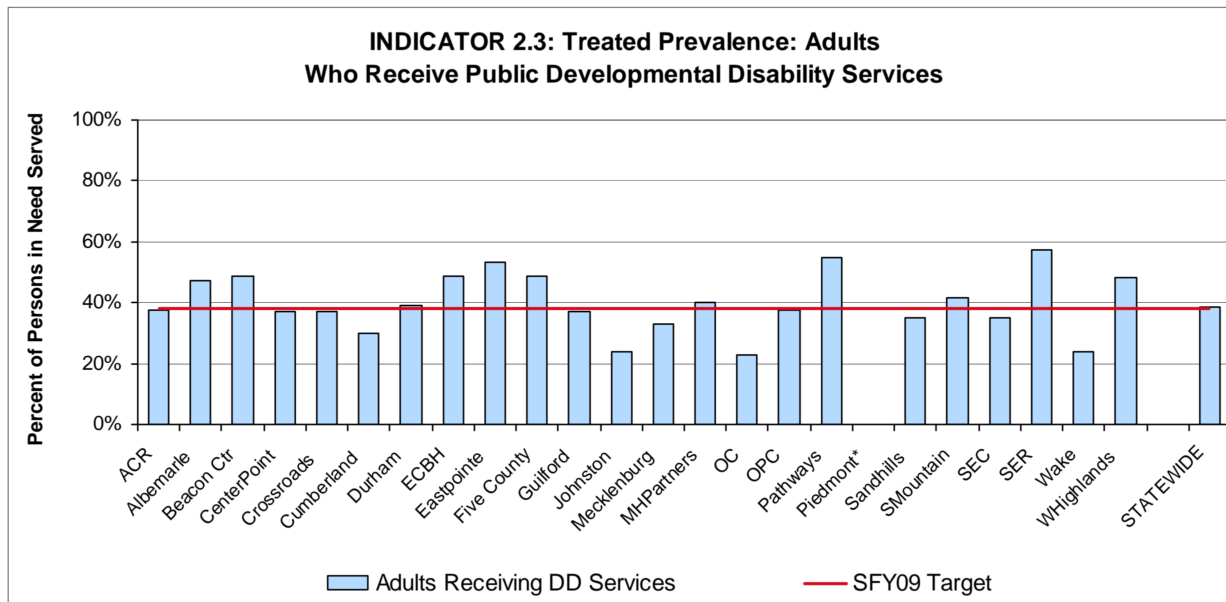
[10] The numbers served reflect children and adolescents, ages 3-17, who received any MH services (including assessments) in the community system, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, private insurance, and private funds. The NC Division of Public Health is responsible for all services from birth through age 2. Therefore 100% of the population is not expected to be served by the public community system.

[11] The SFY 2009 DHHS-LME Performance Contract requirement is 38% or above.

Indicator 2: Services to Persons in Need

2.3 Adult Developmental Disability Services

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



SOURCE: Medicaid and State Service Claims Data, January 1, 2008 to December 31, 2008; N=51,065 adults in need

Statewide, 19,614 adults (38% of those in need of services[12]) received federal or state funded DD services through our community service system from January 2008 through December 2008.[13] The percentage remained the same as last quarter. The rate of adults who were served varied among LMEs from a low of 23% (Onslow-Carteret) to a high of 57% (Southeastern Regional).

The established SFY 2009 target for persons receiving adult developmental disability services is 38%, as indicated by the red line in the graph above[14]. Of the 23 LMEs with service claims data, almost half (11 LMEs) met or exceeded the target.

[12] Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), http://rtc.umn.edu/docs/fs0102.html. Prevalence rates for persons ages 3-5 = 3.8%, ages 6-16 = 3.2%, ages 17-24 = 1.5%, ages 25-34 = 0.9%, ages 35-44 = 0.8%, ages 45-54 = 0.7%, ages 55-64 = 0.5%, ages 65 and older = 0.4%. Age appropriate estimates applied to county population as of July 2008 (See *Appendix*).

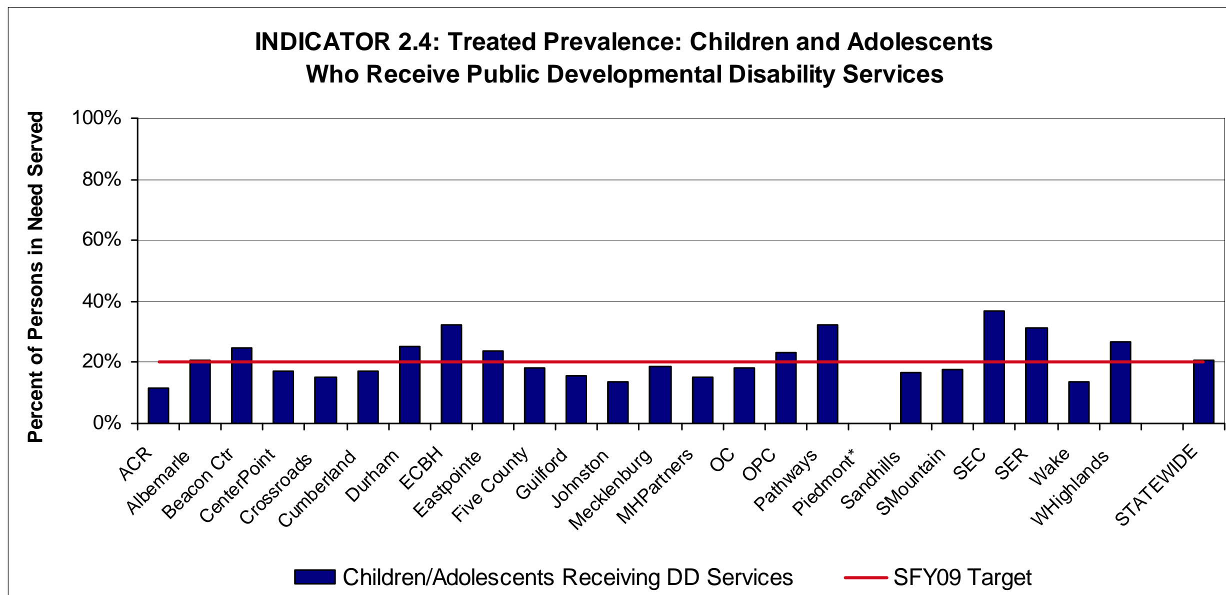
[13] The numbers served reflect adults, ages 18 and over, who received any DD services (including assessments) in the community system, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, private insurance, and private sources. Therefore 100% of the population is not expected to be served by the public community system.

[14] The SFY 2009 DHHS-LME Performance Contract requirement is 36% or above.

Indicator 2: Services to Persons in Need

2.4 Child and Adolescent Developmental Disability Services

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



SOURCE: Medicaid and State Service Claims Data, January 1, 2008 to December 31, 2008; N=54,613 children and adolescents in need

Statewide, 11,210 children and adolescents (21% of those in need of services[15]) received federal or state funded DD services through our community service system from January 2008 through December 2008.[16] [17] The rate of those who were served varied among LMEs from a low of 12% (Alamance-Caswell-Rockingham) to a high of 37% (Southeastern Center).

The established SFY 2009 target for persons receiving child developmental disability services is 20%, as indicated by the red line in the graph above[18]. Of the 23 LMEs with service claims data, two-fifths of the LMEs (10 LMEs) met or exceeded the target.

[15] Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), http://rtc.umn.edu/docs/fs0102.html. Age appropriate estimates applied to county population as of July 2008 (See *Appendix*).

[16] The numbers reflect children and adolescents, ages 3-17, who received any DD services (including assessments) in the community system, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, private insurance, and private sources. Therefore 100% of the population is not expected to be served by the public community system.

[17] The NC Division of Public Health is responsible for all services from birth through age 2. Local educational systems are responsible for educational services to children with developmental disabilities through age 21.

[18] The SFY 2009 DHHS-LME Performance Contract requirement is 19% or above.

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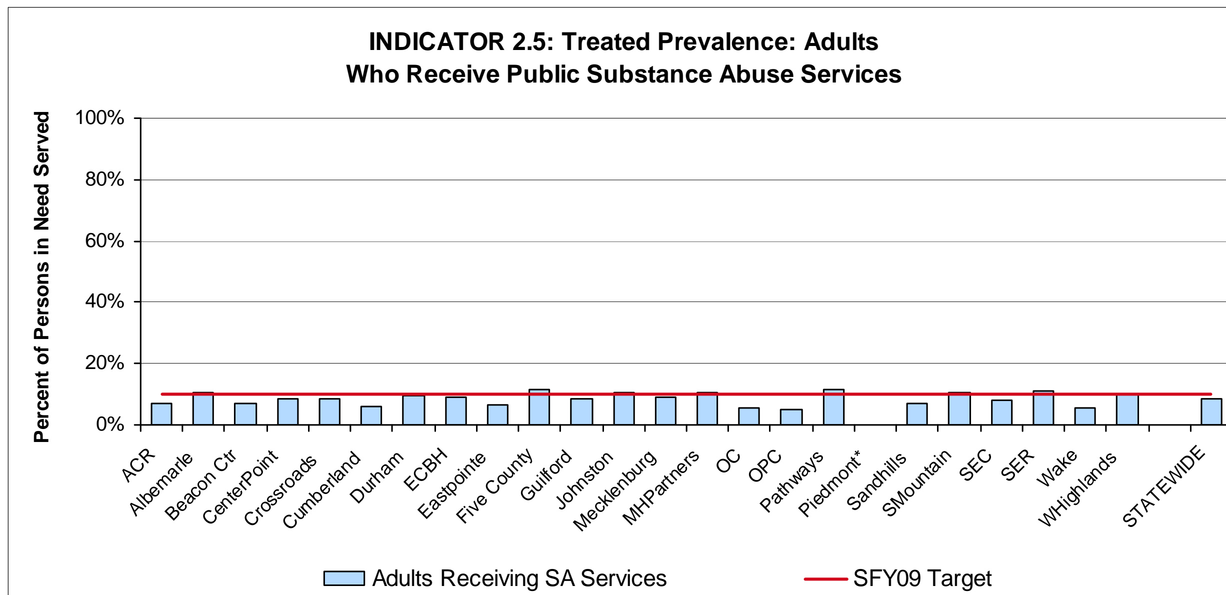
Indicator 2: Services to Persons in Need

2.5 Adult Substance Abuse Services

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



SOURCE: Medicaid and State Service Claims Data, January 1, 2008 to December 31, 2008; N=564,796 adults in need

Statewide, 47,738 adults (8% of those in need of services[19]) received federal or state funded SA services through our community service system from January 2008 through December 2008.[20] The number served increased, but the percentage remained the same as last quarter. The rate of adults who were served varied among LMEs from a low of 5% (Orange-Person-Chatham) to a high of 12% (Five County).

The established SFY 2009 target for persons receiving adult substance abuse services is 10%, as indicated by the red line in the graph above[21]. Of the 23 LMEs with service claims data, almost two-fifths (9 LMEs) met or exceeded the target.

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[19] *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health,* Table B.20, published February 2008, http://oas.samhsa.gov/nsduh.htm. Adults (ages 18-25) = 18.87%, and adults (ages 26+) = 6.84%. Age appropriate estimates applied to county population as of July 2008 (See *Appendix*).

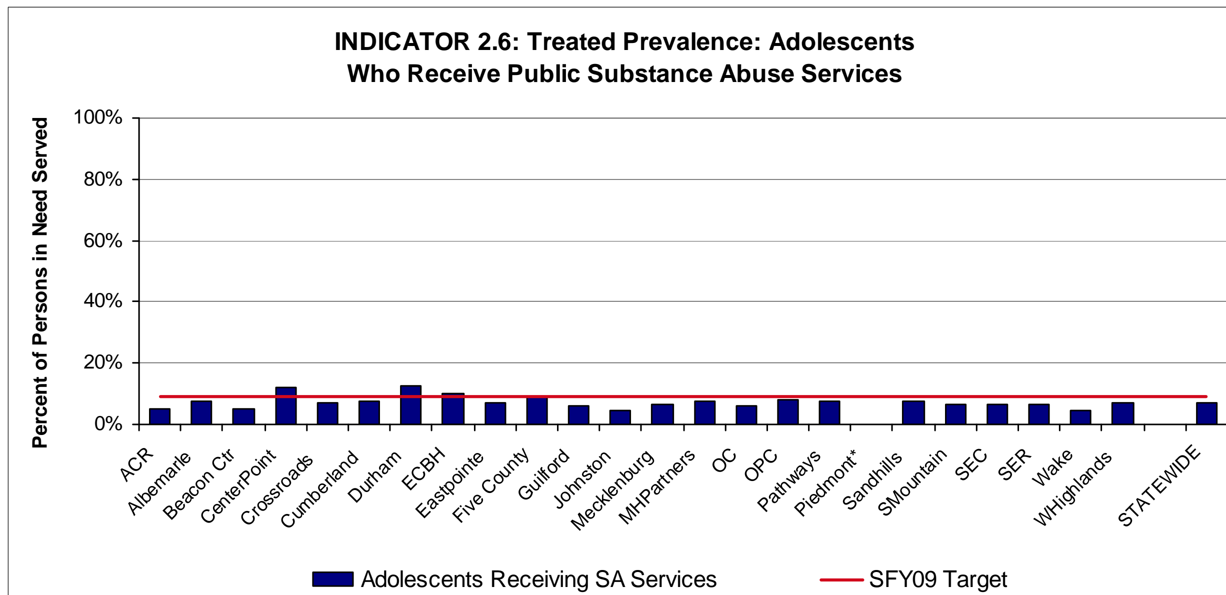
[20] The numbers served reflect adults, ages 18 and over, who received any SA services (including assessments) in the community system, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, private insurance, and private sources. Therefore 100% of the population is not expected to be served by the public community system.

[21] The SFY 2009 DHHS-LME Performance Contract requirement is 8% or above.

Indicator 2: Services to Persons in Need

2.6 Adolescent Substance Abuse Services

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



SOURCE: Medicaid and State Service Claims Data, January 1, 2008 to December 31, 2008; N=53,144 adolescents in need

Statewide, 3,763 adolescents (7% of those in need of services[22]) received federal or state funded services through our community service system from January 2008 through December 2008.[23] This represents no change from the prior quarter. The rate of targeted adolescents who were served varied among LMEs from a low of 4% (Wake) to a high of 13% (Durham).

The established SFY 2009 target for persons receiving child substance abuse services is 9%, as indicated by the red line in the graph above[24]. Of the 23 LMEs with service claims data, almost one-fifth (four LMEs) met or exceeded the target.

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[22] *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health,* Table B.20, published February 2008 http://oas.samhsa.gov/nsduh.htm. Ages 12-17 = 7.83%. Estimates applied to county population as of July 2008.

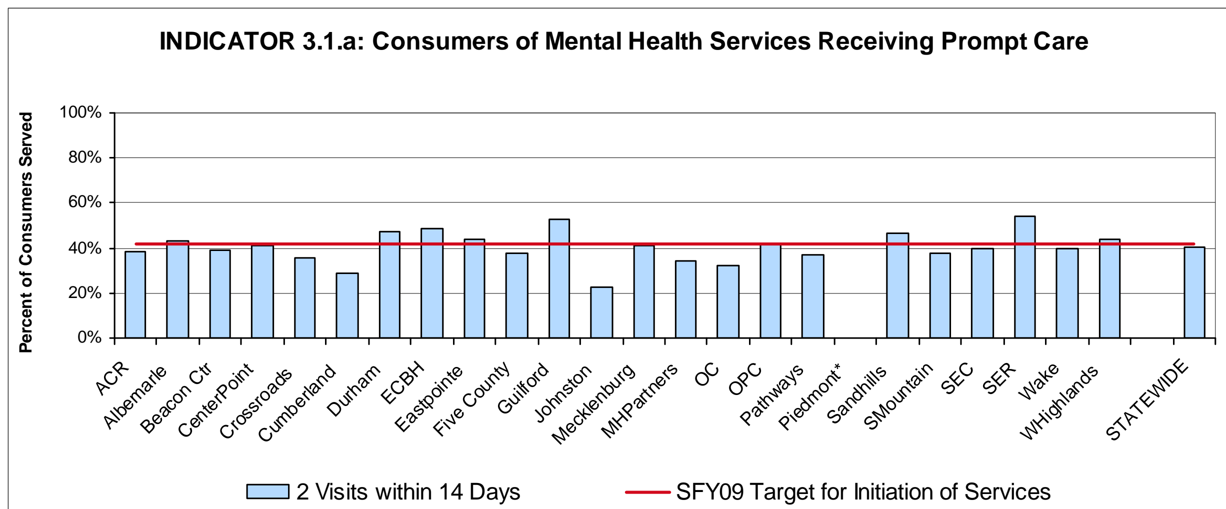
[23] The numbers served reflect children and adolescents, under age 18, who received any SA services (including assessments) in the community system, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, private insurance, and private sources. Therefore 100% of the population is not expected to be served by the public community system.

[24] The SFY 2009 DHHS-LME Performance Contract requirement is 7% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.1.a Initiation of Consumers of Mental Health Services

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



SOURCE: Medicaid and State Service Claims Data, October 1 - December 31, 2008 (first service received); N=43,653 consumers

Forty-one percent of NC residents (all age groups) who received Medicaid or State funded mental health services had two visits in the first 14 days of care, the same as last quarter. Among LMEs, this percent ranged from a low of 22% (Johnston) to a high of 54% (Southeastern Regional). Compared to the other disability groups, consumers with mental illness had the lowest percentage receiving two visits in the first 14 days of care.

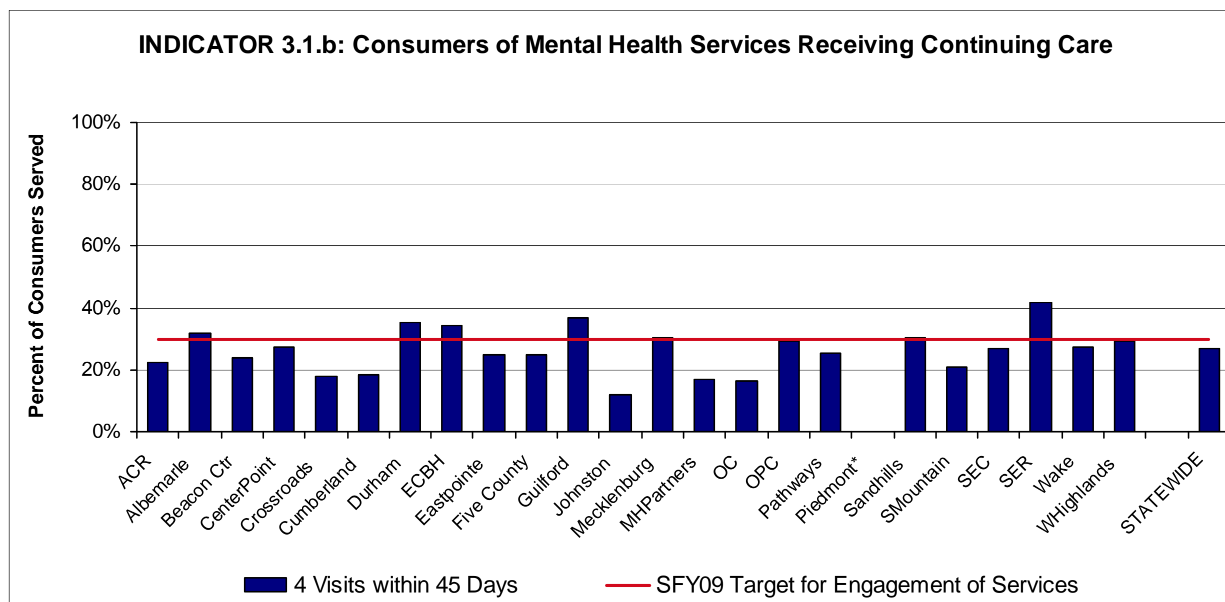
The established SFY 2009 target for initiation into care of consumers of mental health services is 42%, as indicated by the red line in the graph above[25]. Of the 23 LMEs with service claims data, two-fifths (9 LMEs) met or exceeded the target.

[25] The SFY 2009 DHHS-LME Performance Contract requirement is 37% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.1.b Engagement of Consumers of Mental Health Services

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



SOURCE: Medicaid and State Service Claims Data, October 1 - December 31, 2008 (first service received); N=43,653 consumers

More than one-fourth (27%) of consumers of mental health services met the initiation standard (two visits within 14 days of care) and had an additional two visits within the next 30 days, making a total of four visits in the first 45 days (a best practice for engagement in care). This was the same as last quarter. Among LMEs, engagement ranged from a low of 12% (Johnston) to a high of 42% (Southeastern Regional). Compared to the other disability groups, consumers of mental health services had the lowest percentage of persons receiving four visits in the first 45 days of care.

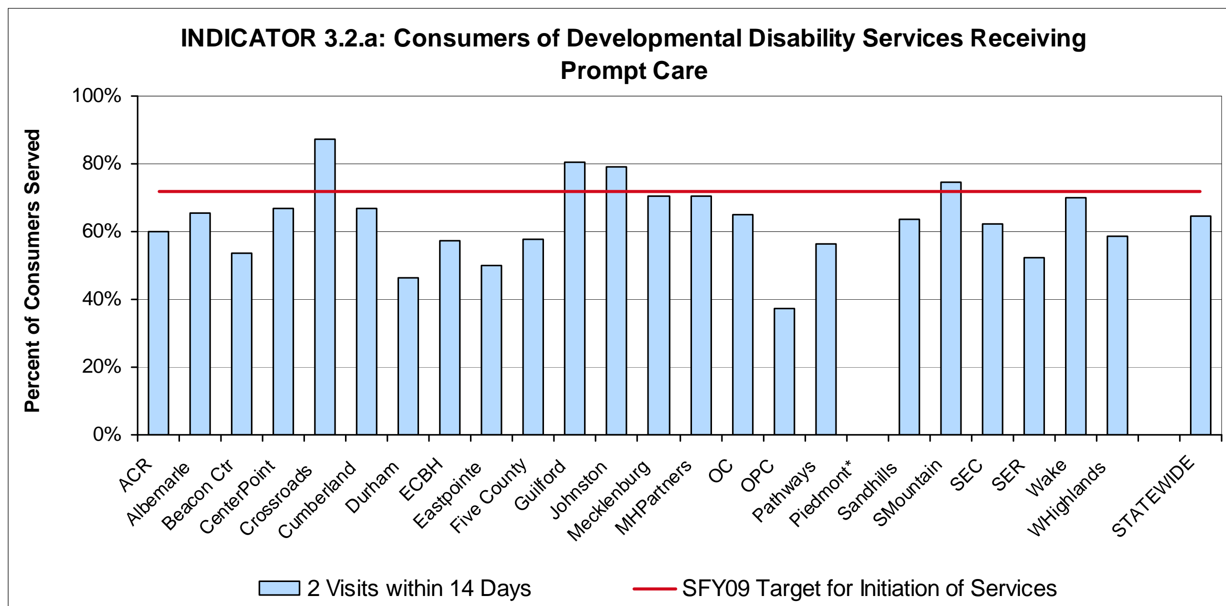
The established SFY 2009 target for engagement into care of consumers of mental health services is 30%, as indicated by the red line in the graph above[26]. Of the 23 LMEs with service claims data, over one-third of the LMES (8 LMEs) met or exceeded the target.

[26] The SFY 2009 DHHS-LME Performance Contract requirement is 25% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.2.a Initiation of Consumers of Developmental Disability Services

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



SOURCE: Medicaid and State Service Claims Data, October 1 - December 31, 2008 (first service received); N=838 consumers

Sixty-four percent of NC residents (all age groups) who received Medicaid or State funded developmental disability services/supports had two visits in the first 14 days of care (the standard for prompt initiation of care). This is a decrease since last quarter. Among LMEs, this percent ranged from a low of 38% (OPC) to a high of 88% (Crossroads). Compared to the other disability groups, consumers of developmental disability services had the highest percentage receiving two visits in the first 14 days of care.

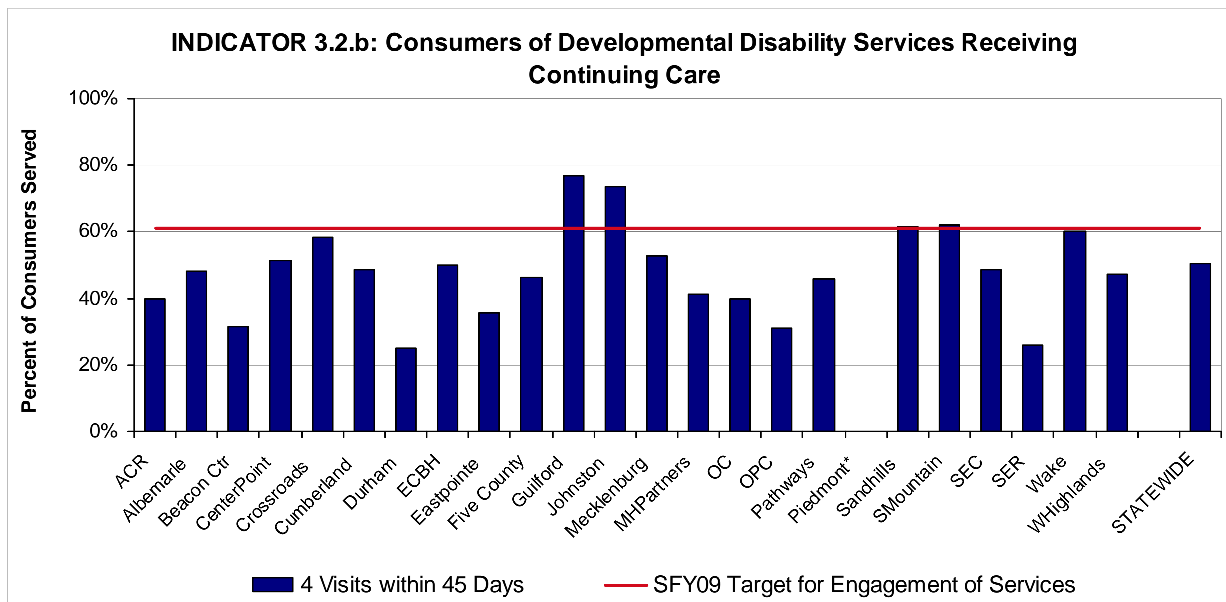
The established SFY 2009 target for initiation into care of consumers of developmental disability services is 72%, as indicated by the red line in the graph above[27]. Of the 23 LMEs with service claims data, one-sixth of the LMEs (4 LMEs) met or exceeded the target.

[27] The SFY 2009 DHHS-LME Performance Contract requirement is 62% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.2.b Engagement of Consumers of Developmental Disability Services

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



SOURCE: Medicaid and State Service Claims Data, October 1 - December 31, 2008 (first service received); N=838 consumers

Fifty-one percent of consumers of developmental disability services met the initiation standard (two visits within 14 days of care) and had an additional two visits within 30 days, making a total of four visits in the first 45 days (a best practice for engagement in care). This is a decrease from the prior quarter. Among LMEs, engagement ranged from a low of 25% (Durham) to a high of 77% (Guilford). Compared to the other disability groups, consumers of developmental disability services had the highest percentage of persons receiving four visits in the first 45 days of care.

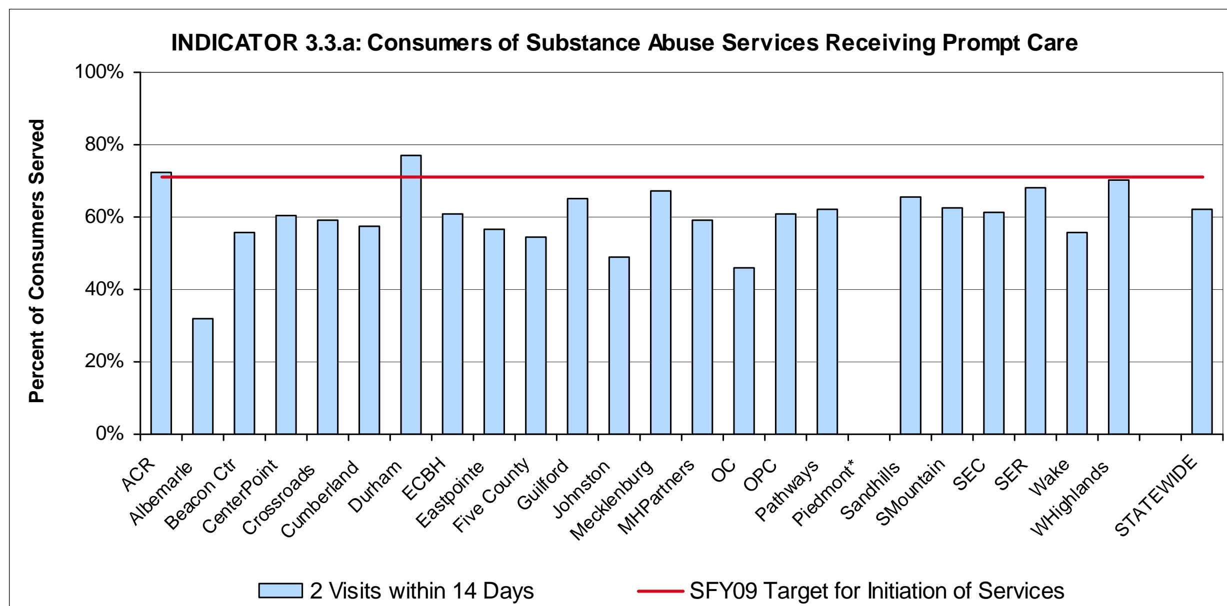
The established SFY 2009 target for engagement into care of consumers of developmental disability services is 61%, as indicated by the red line in the graph above[28]. Of the 23 LMEs with service claims data, one-sixth of LMEs (4 LMEs) met or exceeded the target.

[28] The SFY 2009 DHHS-LME Performance Contract requirement is 51% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.3.a Initiation of Consumers of Substance Abuse Services

Rationale: National standards[29] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data, October 1 - December 31, 2008 (first service received); N=5,147 consumers

Sixty-two percent of NC residents (all age groups) who received Medicaid or State funded substance abuse services had two visits in the first 14 days of care (the standard for prompt initiation of care). This is the same as last quarter. Among LMEs, this percent ranged from a low of 32% (Albemarle) to a high of 77% (Durham).

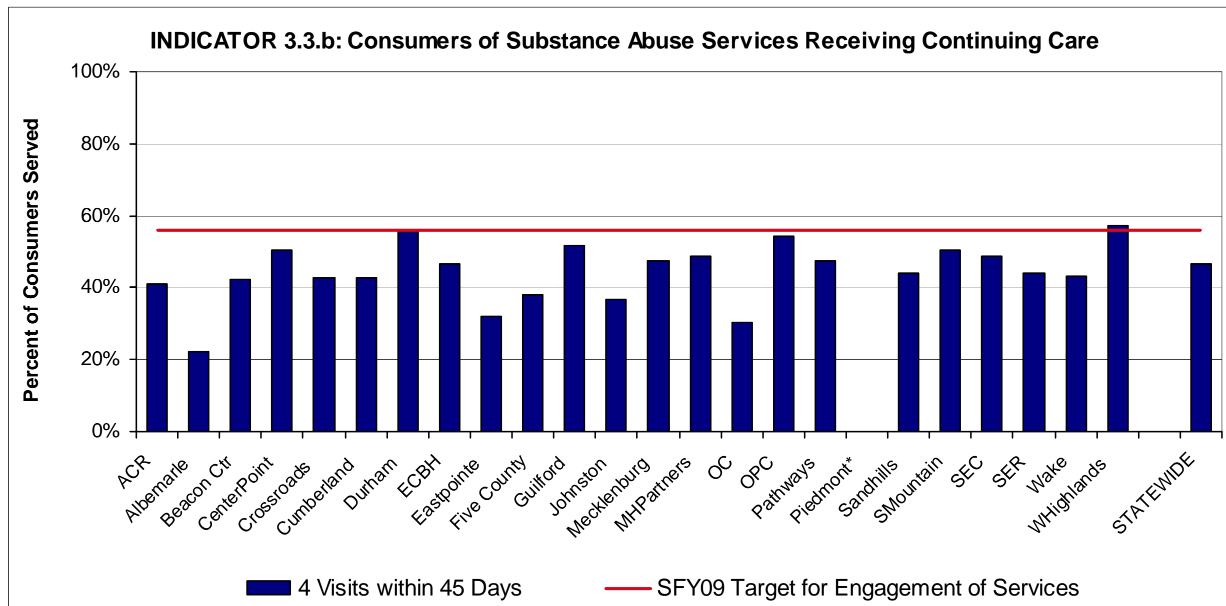
The established SFY 2009 target for initiation into care of consumers of substance abuse services is 71%, as indicated by the red line in the graph above[30]. Of the 23 LMEs with service claims data, 2 LMEs (Durham, Alamance-Caswell-Rockingham) met or exceeded the target.

[29] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.
[30] The SFY 2009 DHHS-LME Performance Contract requirement is 64% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.3.b Engagement of Consumers of Substance Abuse Services

Rationale: National standards[31] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data, October 1 - December 31, 2008 (first service received); N=5,147 consumers

Less than half (46%) of consumers of substance abuse services met the initiation standard (two visits within 14 days of care) and had an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for engagement in care). This is the same as last quarter. Among LMEs, engagement ranged from a low of 22% (Albemarle) to a high of 57% (Western Highlands).

The established SFY 2009 target for engagement into care of consumers of substance abuse services is 56%, as indicated by the red line in the graph above[32]. Of the 23 LMEs with service claims data, two LME (Western Highlands, Durham) met or exceeded the target.

[31] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.
[32] The SFY 2009 DHHS-LME Performance Contract requirement is 47% or above.

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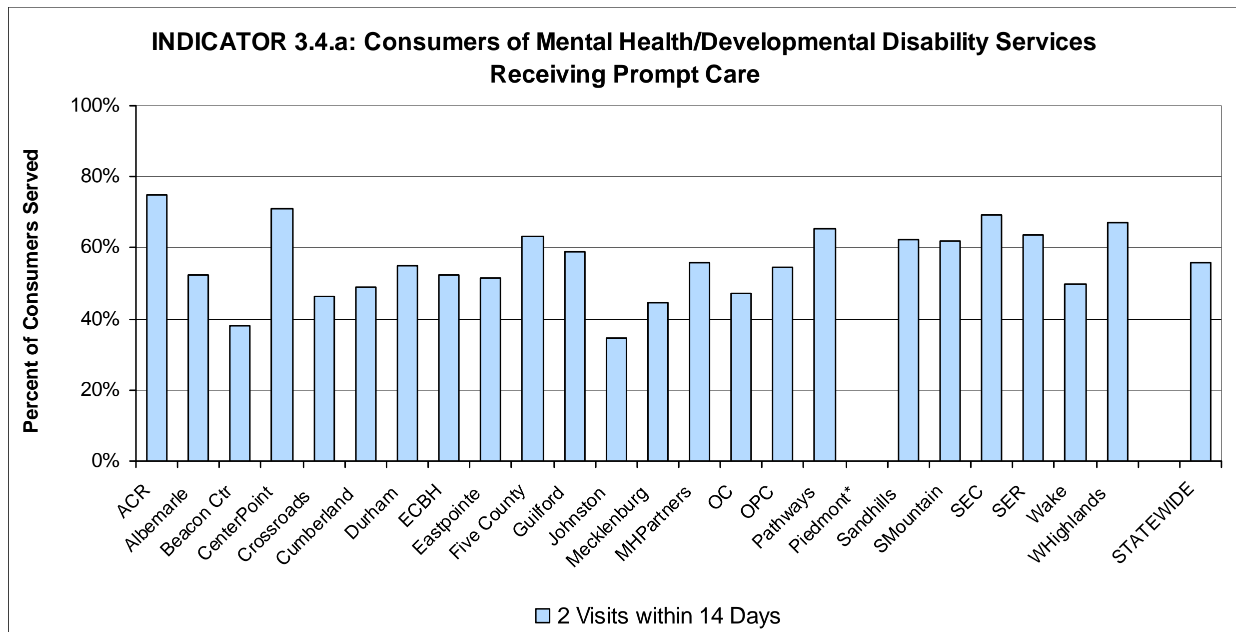
Indicator 3: Timely Initiation and Engagement in Service

3.4.a Initiation of Consumers with Co-Occurring Mental Health/Developmental Disabilities

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



SOURCE: Medicaid and State Service Claims Data, October 1 - December 31, 2008 (first service received); N=1,065 consumers

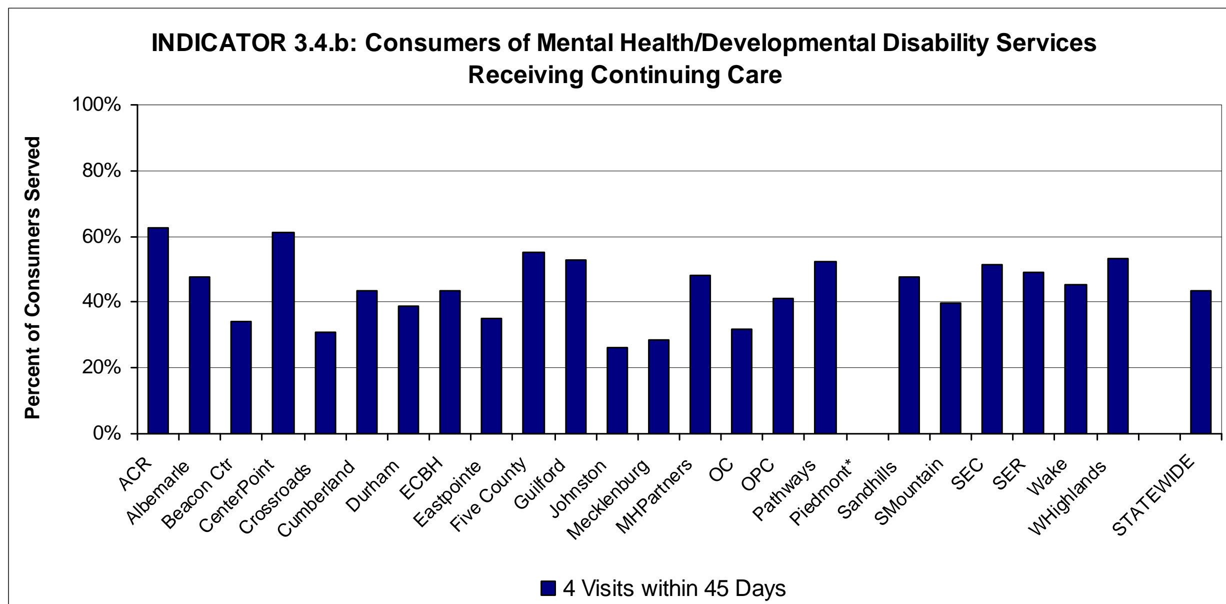
Fifty-six percent of NC residents (all age groups) who received Medicaid or State funded mental health and developmental disability services for co-occurring disorders had two visits in the first 14 days of care (the standard for prompt initiation of care). This is a slight decrease from the prior quarter. Among LMEs, this percent ranged from a low of 35% (Johnston) to a high of 75% (Alamance-Caswell-Rockingham).

A SFY 2009 target for initiation into care for consumers with a co-occurring mental health disorder and developmental disabilities has not been established.

Indicator 3: Timely Initiation and Engagement in Service

3.4.b Engagement of Consumers with Co-Occurring Mental Health/Developmental Disabilities

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



SOURCE: Medicaid and State Service Claims Data, October 1 - December 31, 2008 (first service received); N=1,065 consumers

Forty-three percent of NC consumers who received Medicaid or State funded mental health and developmental disability services for co-occurring disorders met the initiation standard of two visits within 14 days and had an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for engagement in care). This is a slight decrease from the prior quarter. Among LMEs, engagement ranged from a low of 26% (Johnston) to a high of 63% (Alamance-Caswell-Rockingham).

A SFY 2009 target for engagement into care for consumers with a co-occurring mental health disorder and developmental disabilities has not been established.

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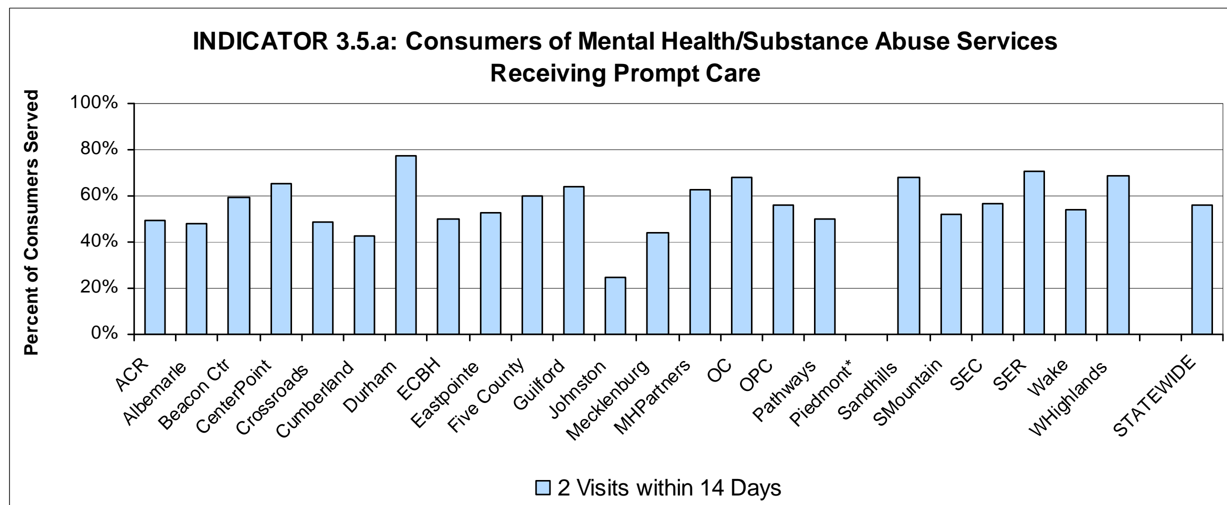
Indicator 3: Timely Initiation and Engagement in Service

3.5.a Initiation of Consumers with a Co-Occurring Mental Health/Substance Abuse Disorder

Rationale: National standards[33] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data, October 1 - December 31, 2008 (first service received); N=5,765 consumers

Fifty-six percent of NC consumers (all age groups) who received Medicaid or State funded mental health and substance abuse services for co-occurring disorders had two visits in the first 14 days of care (the standard for prompt initiation of care). This is the same as last quarter. Among LMEs, this percent ranged from a low of 24% (Johnston) to a high of 77% (Durham).

A SFY 2009 target for initiation into care for consumers with a co-occurring mental health and substance abuse disorder has not been established.

[33] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

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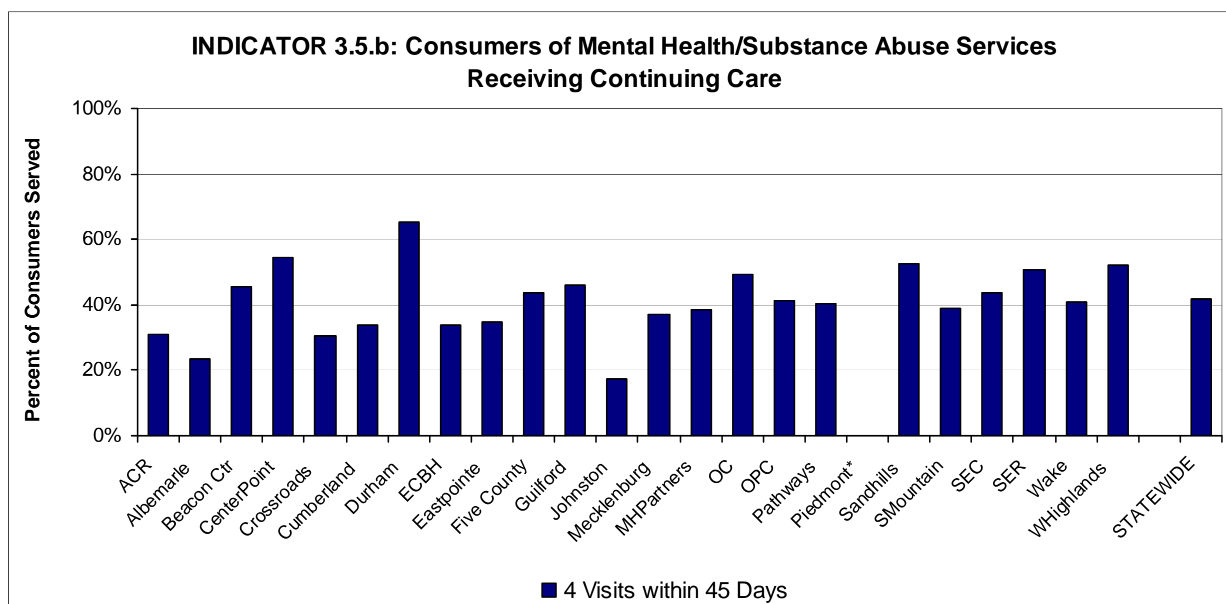
Indicator 3: Timely Initiation and Engagement in Service

3.5.b Engagement of Consumers with a Co-Occurring Mental Health/Substance Abuse Disorder

Rationale: National standards[34] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data, October 1 - December 31, 2008 (first service received); N=5,765 consumers

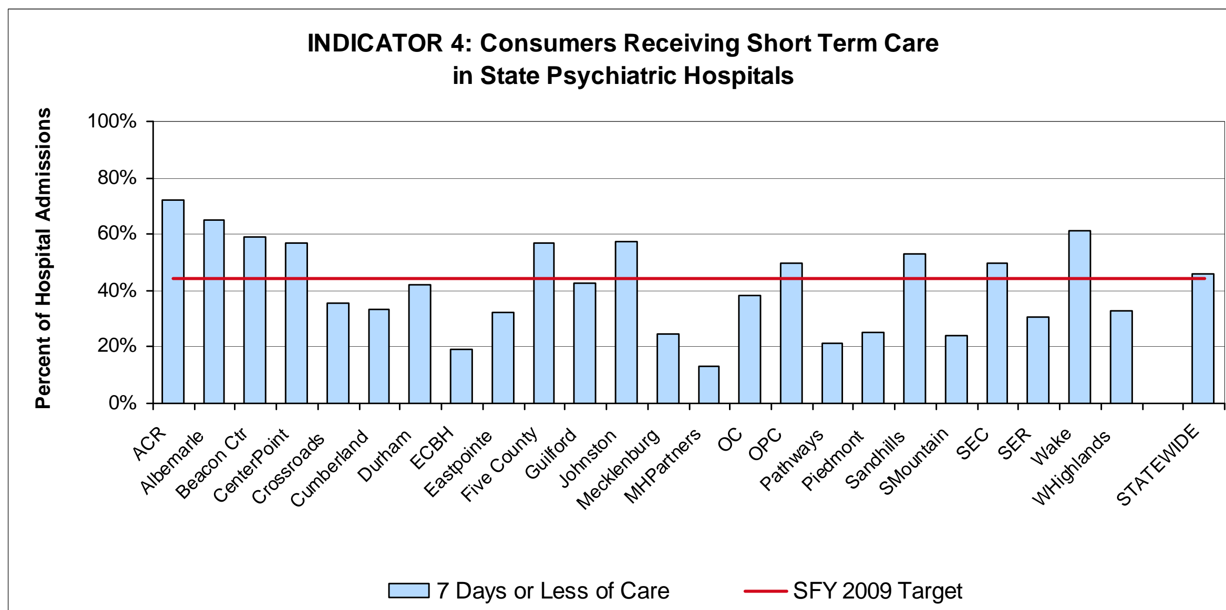
Forty-two percent of NC consumers who received Medicaid or State funded mental health and substance abuse services for co-occurring disorders met the initiation standard of two visits within 14 days and had an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for engagement in care). This is the same as last quarter. Among LMEs, engagement ranged from a low of 17% (Johnston) to a high of 65% (Durham).

A SFY 2009 target for engagement into care for consumers with a co-occurring mental health and substance abuse disorder has not yet been established.

[34] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

Indicator 4: 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.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) data for hospital discharges during January 1 - March 31, 2009; N=1,711 discharges

Of the statewide hospital discharges from January through March 2008, less than half (46%) of the persons discharged were hospitalized for 7 days or less. This is the same as last quarter. (Note: As seen in the *Appendix*, an additional two-fifths, 39%, were hospitalized for 8-30 days. This is an increase over last quarter.). Persons discharged with lengths of stay of 1-7 days varied by LME from a high of 72% (Alamance-Caswell-Rockingham) to a low of 13% (Mental Health Partners).

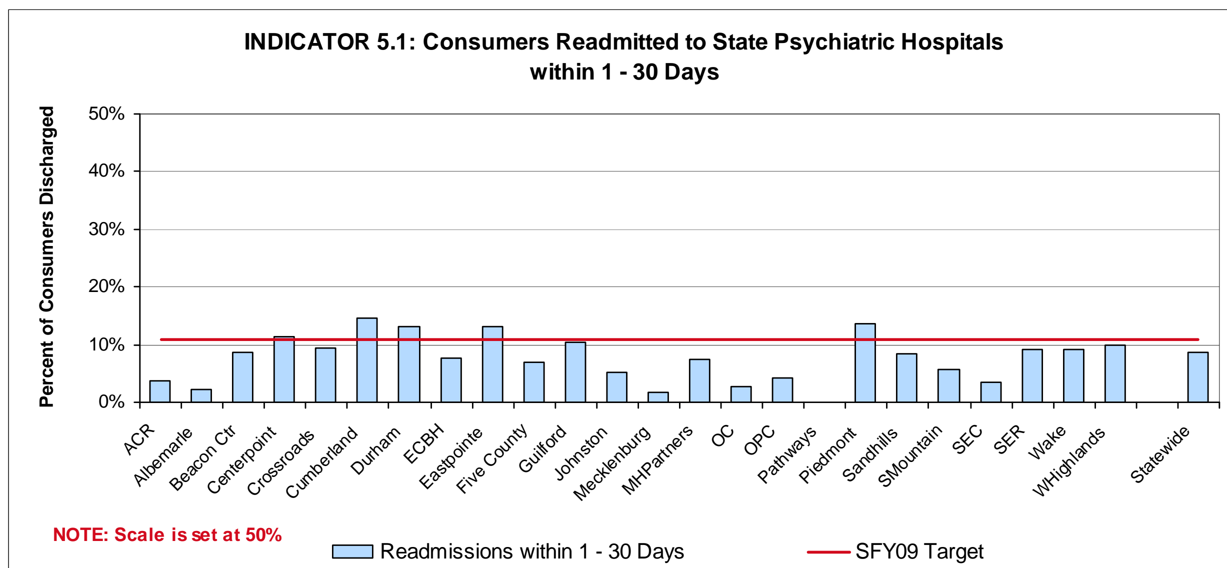
The established SFY 2009 target for short-term (7 days or less) use of state psychiatric hospitals is no more than 44%, as indicated by the red line in the graph above[35]. Of the 24 LMEs with HEARTS data, three-fifths of LMEs (14 LMEs) met or exceeded the target.

[35] The SFY 2009 DHHS-LME Performance Contract requirement is 55% or below.

Indicator 5: State Psychiatric Hospital Readmissions

5.1 State Psychiatric Hospital Readmissions within 1-30 Days

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: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) data for hospital discharges during July 1 - September 30, 2008; N=2,454 discharges

Fewer than nine percent of consumers discharged from state psychiatric hospitals were readmitted to a psychiatric hospital within 30 days. This is a decrease from last quarter. Among LMEs, the percent of consumers readmitted within 30 days varied from a high of 15% (Cumberland) to a low of 0% (Pathways).

The established SFY 2009 target for readmissions within 30 days of discharge from a state psychiatric hospital is no more than 11%, as indicated by the red line in the graph above[36]. Almost four-fifths of the LMEs (19 LMEs) met or exceeded the target.

[36] The SFY 2009 DHHS-LME Performance Contract requirement is 12% or below.

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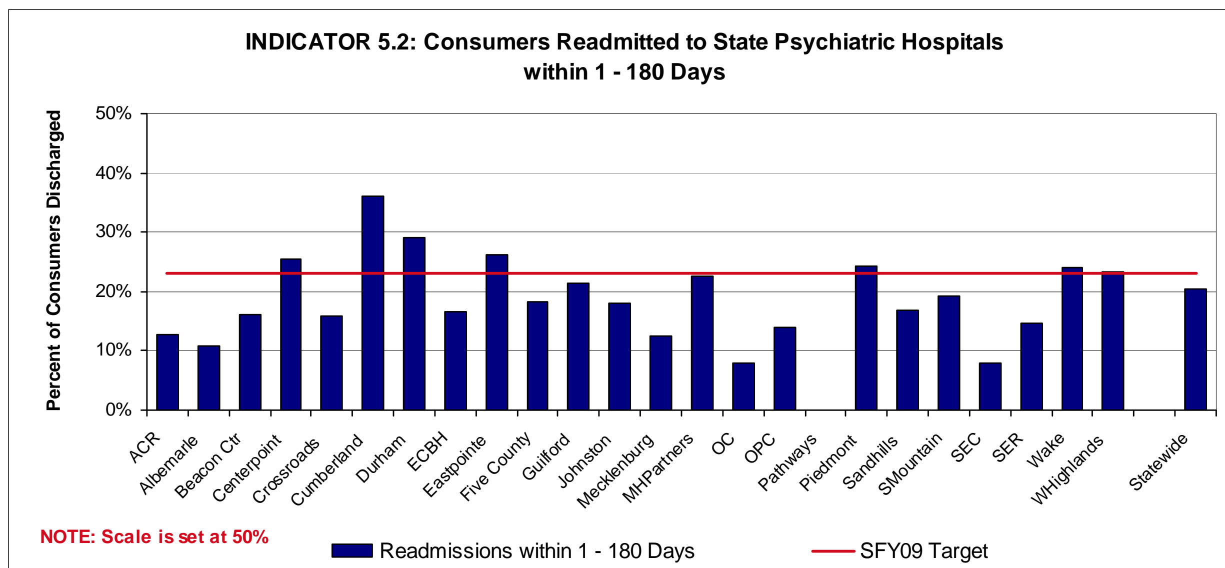
Indicator 5: State Psychiatric Hospital Readmissions

5.2 State Psychiatric Hospital Readmissions within 1-180 Days

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: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) data for hospital discharges during July 1 - September 30, 2008; N=2,454 discharges

One-fifth (20%) of consumers discharged from state psychiatric hospitals were readmitted to a psychiatric hospital within 180 days. This is a slight decrease from last quarter. Among LMEs, the percent of consumers readmitted within 180 days varied from a high of 36% (Cumberland) to a low of 0% (Pathways).

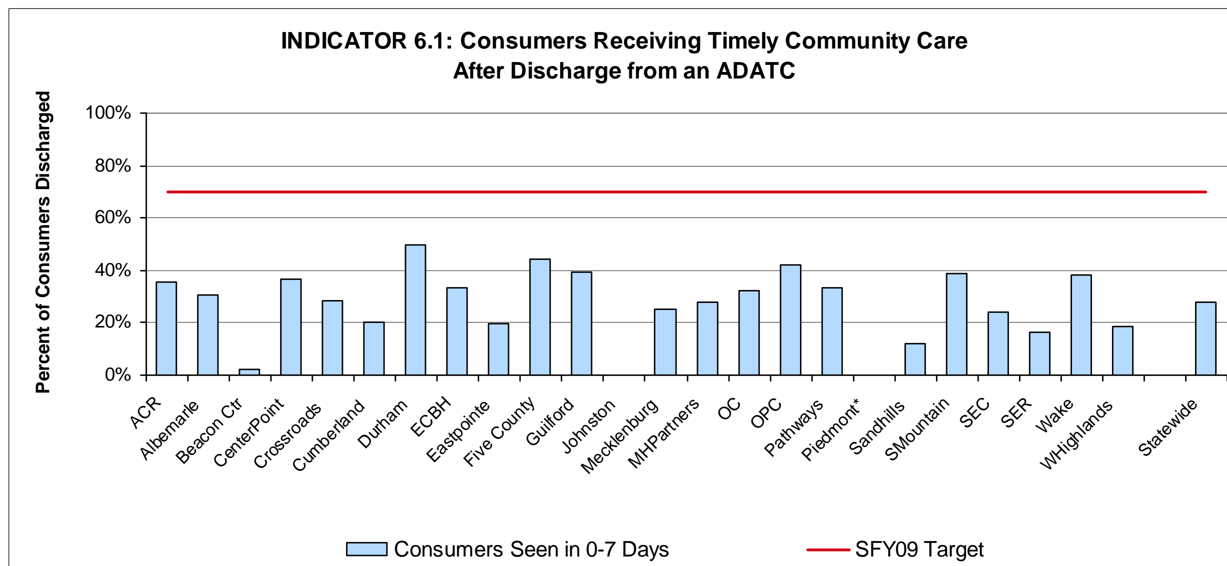
The established SFY 2009 target for readmissions within 180 days of discharge from a state psychiatric hospital is no more than 23%, as indicated by the red line in the graph above[37]. Two-thirds of LMEs (16 LMEs) met or exceeded the target.

[37] The SFY 2009 DHHS-LME Performance Contract requirement is 26% or below.

Indicator 6: Timely Follow-Up after Inpatient Care

6.1 ADATCs

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.[38]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) data for ADATC discharges October 1 - December 30, 2008; Medicaid and State Service Claims Data for claims paid through April 30, 2009; N=757 discharges

Statewide, slightly more than one-fourth (28%) of consumers discharged from an ADATC received follow-up care in the community within 7 days. An additional 17% of NC consumers were seen within 8-30 days of discharge (not shown in the graph above; see *Appendix*). This is an increase over the prior quarter.

Among LMEs, the percentage of consumers receiving follow-up care within 7 days varied from a low of 0% (Johnston) to a high of 50% (Durham).

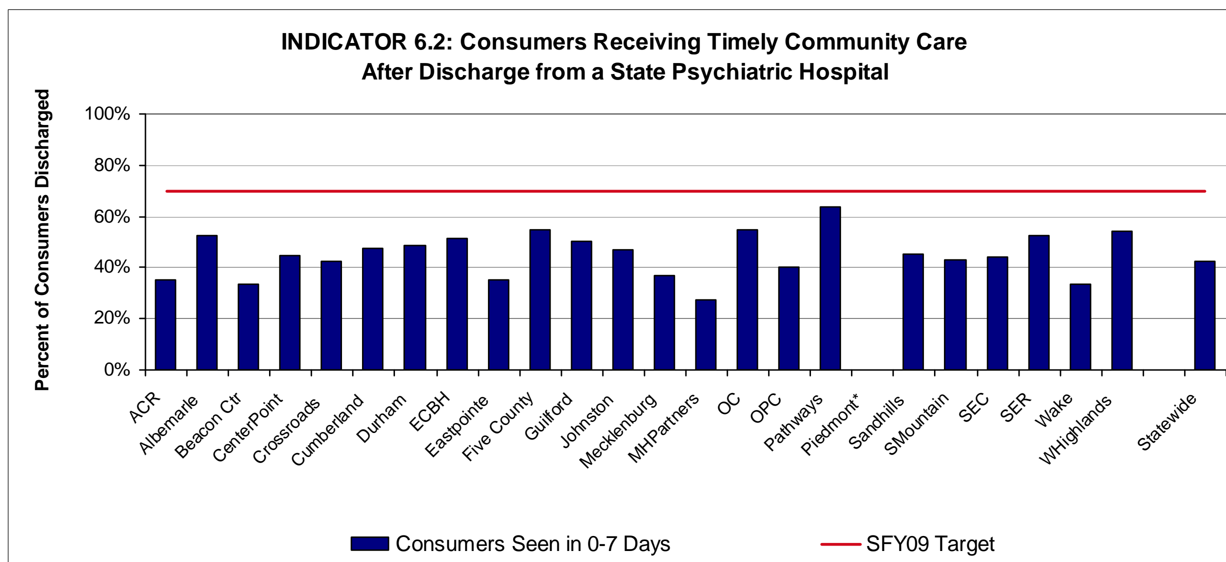
The established SFY 2009 target for follow-up care in the community within 7 days of discharge from an ADATC is 70%, as indicated by the red line in the graph above[39]. Of the 23 LMEs with service claims data, no LMEs met or exceeded the target.

[38] This is a Health Plan Employer Data and Information Set (HEDIS®) measure.
[39] The SFY 2009 DHHS-LME Performance Contract requirement is 26% or above.

Indicator 6: Timely Follow-Up after Inpatient Care

6.2 State Psychiatric Hospitals

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.[40]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) data for Hospital discharges October 1 - December 30, 2008; Medicaid and State Service Claims Data for claims paid through April 30, 2009; N=1,814 discharges

Statewide, over two-fifths (42%) of consumers discharged from state psychiatric hospitals received follow-up care in the community within 7 days. An additional 16% of NC consumers were seen within 8-30 days of discharge (not shown in the graph above; see *Appendix*). This is an increase over the prior quarter. Among LMEs, the percent of consumers receiving follow-up care within 7 days varied from a low of 27% (Mental Health Partners) to a high of 64% (Pathways).

The established SFY 2009 target for follow-up care in the community within 7 days of discharge from a state psychiatric hospital is 70%, as indicated by the red line in the graph above[41]. Of the 23 LMEs with service claims data, no LMEs met or exceeded the target.

[40] This is a Health Plan Employer Data and Information Set (HEDIS®) measure.
[41] The SFY 2009 DHHS-LME Performance Contract requirement is 35% or above.

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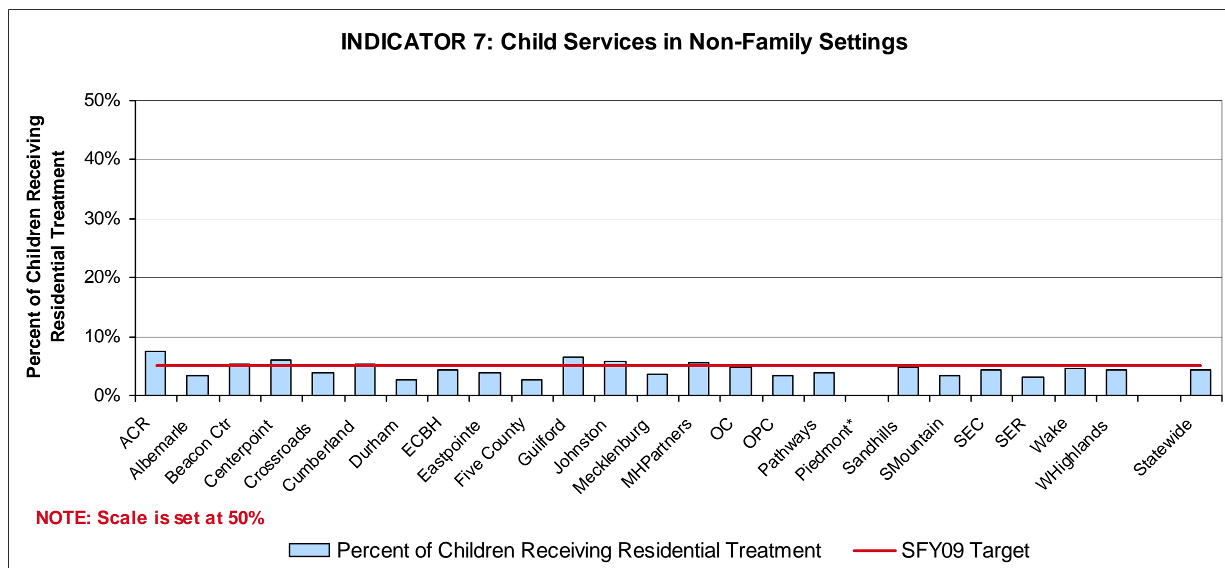
Indicator 7: Child Services in Non-Family Settings

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.



SOURCE: Medicaid and State Service Claims Data for services received October 1 - December 31, 2008 paid through April 30, 2009; N=60,524 child and adolescent consumers served with a MH or SA diagnosis (includes those with co-occurring DD)

Statewide, 2,590 (4%) children and adolescents receiving mental health and/or substance abuse services were served in residential treatment settings[42]. This is the same as last quarter. Among LMEs, the percentage of child and adolescent consumers served in residential settings ranged from a high of 8% (Alamance-Caswell-Rockingham) to a low of 3% (Albemarle, Durham, Five County, Orange-Person-Chatham, Smoky Mountain, and Southeastern Regional).

The established SFY 2009 target for child services in non-family settings is no more than 5%, as indicated by the red line in the graph above[43]. Of the 23 LMEs with service claims data, more than four-fifths of LMEs (19 LMEs) met or exceeded the target.

[42] Includes Level 2 (Program Type), Level 3, and Level 4 Residential Treatment Services.
[43] The SFY 2009 DHHS-LME Performance Contract requirement is 6% or below.

The MH/DD/SAS *Community Systems Progress Report*, *Report Appendices* and *Critical Measures at a Glance* are published four times a year on the Division's website:
http://www.ncdhhs.gov/mhddsas/statspublications/reports/

Questions and feedback should be directed to:
NC DMH/DD/SAS Quality Management Team
ContactDMHQuality@ncmail.net
(919/733-0696)

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