



DHHS Business Plan

prepared by:

The Office of Policy and Planning
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Mission

The mission of the North Carolina Department of Health and Human Services is to provide efficient services that enhance the quality of life of North Carolina individuals and families so that they have opportunities for healthier and safer lives resulting ultimately in the achievement of economic and personal independence.

Vision

The North Carolina Department of Health and Human Services will be a national leader in improving the health, safety, and independence of its residents.

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Executive Summary

In 2006, the NC Department of Health and Human Services (DHHS) produced its first business plan. That plan was the result of a detailed approach to gather information relevant to the major components of most operations, whether public or private sector: Management Vision and Control, Workforce, Program and Service Delivery, Budget and Finance, Communications, and Buildings and Facilities. The plan provided the necessary foundation for the development of information technology plans required by the NC Information Technology Services, which was created to help the state move to enterprise management of the state's IT solutions to business needs through better coordination, planning and management. The plan also provided valuable information to multiple layers of DHHS management and produced the department's first business drivers—concepts to help guide decisions about the work of DHHS.

To produce this update, the Office of Policy and Planning employed the same methodology as that used for the 2006 plan. Information was first gathered via a standardized questionnaire completed by every division and office of the department; however, information from those questionnaires reflected little change in demographic trends, operational needs, or the strengths and weaknesses, opportunities and threats of the individual divisions and agencies. For that reason, the appendices which summarized information contained in the questionnaires were not changed; those same appendices are part of this document since they continue to reflect excellent summary information on the department. Likewise, the business drivers developed in 2006 remain the same; they are provided at the end of this Executive Summary.

This document is organized in the following way: Part I is the overall department business plan presented in sections for each of the business functions mentioned above. Part II provides a critical view of DHHS' individual divisions and offices through agency profiles. These profiles contain the Mission Statement, Vision Statement, Current Environment, Key Operational Issues and the status of current Key Indicators. The profiles are grouped into Programmatic Divisions and Offices, which offer excellent overviews of the wide array of services provided to NC residents, and Support Divisions and Offices, which are essential to the operational success of the department's ability to meet its mission.

DHHS continues to struggle with issues identified in 2006—the two most frequently identified are changing demographics, which impact service design and delivery as well as workforce, and information technology. North Carolina's population is growing rapidly and is expected to increase 55% by 2030. In the 65+ age category, the increase will be over 1.2 million, or about 125%. The state also is becoming more multi-lingual and multi-cultural as evidenced by a 420% increase in the foreign born population since 1990. In the same period, the unauthorized immigrant population in North Carolina is estimated to have grown nearly 1,600% (from 25,000 to nearly 400,000), among the highest percentage increases in the nation (see pp. 29-34 for detailed demographics and sources).

These same demographics impact DHHS workforce needs. As baby boomers retire, the department (like all of state government) will be challenged to replace historical knowledge, specific programmatic understanding and past essential skills with a labor force that not only reflects the state's changing demographics but which also provides the skill set needed for a more rapidly changing work place and future workers who expect higher salaries, more obvious career ladders, more benefit options and better IT systems.

Additionally, DHHS struggles with outdated IT systems and lack of funding to replace many inefficient legacy systems which still perform functions critical for day to day operations. The inability to replace

these legacy systems at a rapid pace also sustains the continuation of numerous manual processes. Although IT funding priorities remain paramount, since the 2006 Business Plan the department has created an IT Governance Committee (ITGC) which coordinates the multiple needs, determines priorities and allocates limited money on an enterprise basis. In operation less than a year, the ITGC promises to be a valuable management component in addressing departmental IT needs over time.

Like other government entities, DHHS is delegated enormous responsibility, is expected to satisfy often competing stakeholders and is not in total control of its future in such areas as: legislative funding decisions; state-mandated policies, procedures and oversight; and federal/state mandates that may or may not include associated resources. Some factors within the department's control are better operational management, including adoption of benchmarks and best practices; adapting to cultural change to enable better information sharing with a focus on performance management; and utilizing management tools provided through improved information technology and data sharing.

In closing, it is important to recognize that a business plan is a fluid document that provides a road map to the future. But the challenge is great, and the road map must be referred to often. It must be updated on a routine basis, with consideration given to changing internal and external challenges, and implemented with the consistent leadership of executive management. The business drivers developed in 2006 are still valid, and if referred to routinely, will continue to be helpful in making necessary changes to improve business operations. However, it must also be recognized that DHHS' success is contingent upon receiving the support and cooperation of external entities.

Business Drivers

- ✓ **DHHS will employ an enterprise-wide approach in the design and delivery of programs and services for the ultimate benefit of North Carolina residents by:**
 - Implementing evidence based practices with an emphasis on prevention
 - Providing seamless access to an array of services that are locally available, client and family centric and outcome oriented
 - Utilizing program funds in a flexible manner that is responsive to changing needs, maximizes outcomes and meets state and federal requirements
 - Ensuring access to services by people with disabilities and those who may have special needs relating to language, culture, or ethnicity.

- ✓ **DHHS will sustain a culture of continuous improvement by:**
 - Identifying and implementing best practices and measuring for results
 - Empowering decision makers
 - Sustaining a high performance workforce
 - Providing tools to enable decision making

- ✓ **DHHS business needs will drive operational decisions and resource allocation by:**
 - Maximizing the use of human, technological and financial resources to enable business activities through coordinated planning processes

- ✓ **DHHS will leverage resources to achieve operational efficiencies by:**
 - Streamlining business processes
 - Implementing process improvement prior to automation
 - Enhancing access and transparency of information
 - Identifying opportunities for cost avoidance, savings and recovery
 - Ensuring the continuity, reliability and security of data and support systems

- ✓ **DHHS will enhance internal and external communications and marketing efforts to continue our focus on customer service by:**
 - Analyzing complaints and call center data to shorten response times and improve programs and services
 - Applying technology and best business practices to improve the ways in which we collect, share, analyze and use information from stakeholders and consumers
 - Targeting messages to the public about DHHS programs and services and their impact on the quality of life in North Carolina
 - Supporting the tools, processes, and resources necessary to inform and connect a large, diverse and geographically dispersed workforce

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Part I: The Business Plan

Summary information provided in this section is based on agency responses to the DHHS business plan questionnaires, the follow-up interviews and additional information when provided. As stated in the Executive Summary, the business plan is presented according to the following business functional areas:

- Management Vision and Control
- Information Technology
- Workforce
- Program and Service Delivery
- Budget and Finance
- Communications
- Buildings and Facilities

Management Vision and Control

As defined in G.S. 143 B-10, the Secretary of DHHS is responsible for the functions of management and administration which include: planning, organizing, staffing, coordinating, evaluating, reporting and budgeting. That same level of responsibility is shared with and delegated to the directors of the agencies of the department.

Management is generally thought of as unified leadership of an organization that includes controlling policy, business and budgetary activities, products and/or programs, internal operational controls, and intelligent foresight so that decisions are centralized, implemented and beneficial to the success of the organization. In other words, management vision and control must include not only the responsibility but also the authority to allocate all available resources in such a manner to achieve the mission and goals of the organization.

Current Environment

Management of DHHS is a challenge not because of a lack of management vision or dedicated leadership; rather the challenge is created by the delegation of enormous responsibility without the independent authority to control the direction and management of the organization. Furthermore, there are a myriad of state and federal laws, rules and regulations that control the majority of DHHS endeavors. Most agree that DHHS has strong leadership in its Secretary and that agency directors are programmatically very committed; yet strong leadership is frustrated by the system in which it must operate. Instead of being nimble and promptly responsive to ever-changing population needs and programmatic mandates, DHHS operates in a system characterized by:

- “silos” of funding streams that limit flexibility;
- multiple layers of review which are time consuming, create disjointed decision making and may result in duplicative requests for information;
- a governmental tendency toward incremental change which may create less than desired outcomes in favor of modest modifications;
- growth in demand for services without a corresponding growth in resources;
- inflexible human resource rules and regulations that stymie management authority, productivity and morale;
- a patchwork of legacy systems that do not communicate or facilitate data sharing;
- a lack of systems to effectively support business processes;
- a historic emphasis on transactions and activities rather than outcomes and performance paired with a wariness toward process improvement analyses;
- a workforce that is spread over the entire state in more than 900 mostly outmoded buildings, 200 leased locations, and hundreds of private homes with LANs, telephone systems, calendar, and email software that are often incompatible, and
- external influences that demand immediate action to the extent that internal planning and control are difficult to achieve.

All of these factors contribute to an environment of frustration and a preference for avoiding the controversy and hassles that accompany change. A work environment with multiple layers of oversight and second guessing produces managers who learn to “make do” by working around system problems rather than solving them.

Key Operational Issues

Management is done by people using skills, information, and tools to conduct analysis and develop recommended courses of action to maximize utilization of scarce resources to achieve mission and goals. Yet, a review of the ten most frequently mentioned operational issues ([see page 144](#)) indicates that both programmatic and support agencies within DHHS do not feel as though they control the necessary resources to provide maximum performance. Out of the top ten issues the operational agencies list four as workforce related, two as process related and one as IT related. The programmatic agencies list three as workforce, three as IT and one as process improvement.

Over the last several years, DHHS senior management has promoted several performance based management initiatives—performance based contracts, creation of centers of excellence, development of a program management database, instituted a program review process, supported such system-wide program performance improvements as NCFast, placed a greater emphasis on customer service, and other efforts to improve the way we manage ourselves and our work. These initiatives are producing results; however, there are numerous operational issues that continue to hinder DHHS management direction and control.

Two of these issues are of pre-eminent importance—our workforce and our need to expand and improve IT resources. Like other governmental agencies, DHHS is facing a looming management “brain drain” that will greatly impact the future leadership of DHHS. Senior managers in most of our agencies are nearing retirement and wondering how and where to identify future leaders (see also the section on [Workforce, p. 18](#)). [On the Horizon](#), published by the Retirement System Division of the NC Department of State Treasurer, spring 2005, stated that “North Carolina is staring at a retirement curve that’s projected to climb steadily over the next 17 years, as more baby boomers leave work and retire. Over the 17-year period, retirements are expected to increase 141%.” Applying these numbers to a department as large and critical as DHHS paints a dire management future. Somehow we must eliminate current inhibitions on attracting, retaining, training and rewarding staff based on performance rather than longevity and programmatic expertise. If DHHS is not able to take immediate steps in this direction, how can future management vision and control be guaranteed?

Additionally, the department collects enormous amounts of information in autonomously designed and funded databases which cannot communicate with each other, thus creating information silos which impede department-wide analysis. These silos are created by both the perception and the reality of restrictive programmatic funding that limits access to information and that earmarks funds for particular purposes. Add to these the layered and time consuming review by IT, budget, contracting and other entities—internally and externally—and our reliance on legacy systems that date as far back as the 1970’s, and it becomes nearly impossible for department management to be nimble, quickly responsive and creative in its decision making. Updating IT needs in a timely and thorough manner would provide a new level of interoperability that will improve communications, reduce silos, and allow broader analysis and utilization of resources to better manage our day-to-day operations and to better serve the people of North Carolina.

Achieving Operational Excellence in Management Vision and Control

To address these operational issues and to achieve operational excellence, DHHS will continue several performance management initiatives currently underway to the extent that human resources and funding are available.

The performance management database (PMD) has become widely accepted as the source for information on programs and services throughout the department and has helped provide the performance foundation mechanism for the department. DHHS is one of the leading departments in the state with an existing and widely accessible database of such information. Utilization of the system to date has resulted in a broader awareness of programs available to residents, the development of a common language around outcomes and performance expectations, and facilitated review of program performance.

In addition to proceeding with recent system design improvements to the PMD, DHHS is moving forward with plans to combine the contracts database and the subrecipient monitoring database with the PMD to develop the first fully integrated management tool around programs. This will allow managers at all levels of the department to fully understand the relationship between program mission and goals, how services are designed to support those programs, and the connection between contracts with subrecipients who deliver those services and how effectively they are being monitored for outcomes.

The PMD also is being used for peer review of programs which offers opportunities for greater collaboration between similar programmatic agencies within the department and broader oversight of program and service performance than ever before. It is also being used to support block grant reports and the expansion budget process. The recent OSBM decision to implement results based budgeting is another opportunity to further utilize the PMD as a management reporting and decision-making tool.

To address the looming workforce challenges, the department has created a small work group to address workforce planning. One of the recommendations from the group was the creation of **LeadershipDHHS**. Now completing its third year, it has generating a lot of enthusiasm throughout the department. While this is proving to be a successful way of identifying potential future leaders who are interested in a long term management career in human services, if the state personnel system does not allow for proper recognition, reward for performance, modernized job descriptions to fit today's needs, and adjust salaries to market rates, **LeadershipDHHS** will fall short of its goal to foster future management.

A third way DHHS is addressing its management vision is through greater use of process improvements. The department has experienced success with efforts to make process improvements, most notably the consolidation of the criminal record check (CRC) function into one central unit which resulted in the elimination of backlogs for CRC requests in the child care arena. This same kind of analysis is underway in other areas also. As acceptance of the value of process analysis grows, there will be many opportunities for automating manual processes. As these are identified, it is especially important to conduct process improvement studies prior to automation of the many manual processes throughout the department and to design these solutions in an enterprise manner so as to maximize cost and utilization.

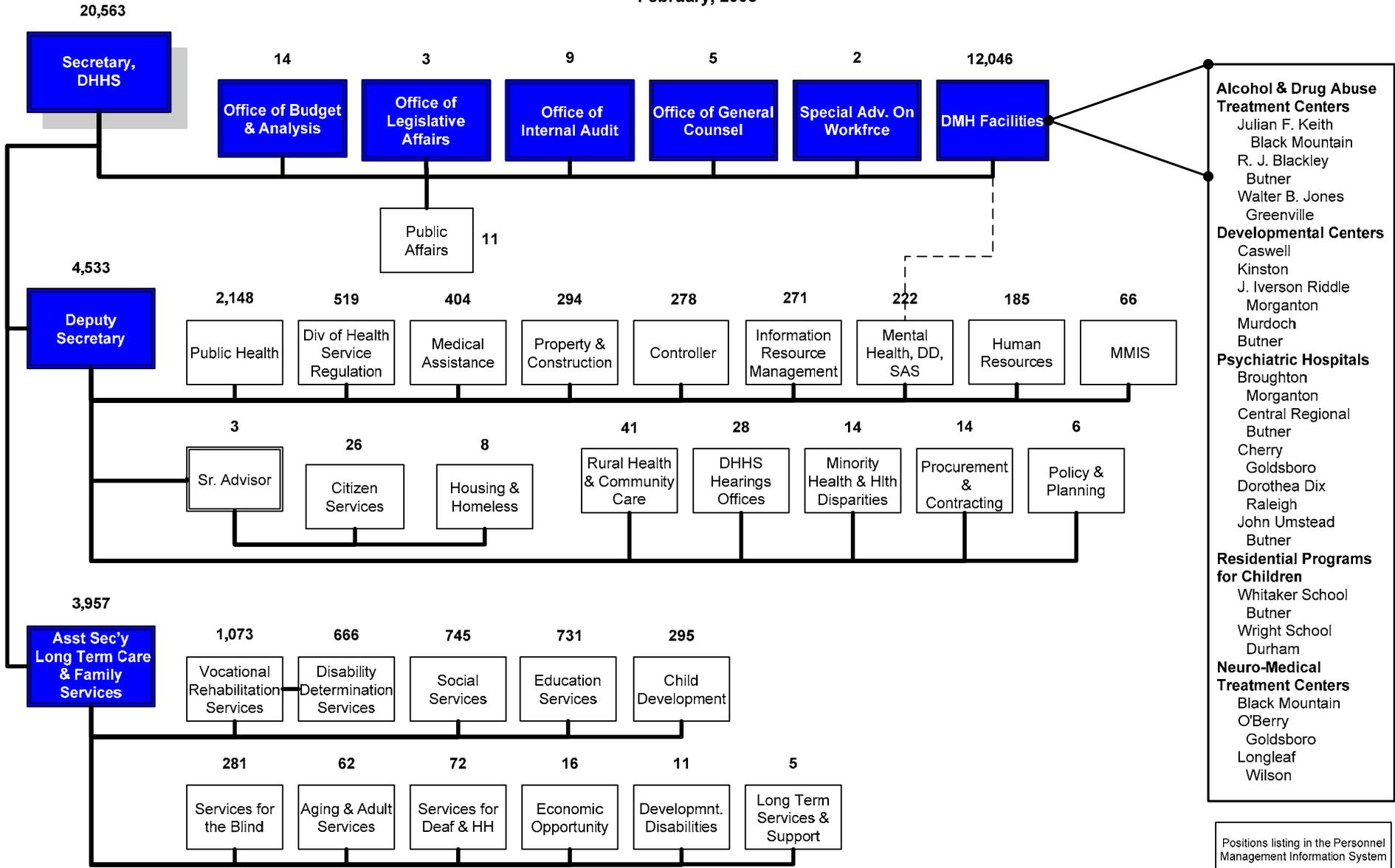
DHHS is currently studying the way it manages its public records. Millions of paper documents consume thousands of square feet of storage space, and yet frequently the "right" document cannot be found when needed. Electronic document management systems that provide scanning, archiving and search capability across the department are immediate requirements. Utilizing such capability will facilitate information sharing, provide additional workspace, secure vital records, eliminate a lot of paper handling and provide greater efficiency.

In addition to these specific efforts, current DHHS executive leadership has established a management culture that encourages cost containment, is supportive of setting performance expectations, strives to offer services that are evidence based and available in the community, places emphasis on keeping a consumer focus in program design and delivery, and has a growing awareness of the value of process improvements and better collaboration. Being successful at these things is predicated on management authority to maximize utilization of scarce resources (primarily human resources and information technology) to achieve mission and goals. This can only happen if other governmental oversight and systems support management, add value and enhance responsiveness.

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North Carolina Department of Health & Human Services

February, 2008



Information Technology

Information Technology refers to the management of all electronic information resources for the entire organization, whether managed centrally or under the control of individual divisions and offices. This includes hardware, software, networking and telecommunications technology utilized to facilitate the sharing of information, automation of business processes, management and analysis of business data, and support of general work functions to support business operations and achieve the organization's objectives.

The Current Environment

DHHS is one of the largest departments in NC state government with one of the largest IT budgets. The department has offices and facilities spread across the state. The number of programs and services administered through the department is in the hundreds, and at some point every person in the state is directly impacted by them. The work of the department is funded by many different sources, including numerous federal grants, state appropriations and private grants. Each of the different funding sources comes with its own set of compliance requirements, which makes collaborating around common initiatives difficult. The nature of health and human services work is complicated and diverse; consequently, identifying stable, repeatable processes is a challenge.

Nonetheless, the department has many strengths in the area of IT. Most notable is the elevated recognition that IT is critical to business functions. The department also has a wealth of data in many systems that support its programs and services and strong automated federal reporting capabilities. Also, as a result of the department's depth of knowledge about the needs of people with disabilities, IT is very supportive of accessibility requirements. Finally, though there are many legacy systems, creative problem solving has extended the life of these systems beyond expected life cycles.

The Division of Information Resource Management (DIRM) has the primary responsibility of providing leadership in the use of information technology. While some divisions rely heavily on DIRM to provide IT support, others have traditionally operated independently. Multiple efforts are underway to enhance IT in the department; for example:

- There is a growing emphasis to align essential IT functions throughout DHHS. Significant details have been learned about departmental IT activities as a result of business planning. Continual advancements in the department's IT responsibilities over the next few years are expected.
- DIRM has relied heavily on contract staff to fill voids in new technology. DIRM is currently in the process of replacing a significant portion of its consultant workforce with state positions. Initial training dollars have been identified to assist in continuing education for the current staff. This will require sufficient funding sources allocated on an annual basis for the training of employees in emerging and applied technologies. This approach will allow DIRM to provide the technology leadership needed to advance DHHS in the coming years.
- Senate Bill 991 has stepped up the state's efforts to better plan, budget and manage IT resources. This process has been a work in progress. Measures are now in place to regulate project management practices and authorizations. Internal DHHS procedures have been developed and implemented to support the Senate Bill 991 requirements.

While these improvements to the management of IT in the department positive, there will continue to be additional opportunities for DIRM to redefine its role and restructure its operations to better support departmental IT efforts.

Key Operational Issues

A total of 17 issues related to information technology were reported in the interviews and analysis. These can be seen in the Operational Issues Matrix in [Appendix 2](#) and can be summed up into four areas: Opportunities to Enable Business, Need for an Enterprise Approach, Legacy Systems and Accessibility.

Opportunities to Enable Business

Several of the issues identified reveal specific opportunities where IT that is standard in doing business can greatly enhance the business operations of the department. These issues are a need for better automation of manual processes, a need for ad hoc management analysis of data for decision support, and a need for electronic document management.

The most reported operational issue related to Information Technology, and the second most reported issue in all functional areas, is a need for more automation of manual processes. Throughout the department there are numerous business processes that are manual and paper driven. These include getting signatures for official documents when approvers are in multiple physical locations, receiving and paying invoices, and collecting data from external entities. There is significant opportunity to improve these and other situations through the effective application of IT in conjunction with process re-engineering.

Related to better automation of manual processes is a strong desire for electronic document management. One reason is a need to free space that is currently occupied by rows of filing cabinets and stacks of boxes. Another reason is the need to access important documents quickly and easily, regardless of physical location. A third reason is the need to more easily determine what documentation the department has. Finally, electronic documents would allow not only concurrent approvals and conserve staff time spent driving documents around for signatures; it would also decrease overall processing time.

A final enabling business issue is a need to access data for decision support and management analysis. In spite of the wealth of data residing in many systems, frequently managers cannot easily access that data to do ad hoc analysis. Usually, if a manager wants to get answers to a question from data, s/he has to involve IT staff which greatly delays getting answers and prevents IT personnel from working on other tasks. Powerful tools exist that put managers in the driver's seat when trying to access and analyze data, as is the case of the department's Client Services Data Warehouse (CSDW). An opportunity exists for educating leadership about this tool and incorporating more data in it to support things like evidence based decision making and evaluation of outcomes.

Need for an Enterprise Approach to Information Technology

Throughout DHHS, there are existing and planned systems that provide much value to the programs and services they support. However, it is not uncommon for functionality, such as patient billing, case management and various registries, to be duplicated in multiple systems. Smaller divisions see potential benefit from the functionality in applications being developed like NC FAST, but have difficulty getting their interests represented in such a system. For this reason, an enterprise-wide process to is needed to ensure that when the department invests in new systems or enhancements, a holistic view of its applications to the department is considered.

There is also a need for a more unified and consistent approach to managing the basic technology infrastructure. Some agencies have current computers that are being managed and kept up to date; others

have to make do with cast-offs from other state departments. Some office locations are supported by a help desk and technicians using standards for ticket tracking and issue resolution; others are not. Numerous historical reasons exist for this; however, such an approach is expensive and very difficult to manage.

A frequently expressed need was for enhanced sharing of data, yet two barriers were identified: lack of a technical link between related data or systems and a reluctance to share data. For example, all counties do not use the same system to track Child Protective Services cases. When individuals move across county lines, social workers who encounter the family in the new county have no idea that there was a Child Protective Services case in the other county. In this example, the parties involved are willing to share the data, but the technical links to do so are not in place.

The reluctance to share data seems to primarily result from fear of violating HIPAA or other security regulations and confusion over data “ownership.” While HIPAA and other security guidelines need to be taken seriously, fear of violating the guidelines sometimes causes unnecessary restrictions, such as preventing the analysis of de-identified data. To address this barrier, clear guidelines need to be established around data ownership, along with a process for arbitration.

While most agree that an enterprise approach to managing and delivering IT services is ideal, smaller divisions were concerned that their specific needs would be lost in the discussion. Others felt that expanding systems to meet smaller needs would drive up the cost and lengthen the implementation of such systems. Still others felt that guidelines coming from differing sources (e.g., departmental, state, federal) would potentially conflict and delay progress. It is clear that consistent, fair guidelines are needed to achieve an enterprise approach.

Legacy Systems

Outdated technology is mentioned frequently, but the risks remain great that the systems will become increasingly expensive to support and eventually become unsupportable. The current issue with most legacy systems is that making enhancements is very difficult. Fortunately most of the large IT system projects currently underway will replace legacy systems.

Accessibility

Accessibility is important both to DHHS staff and to external business partners. It is common for employees to work in the field (such as conducting inspections) or actually be located in the field (such as vocational rehabilitation counselors who are located in the schools). In most instances, these employees are not able to access information resources back at the office nor do they have mobile tools, such as laptops, that would greatly improve their efficiency in remote locations and assignments. Instead, these workers must take notes and complete paper forms and then enter them electronically once back at the office. They are also not able to answer questions where they have to look up information. These workers need the tools to work effectively remotely and be able to access the information resources of the department. Also, employees who are not field workers would benefit from being able to access information resources when there is need to work from home.

Additionally, for those divisions with remotely located staff, it is difficult to have routine staff meetings that do not involve the extra expense and downtime of travel. Videoconferencing technology would not only allow face to face communication but would also be available for remote training and communications with constituents.

Another accessibility issue reported related to external business partners (such as universities, non-profits and other state agencies) being able to access information. This type of access would be more than what is available to the general public through public web sites.

While IT enables effective distribution of department information to employees and enables employees to manage their own human resources information online, not all employees at DHHS have computers. These include nurses in the hospitals, custodians and maintenance personnel. To ensure that information management strategies do not leave out these employees, the department needs to make the resources available to them through kiosks or other means.

Finally, any application or web site developed in the department must be accessible to people with disabilities of all kinds, both mental and physical. Fortunately, many in the department are already aware of this need and will continue to keep it in the forefront.

Achieving Operational Excellence in Information Technology

In the 2006 Business Plan, the need for establishing an IT governance board staffed primarily with business leaders from the department was identified. Nearly a year ago, DHHS created the IT Governance Committee (ITGC) to help coordinate the many IT needs of the department. The committee is composed of DHHS “business owners” and others who bring a department-wide focus to IT project discussions since ultimately every IT decision is a business decision not a technological decision. Furthermore, since there are very few divisional business decisions that do not also impact other divisions’ operations, the IT governance board ensures that business needs drive technology decisions and that a holistic, organization-wide approach is taken for IT initiatives. As recommended in the 2006 Business Plan, the authority for the ITGC is founded on a secretarial directive.

Even with the creation of a governance board, lack of funding could undermine both one-time and recurring needs. Each year the department struggles to locate enough money to cover basic IT operating costs, including funds to identify, hire and retain the proper human resources to support a department as vast as DHHS. Recent OSBM instructions which limit the availability of lapsed salaries takes away one more available source of funds.

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Workforce

Workforce is defined as all the people working or available to work in the Department of Health and Human Services. As it is used here, it does not refer to any particular human resource office or function; it refers to the staff in aggregate that performs the daily acts of government within the realm of DHHS.

Current Environment

DHHS benefits by having a diverse, experienced workforce of (approximately 20,000 employees) who have strong program and technical expertise and a commitment to serve the public. Skills and education levels range from those at entry level positions with less than high school degrees to professionals with degrees in business, engineering, health and social sciences, to nationally recognized experts with advanced degrees including PhDs, physicians, psychologists, psychiatrists and attorneys. Of the roughly 3,500 job classifications in the state, DHHS employees occupy more than 2,000, demonstrating the scope and diversity of the workforce. DHHS employs over 20% of all government employees in North Carolina.

Over half of these employees are involved in direct service delivery to the public, usually in specialized settings such as a psychiatric hospital or vocational rehabilitation center. While programmatic and service expertise are primary skill sets, an increasing number of DHHS employees spend much of their time managing partnerships with private companies, nonprofits, and federal or local governments. In these settings, business expertise such as finance, accounting, contracting and negotiating are the primary skill sets. Supplementing this workforce are about 2,000 contractors, temporary employees, students and interns. The Division of Information Resource Management (DIRM), which has traditionally relied on a large contract workforce composing up to 40% of its population, is actively recruiting full time employees to replace many contractors in areas where it is essential to retain a knowledge base within the DHHS workforce. Progress has been slow, in part because contractors with specialized IT skill sets have been able to command higher salaries than those paid to state employees.

Overall, DHHS turnover averages about 15% annually, which translates into a need for hiring nearly 3,000 people each year. The majority of open [positions](#) listed for DHHS are for critical nursing or nurse aide and related positions in the divisions of Health Service Regulation, Mental Health, Medical Assistance and Public Health. Many more positions remain unfilled for clinical social workers, occupational and physical therapists, physicians, psychologists, other health care specialists, and information systems personnel.

Part of the turnover in DHHS is due to retirements. By the end of 2008, slightly more than 20% of the workforce will be retirement eligible, including a high percentage of senior managers. An [additional](#) 29% will become retirement eligible by 2016. When added to other attrition, shortages in needed skill sets such as nursing, and a highly competitive job market in general, the result often is a very thin skills base in key areas that stresses the workforce and inevitably impacts performance.

The [chart](#) on page 24 illustrates another aspect of attrition. Over 50% of DHHS employees have from one to five years of service. After five years, however, the percentages drop rapidly, indicating that the department cannot sustain new employment for a large percentage of its workforce. This attrition at the front end combines with retirements at the back end to squeeze the resources in the middle which too often lack the numbers and the expertise to perform effectively.

For example, in almost every division contract administration has suffered by turnover of experienced administrators who are primarily responsible for writing the Statement of Work (SOW) that is the key portion of contracts. The SOW includes programmatic requirements, funding sources, performance measures, and payment and compliance criteria. Administrator mistakes, omissions and rewrites extend an already burdensome approval process, increasing costs and often resulting in missed deadlines. Many contracts end up with inadequate performance criteria or program/service specifications because there are not enough qualified resources to review and revise all of the documentation.

While DHHS managers almost universally complain that they cannot offer attractive wages to hire qualified candidates, especially in nursing, engineering and information systems, there have been some improvements made, especially for nursing positions. The Division of Social Services and Division of Mental Health/Developmental Disabilities/Substance Abuse Services have found that wages at the county level often exceed those paid by the state so that recruiting experienced personnel from county offices is difficult; and, in the case of executive personnel, nearly impossible.

Like other state departments, DHHS wages have fallen behind market averages. In the period 2000-2005, state wages increased at less than ½ the rate of inflation. More recent increases have been better (5.5% in 2006 and 3% in 2007), but it would take several years of sustained increases above market rate to bring the total workforce up to market parity. With inflation projected to be higher in coming years and with continued pressure on the state budget, the prospects of achieving market equity soon are not good. As discussed in Management Vision and Control, the department has initiated *LeadershipDHHS*, a program that seeks to identify and develop future leaders in DHHS. While this program is not a solution for the lack of workforce planning in the divisions, it has been well received and is a positive step to address some of the turnover and recruitment issues that otherwise seem intractable.

Key Operational Issues

As of April, 2008, DHHS replaced its outdated personnel system with the state's new integrated personnel/payroll system called BEACON, an acronym for Building Enterprise Access for North Carolina's Core Operation Needs. The system maintains standard employee and position data such as hire date, classification, position, demographic information, organizational assignment, salary information, employment status and grievance information. But it is much more than a repository. BEACON is a statewide collaborative effort designed to transform the way North Carolina does business by modernizing and standardizing key business processes in human resources, payroll, data storage and accounting. More and more benefits will emerge as the conversion effort proceeds throughout 2008.

During the development of the 2006 Business Plan, top managers of divisions and offices throughout DHHS were interviewed. In 2008, questionnaire information indicated very little deviation from 2006, therefore the one-on-one interviews were skipped. However, in 2006 and 2008, the most frequent and consistent comments centered around human resource issues and the difficulty encountered by managers attempting to navigate the state's personnel policies and regulations. Managers were nearly universal in their opinions that if one thing could be fixed in state government, their choice would be the "personnel system." By this, they mean a broad range of personnel issues including classification and pay for performance, recruitment and personnel selection, disciplinary appeals and grievances, contracting, organizational responsibilities and training.

Personnel reform in the public arena is not easy. It is a lengthy, complicated process requiring political consensus of diverse constituencies and usually has mixed results. Still, several states have dealt with the issues and claim progress in many areas. These states include:

Arizona	Maryland	Pennsylvania
California	Massachusetts	South Carolina
Colorado	Minnesota	Texas
Florida	Nebraska	Washington
Georgia	New Mexico	Wisconsin
Illinois	New York	Virginia
Louisiana	Ohio	

In North Carolina, the few efforts to change the system seem to have occurred in isolation with little or no public debate and have not had a significant impact on changing the work environment for state employees.

One division referred to legislation ratified in 1997 that required personnel policy changes to ensure that only those applicants who clearly exceed job requirements are hired. The subsequent DHHS Merit-Based Employment Plan defines “highly qualified employee” and directs that “only applicants designated as highly qualified shall be interviewed” for open positions. In actuality, the policy appears to be ineffective in some divisions. While recognizing that an experienced workforce is essential, a senior executive lamented, “The state’s primary criteria for filling a job seems to be longevity rather than skills and abilities—in contradiction to the General Assembly’s intent in producing the Merit Based Employment policy.”

When asked for examples, managers relate experiences where they have spent weeks or even months justifying new hires, transfers, classification changes, or pay adjustments to obviously qualified employees. Managers spoke of instances where HR denied requested pay grades because the state’s job specifications either did not recognize or did not assign significant value to operational skills such as business, finance and contracting. “Too many of our job specifications are clinical,” complained one manager, “and do not adequately reflect operational expertise needed in today’s world.”

Some divisions have had success in negotiating the complicated, bureaucratic HR process, while other divisions have simply given up their attempts to advocate for needed changes. DHHS Human Resources does an admirable job in “managing by exception” to respond to management requests and negotiate the personnel bureaucracy to achieve results. The problem is that these are work-around efforts and do not have long-term systemic improvements. Rules, regulations, legislation, culture and lack of autonomy all conspire to inhibit the department’s efforts to move faster and respond to the competitive labor environment.

To address non-competitive pay issues, HR has persuasively argued for special monies to be applied to various nursing and other direct care positions. Less successful techniques used to obtain increased pay for high performing employees include creating vertical reporting structures that create unnecessary supervisory positions, documenting increased scope of work to obtain in-range increases, and petitioning OSP for job reclassifications. All of these activities are time consuming, are often artificial, and ultimately do not solve most of the issues surrounding employee compensation. In fact, other problems may arise such as perceived inequity in the workforce among employees who do not benefit from special increases, poor communications across or up and down the vertical reporting structures, and inaccurate descriptions of job duties or requirements.

Proponents of personnel policy reform are at odds with an embedded culture that encourages homogeneity in pay and performance. Because many managers try to work around a system that is not meeting their needs, HR all too often is required to be the enforcer rather than the enabling business partner.¹

Other change initiatives have proved to be difficult. In the past several years there has been a major effort to introduce a new career banded job classification system in NC. Briefly, career banding (also referred to as “broadbanding”) is a way of changing from traditional, narrowly defined job classifications to a system of broad occupational career paths. Career banding is not an end objective; rather, it is a means to an end, that being to provide more flexibility in pay progression, competitive recruitment of quality candidates, and advancement within the bands based on performance or achievement of established competencies.

As part of the implementation effort, career banding was piloted in the state’s information technology sections. In explaining the system in the context of retention and recruitment, the Office of Information Technology Services (ITS) writes “... broadbanding is increasingly popular in the private sector. In addition to being used to bring salaries in line with performance it is a motivator towards creating more of a team environment, breaking down barriers, and instituting cultural change.”²

Despite these positive statements, career banding in this state has been suspended, largely due to opposition from constituencies that either do not agree with the goals or do not believe that the issues have been articulated properly in public debate. While the benefit of career banding to state employees may be debated, DHHS managers mutually agree that the present system of classifying and rewarding employees must be reformed if the department is to move forward.

Despite the setbacks, at least one change initiative is proceeding. As stated in the DHHS Human Resource profile included in Part II of this business plan:

DHHS management and HR must participate more fully as partners in strategic planning for program operations. Improved technology through implementation of a robust Human Resource Information System (HRIS) is a key to helping HR become consultative and less transactional by redirecting resources to organizational planning and workforce development. Moving to a consultative HR is enabled by HRIS providing a mechanism for management to access HR information, including more involvement in workforce planning. In addition, substantial numbers of DHHS employees have internet or intranet access, permitting more educational offerings to be developed by HR as web-based classes.

It remains to be seen, however, whether a technology enhancement will truly enable change where the system has traditionally rewarded regulation, rigidity, homogeneity and compliance. The bottom line is

¹ The following quote is from a white paper published by the Pioneer Institute for Public Policy Research:
“Unfortunately, civil service rule rigidity and enforcement have become something of a self-fulfilling, self-reinforcing proposition. As civil service systems have become more rigid, the inclination on the part of agencies to sidestep the rules has increased and the inclination of central personnel departments to crack down on rogue agencies has increased proportionally. Growing numbers of jurisdictions—including states and localities—have been able to break this cycle, however. In such places, there has been a gradual but significant shift in the role—and even more important—the attitude of the central personnel office. In at least two dozen states, personnel executives are working hard to reengineer their relationship with their agencies. Some of the leaders in this effort include Florida, Nebraska, Michigan, Connecticut, Wisconsin, Kansas, Washington, and New York. In these states, personnel executives have begun to view themselves as consultants who work for their “customer” agencies.” (Walters, Jonathan, Pioneer Institute for Public Policy Research - White Paper No. 13, September, 2000)

² North Carolina Office of Information Technology Services, IT Professional Retention and Recruitment, 2006

that the tools given to managers today are not adequate to deal with the host of workforce issues facing the department. DHHS Human Resources recognizes this, but is not empowered to act independently of the rules and regulations established at state-level.

Achieving Operational Excellence in Workforce

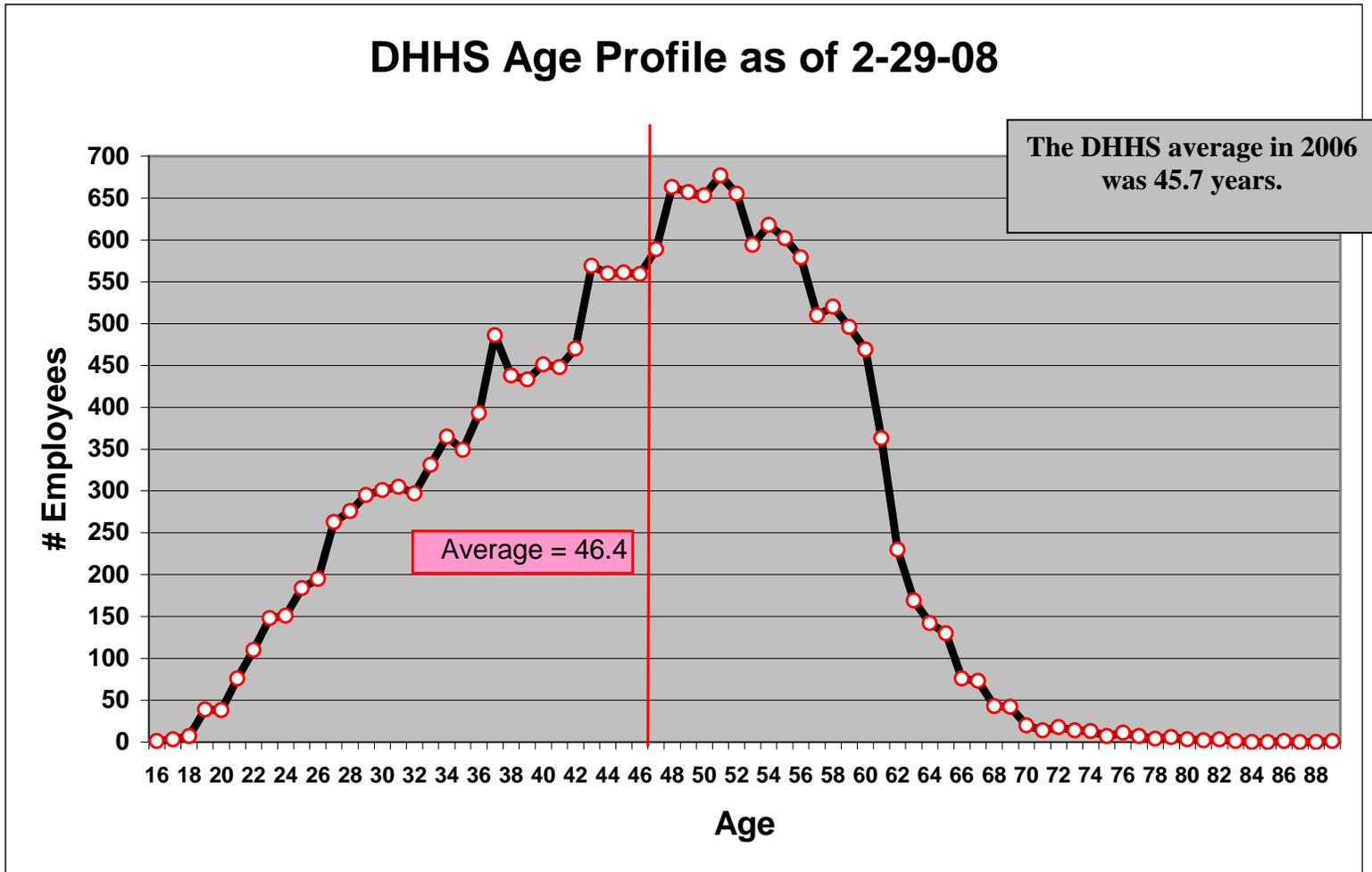
In the absence of comprehensive policy reform at the state level, there are certain tools in DHHS that can be used to measure improvement in workforce status and performance. In addition to those presented in the Human Resources profile in Section Three of this document, operational managers must assume responsibility as managers of the department's "human resources." For example, even though DHHS does not have a formal workforce planning process, this does not prevent individual divisions and offices from participating in the *LeadershipDHHS* program and establishing their own workforce plans for managerial and supervisory positions. To establish these workforce plans, managers must have the flexibility and authority to identify and develop the best and brightest candidates and designate them as high potential employees.

HR must ensure that all divisions and offices annually update job descriptions and work plans to reflect the actual competencies, skills and abilities required for each position. Managers must identify and fund individual training requirements, both technical and developmental, that correlate with needs identified in work plans, performance reviews and departmental expectations. When it becomes necessary to fill a job, the hiring process must be simplified so that candidates can be identified and hired within weeks, not months. While DHHS HR has made progress in reducing the time required to fill positions once they are vacant ([see page 119](#)) and some hard to fill positions may always take time, HR is exploring many opportunities to improve the hiring process such as enhancing the Job Opportunities website and implementing a comprehensive electronic application process.

Even though much of the HR agenda is externally controlled through the State Personnel Act (such as career banding and classification, pay for performance, etc.), DHHS management will continue to advocate for progressive changes that will aid—not hinder—management in recruiting, retaining and rewarding good performers.

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DHHS Age Profile as of 2-29-08

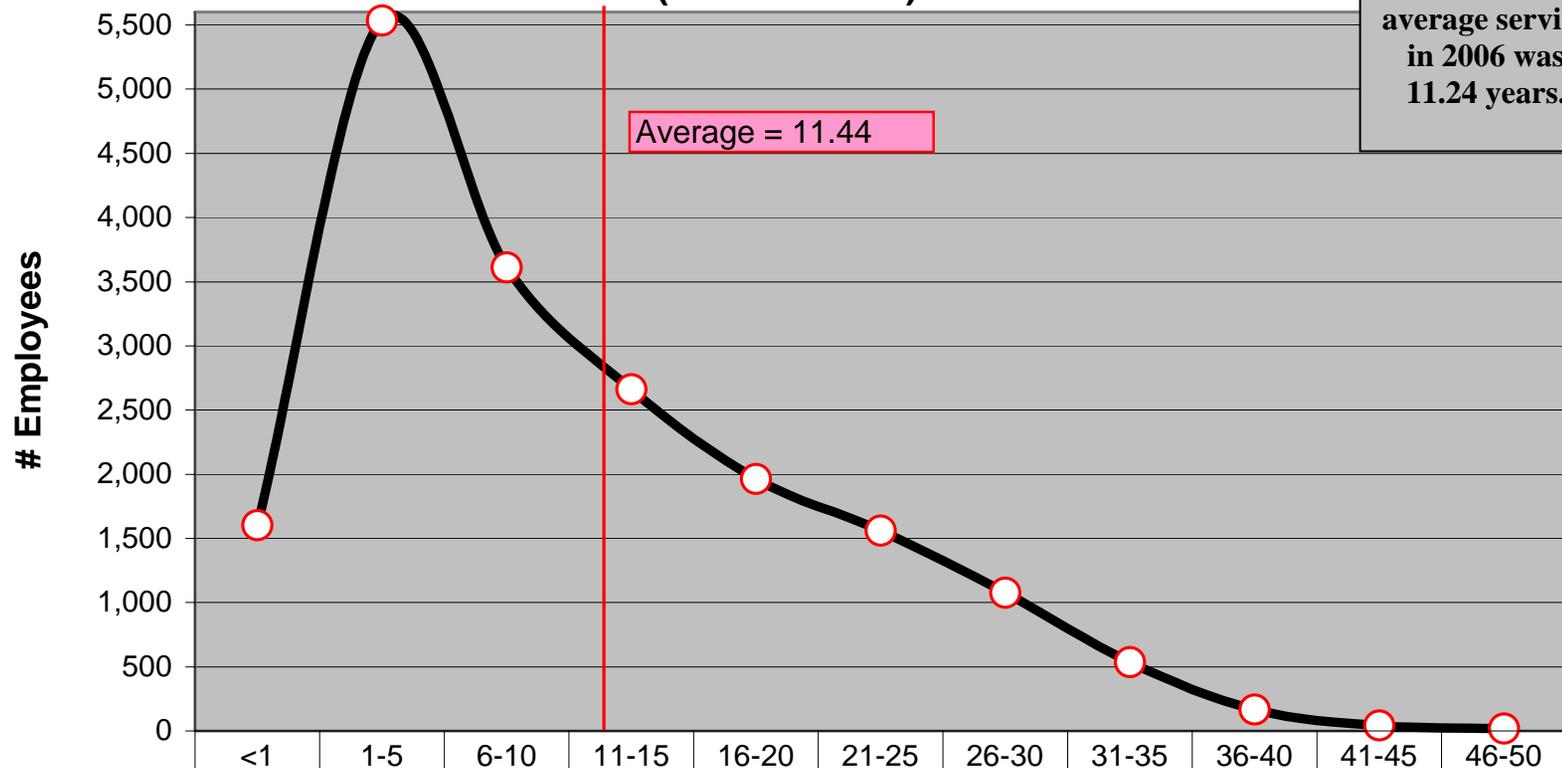


Age	# Emp	22	110	30	301	38	438	46	559	54	618	62	230	70	20	78	4
16	1	23	148	31	305	39	433	47	589	55	602	63	169	71	14	79	6
17	3	24	151	32	297	40	451	48	663	56	579	64	142	72	18	80	3
18	7	25	184	33	331	41	448	49	657	57	510	65	130	73	14	81	2
19	39	26	195	34	365	42	470	50	653	58	520	66	76	74	13	82	3
20	28	27	263	35	349	43	569	51	677	59	496	67	73	75	7	83	1
21	76	28	276	36	393	44	560	52	655	60	469	68	43	76	11	86	1
		29	295	37	486	45	561	53	594	61	363	69	42	77	7	89	1

DHHS Population By Service

(As of 2/29/08)

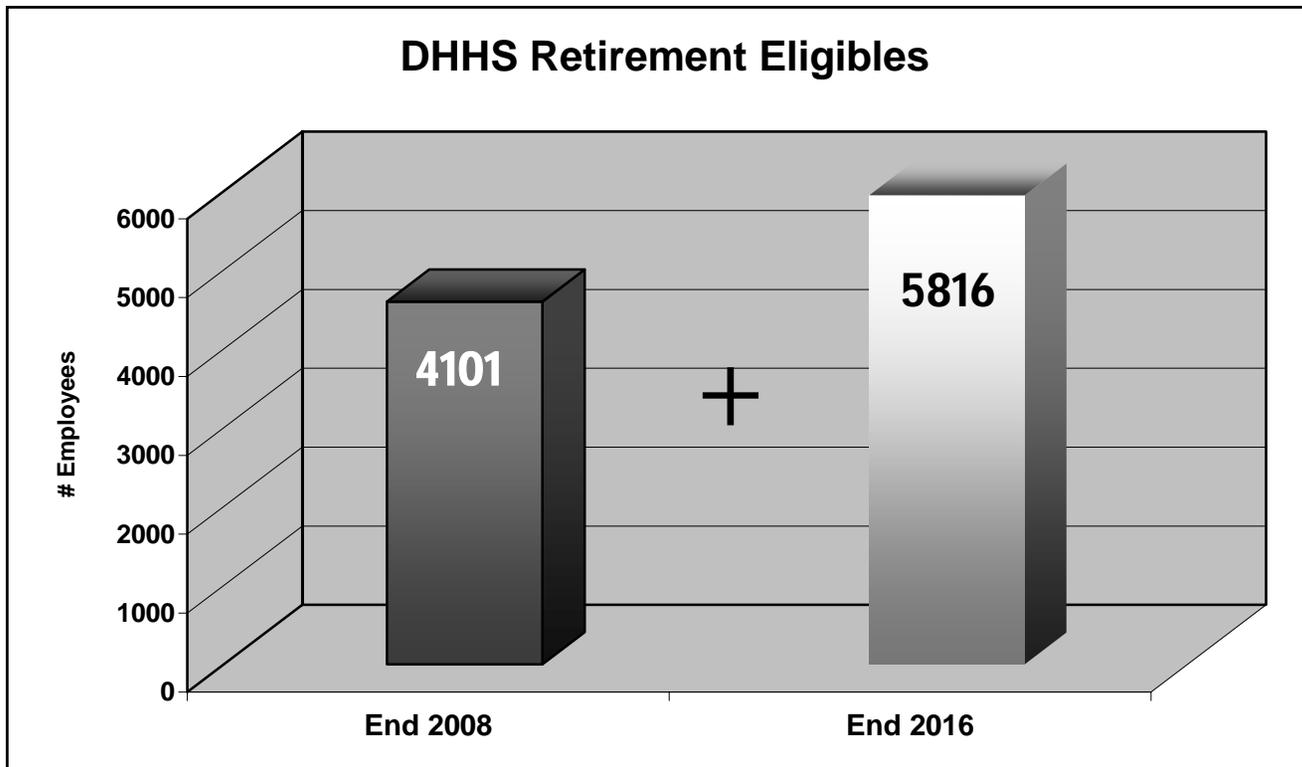
The DHHS average service in 2006 was 11.24 years.



○—# Employees	1,604	5,533	3,611	2,660	1,962	1,559	1,076	535	165	43	18
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Service	# Emp	4	864	10	612	16	406	22	368	28	245	34	70	40	22	46	4
		5	619	11	548	17	341	23	413	29	197	35	66	41	15	47	2
<1	1,604	6	699	12	569	18	396	24	293	30	174	36	40	42	9	48	4
1	1,522	7	868	13	594	19	425	25	229	31	149	37	39	43	11	49	3
2	1,248	8	714	14	489	20	394	26	235	32	114	38	30	44	5	50	5
3	1,280	9	718	15	460	21	256	27	225	33	136	39	34	45	3		
																Service	# Emp

Retirement projections are that 20% of the workforce will be retirement eligible by year-end 2008 and an **additional** 28% can retire by year-end 2016 (individuals in column one are not included in column two). These projections are based on the current workforce profile and do not factor in demographic changes that might occur.



The "Retirement Eligible" population was estimated based on projections for 12/31/08 and 12/31/16. "Retirement Eligible" is defined as any employee who will achieve the following by those dates: (1) 30 years of service regardless of age (2) Age 50 with at least 20 years of service (3) Age 60 with at least 5 years of service (4) Age 65 with at least 5 years of service.

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Program and Service Delivery

In a private sector business plan, this functional area would be called “Product” and would address such issues as: is there still a need for the product, is demand for the product increasing or decreasing, are customers of the product satisfied, have our customer needs changed, and who else is manufacturing the same or similar product. Many believe that government does not have a product, but in fact it does—government’s product is the service it delivers to the public. In The Change Agent’s Guide to Radical Improvement, Ken Miller defines a product as “something created by work which can be given to someone else to achieve a desired outcome.” This is the definition used in this business plan.

Current Environment

Programmatic expertise within DHHS is very strong; and, supported by federal and state requirements as well as funding, the department provides a wide array of services to North Carolina residents. As part of this business planning process, DHHS agencies provided information about the impact of demographic factors on their operations. It is important to note that the top three issues mentioned by the programmatic divisions of DHHS were: workforce, information technology, and program and service delivery. In fact, they were mentioned eight out of ten times. This indicates the strong need for operational support improvements around HR and IT to improve and support long term stability of program performance and delivery.

Not surprisingly, in the operational units, program and service delivery is not mentioned. However, mentioned in five out of ten were workforce and IT—again showing the strong link between HR and IT to provide the operational strength of the department necessary to efficient program and service delivery. (See [Appendix 3](#) for a summary of all demographic influences identified during this business planning process.)

As expected, programs are impacted by North Carolina’s population growth, an increase in the number of elderly residents, a surge in the immigrant population, increasing demands for multi-lingual and multi-cultural state and local staff, economic fluctuations, health care cost increases and other factors. As demand grows, staff serving the recipient populations need to be flexible enough to change; yet DHHS is experiencing shortages of certain specialties (nurses, psychiatrists, dentists, architects, for example) and often is trying to place people with new skills into positions with out-of-date job classifications and compensation. Some of these skill shortages are national in nature and reflect an imbalance between supply and demand; others are shortages created by the unwillingness of these highly trained and skilled professionals to work for the state at noncompetitive pay levels. Additionally, North Carolina’s more diverse population places language and cultural competency requirements on how we communicate and deliver services. This combination of internal handicaps paired with the external limitations and demographic changes stresses the department’s service delivery system.

Over the last several years there has been a national emphasis on program outcomes, consumer choice, seamlessness of service delivery, providing services in the community rather than in institutional settings, designing services around evidence based practices, cost containment and a growing awareness of the need to move from treatment of chronic problems to prevention. All of these are excellent improvements to program and service delivery because they strengthen the benefit of the service and lead to greater efficiencies in the use of resources; but to respond to these new expectations, the department must be

nimble enough to change in a timely manner. Unfortunately, program and service redesign is limited by funding stream restrictions and a reliance on legacy IT systems that are decades old.

Key Operational Issues

Throughout the years North Carolina has developed a wide network of community partners which provide services directly to the people. DSS and DPH state supervised, county administered systems have fostered the development of strong networks within the 100 counties that facilitate resident access to services. The Community Care of North Carolina (CCNC) program has built a strong network by partnering with local clinics and hospitals to further reach out to those with a need for primary health care who reside in underserved areas. Creation of Local Management Entities to push mental health, substance abuse and developmental disability services away from institutional settings and into the community further expands the state-wide network supporting service delivery. And, of course, there are numerous regional staff which allow the state to have a presence, in some cases deliver services, and conduct outreach and supervision. Such a large network of providers does, however, require communications, tracking and monitoring systems to fully maintain control and supervision.

Additionally, while this network meets many program and service outreach and delivery goals, it is hindered by DHHS' inability to share client data and to conduct cross program case management. An example of how the department is working to overcome this obstacle is NCFAST. NCFAST will facilitate better eligibility determination and case management, but this system has been evolving over a lengthy period of time and faces regular funding review and challenges.

Technology is changing fast in the healthcare field. Tele-medicine allows doctors to remotely interact with patients. E-health records allow for faster and more accurate recording, transmitting and sharing of individual patient records. While these new technologies offer amazing efficiency, improved service, and allow for extending care, the state is building the new Butner hospital without the appropriate information infrastructure. Without additional funding support, a facility originally envisioned to be state-of-the-art will operate without the appropriate clinical systems.

As mentioned previously, DHHS has built a program management database (PMD) which stores program and service information in a web based, central location easily accessed by management at all levels. The PMD contains such information as funding, program and service description and goals, outcomes and output measures. The PMD and associated activity have been important aids to statewide efforts to revise and reform the budgeting process through Results Based Budgeting.

Achieving Operational Excellence in Program and Service Delivery

DHHS most intimately interacts with North Carolina residents in the delivery of direct services. One way to achieve excellence is to keep the focus on customer service when evaluating and designing programs and services to meet specific needs of the population. DMH/DD/SAS is already in the process of moving services from institutional to community settings, making services more accessible and seamless through our local network of partners, and offering a wider array of services to meet varying consumer needs. Routine use of a nearly completed web-based customer service survey tool will provide an additional avenue for getting feedback from consumers and using that information to improve service design and delivery. Additionally, the telephone based information and referral service, Care Line, and the relatively new NCcareLINK, the web based information and referral service, were expanded in 2007 to provide greater customer service.

Graphical information system (GIS) data allows for better management of emergency situations and program and service distribution and allocation; and many DHHS agencies, from DPH to Property and Construction and DHSR, express a desire to make greater utilization of this technology. The Division of Services for the Blind specifically mentions the need to develop closer interaction with manufacturers of assistive technology because advances in that field offer improved independence for their constituents.

The PMD program review process helps break down information silos and identifies areas for improvement through greater collaboration—all extremely important since more than one agency may serve the same intended beneficiary. Additionally, the usefulness of the PMD will increase as the system is expanded to include the contracts database and the subrecipient monitoring database. In 2008, the department plans to implement a program evaluation process using information contained in the merged PMD system.

Since many divisions serve similar populations, and since the availability of data is critical to establishing performance measures, it has become increasingly clear that more client specific data needs to be shared. Granted, confidential information must be protected, but opportunities exist to provide better service and make better utilization of resources when information can be shared and analyzed for multiple uses. One opportunity to do this is to expand on the already existing Customer Service Data Warehouse (CSDW) and to create greater flexibility in how that data is used.

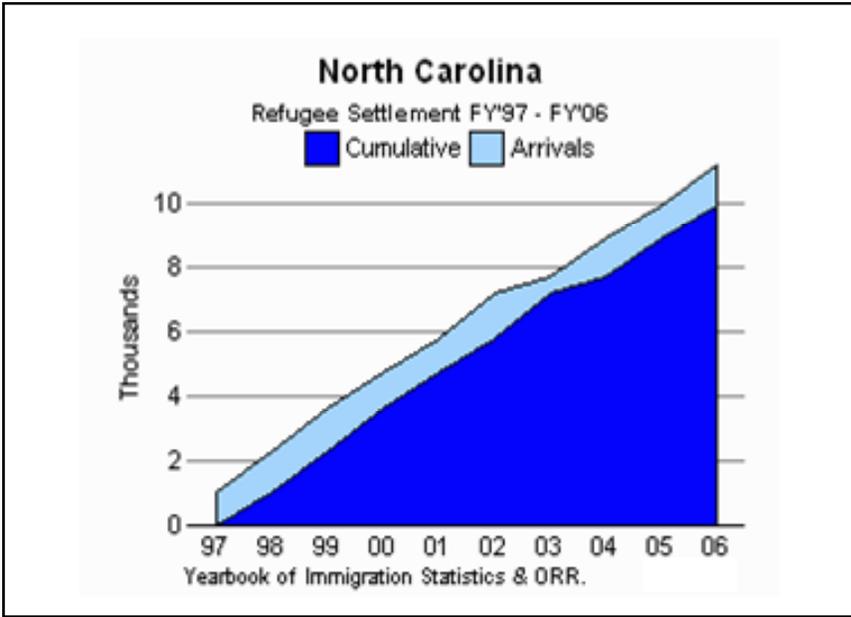
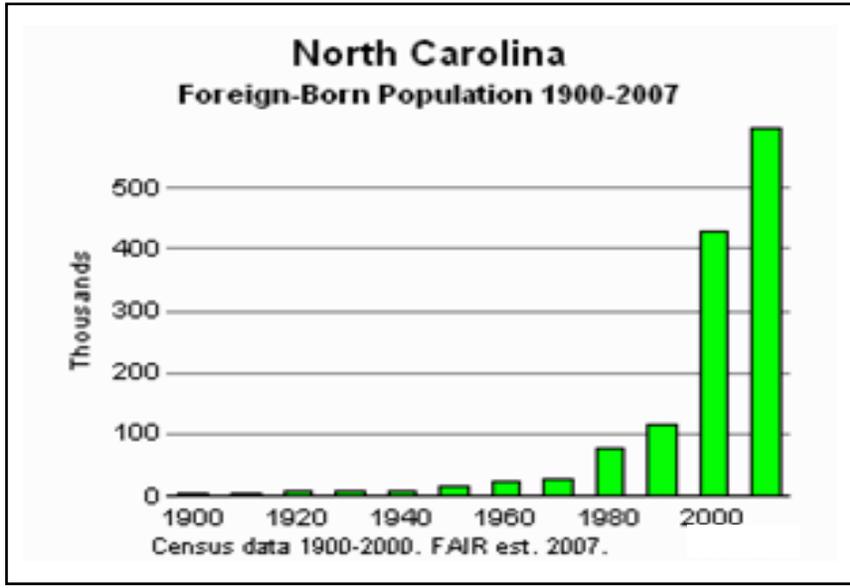
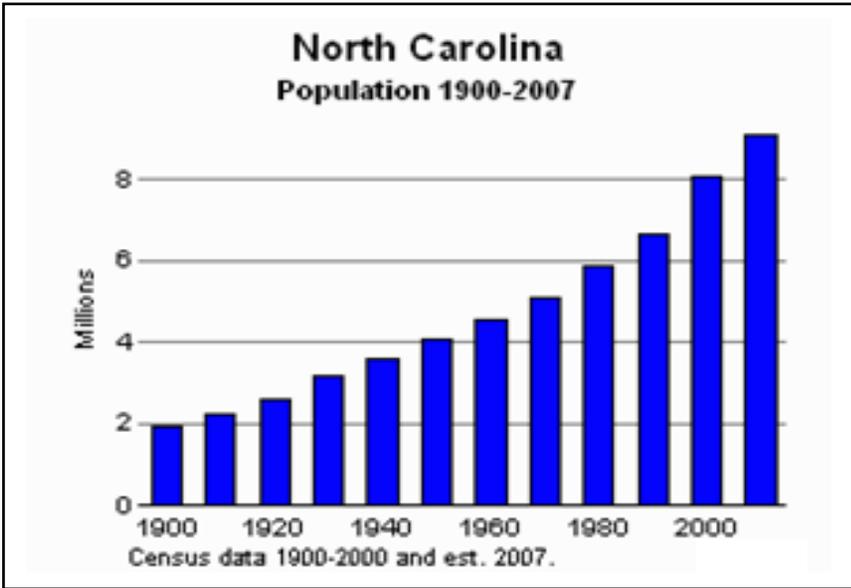
Additionally, several agencies mentioned the need for more extensive outreach to residents in need of service. Others are struggling to meet growth in demand for services without reciprocal growth in resources and are trying to develop better cost containment strategies without impacting the level of needed assistance. DPH believes that program design and outreach would benefit from better race information. Apparently this is not collected as extensively as desired, mostly because intake staff is often reluctant to ask such questions of the public needing assistance.

In sum, programmatic expertise and commitment are strong, and creative and technical solutions are being utilized, but improvement opportunities exist. DIRM has played a significant role in the development of the PMD, design and maintenance of the CSDW and still-evolving customer service survey tool; but their limited staff resources and the department's IT funding limitations make these improvements protracted and frustrating. The department will continue with these and other improvements to the extent that human and financial resources are available.

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**Summary of Demographic Influences Impacting DHHS Programs
(From Responses to Business Plan Questionnaires)**

SUMMARY			
Group	Trend	# Response	Rank
A	Aging Population	14	1
C	Immigration issues, especially Hispanics who don't speak English	13	2
B	Growth of eligible populations (Aged, Children, Disabled, Poor, etc)	10	3
F	Budget shortfalls / issues	10	3
L	Unemployment / layoffs / plant closings	7	5
E	Cost of care / services increasing	6	6
D	Individuals / families in poverty or minimum wage	5	7
Q	Decrease in providers / unavailability of providers or services	5	7
U	Decrease in rural industries / movement from rural to urban	4	9
G	Natural disasters	3	10
H	Technology advances, including medical technologies	3	10
K	Increase / transition to community services	3	10
M	Multiple disabilities / conditions	3	10
P	Aging Workforce	3	10
S	Aging Facilities / Equipment	3	10
T	Recruitment issues / shortages of nurses and other professions	3	10
I	Rise / Fall in Economy	2	17
R	Federal teaching requirements	2	17
V	Job market skills changing	2	17
W	Growth in uninsured	2	17
X	Increasing HS drop out rates	2	17
J	Increase in single parent families	1	22
N	Unfunded mandates	1	22
O	Obesity and associated health risks	1	22



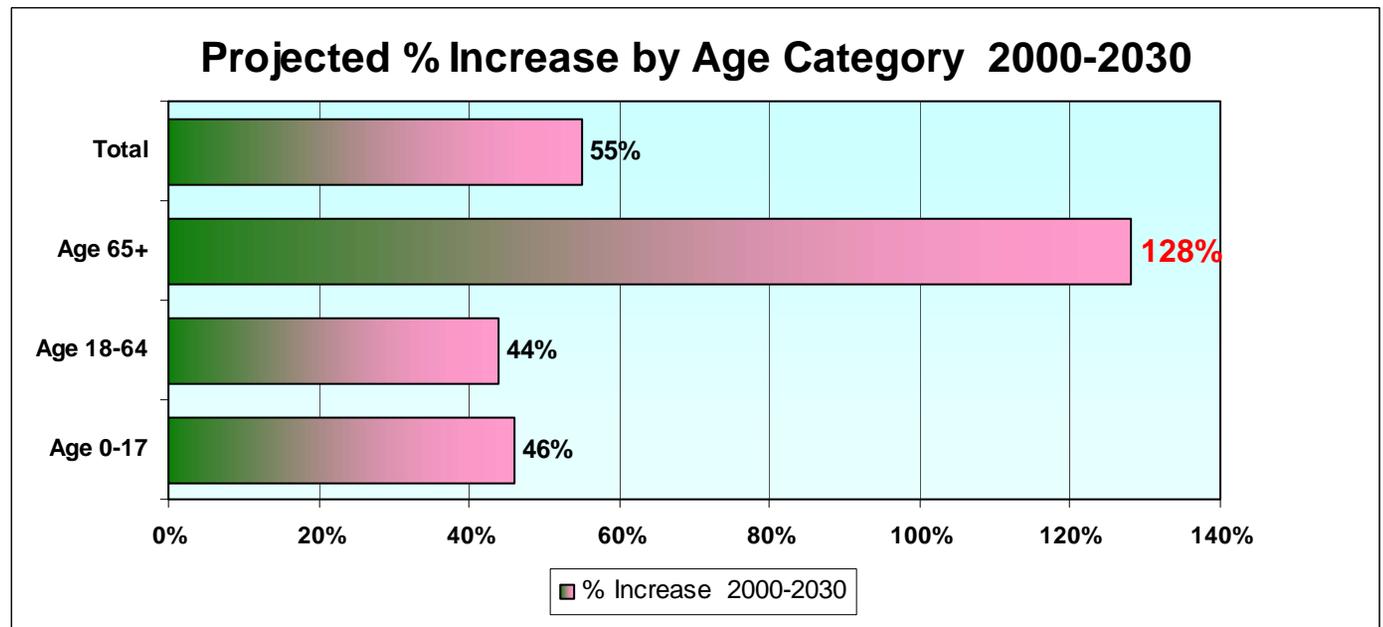
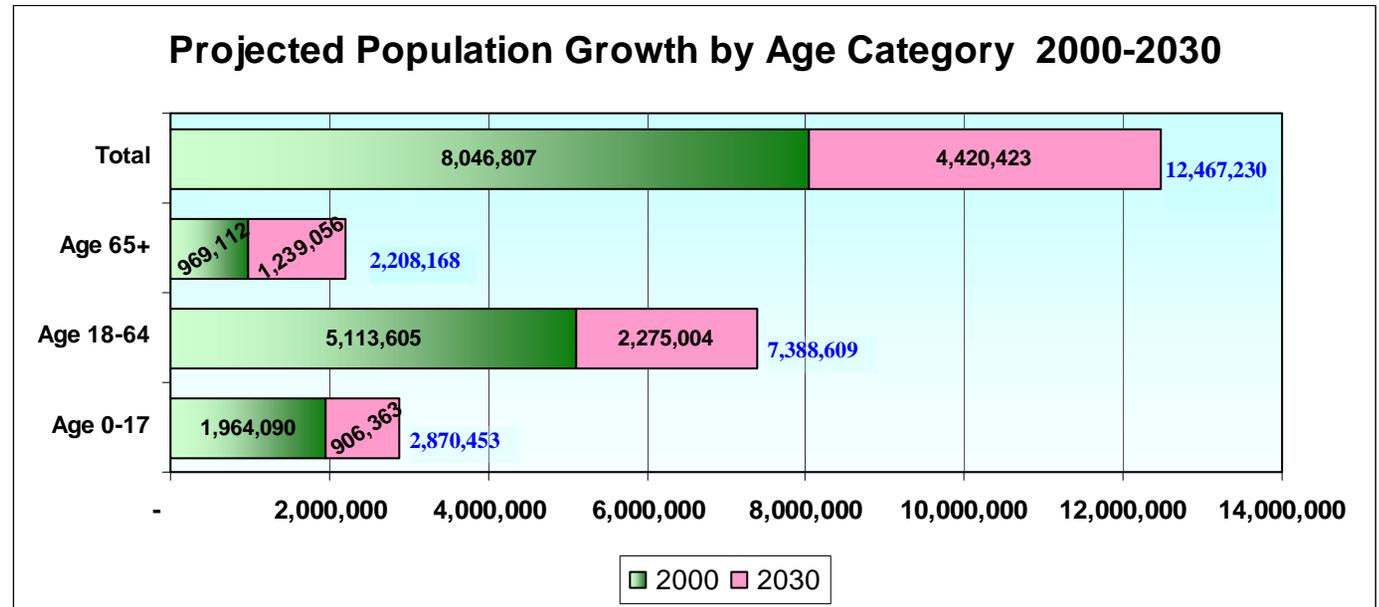
The Federation for American Immigration Reform current estimate of unauthorized immigrants in NC is 385,000 in 2007. This number is in addition to the total listed in "Foreign Born Population" above. Neither number includes the children of foreign born immigrants.

At right are age category projections in North Carolina for the years 2000 through 2030. The first chart depicts growth in number. As one would expect, most individuals fall into the age 18-64 category. The top and bottom categories are about the same, creating a typical bell curve.

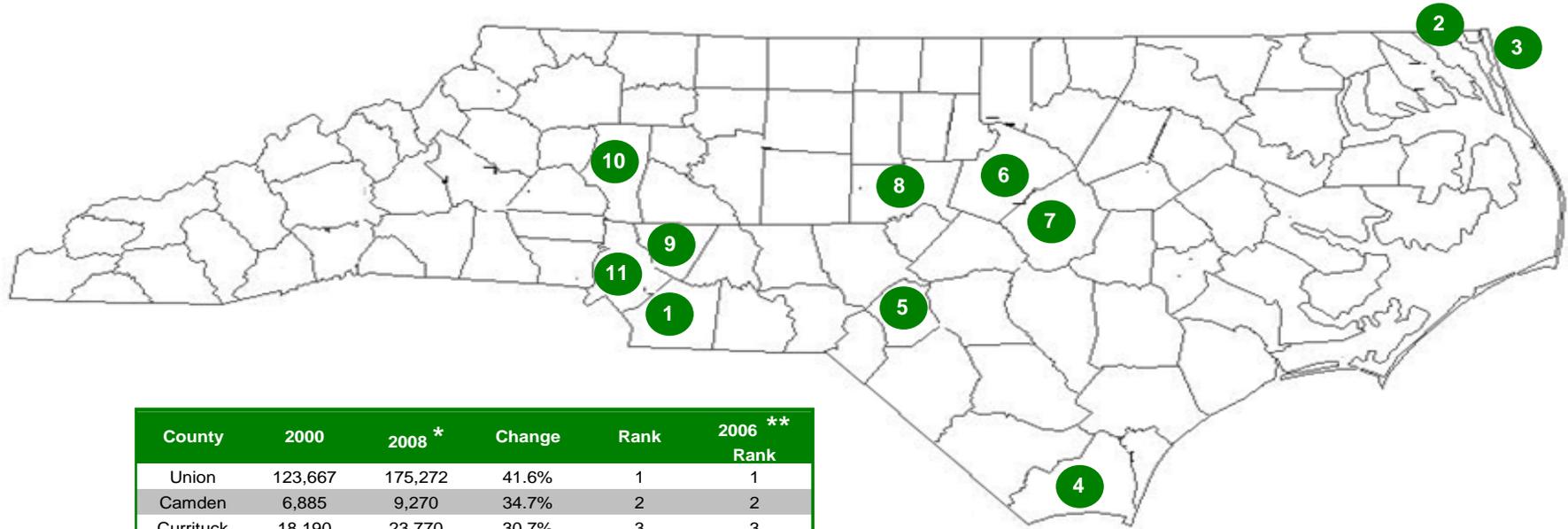
The second chart uses the same data but presents it as the projected percentage increase in each age category. In this view, the percentage growth for 65+ is overwhelmingly greater than that of the other two age categories.

Rapid growth in the aged population correlates to rapid increases in services for the Blind, Deaf and Hard of Hearing as well as residential care facilities and social services targeting the elderly.

Source: DHHS Division of Aging / NC Data Center



Fastest Growing Counties in North Carolina, 2000-2006



County	2000	2008 *	Change	Rank	2006 ** Rank
Union	123,667	175,272	41.6%	1	1
Camden	6,885	9,270	34.7%	2	2
Currituck	18,190	23,770	30.7%	3	3
Brunswick	73,143	94,945	29.8%	4	5
Hoke	33,646	42,303	25.7%	5	4
Wake	627,846	786,522	25.3%	6	7
Johnston	121,965	152,143	24.8%	7	6
Chatham	49,329	60,052	21.7%	8	8
Cabarras	131,063	156,395	19.4%	9	12
Iredell	122,660	146,206	19.2%	10	10
Mecklenburg	695,454	827,445	19.0%	11	14

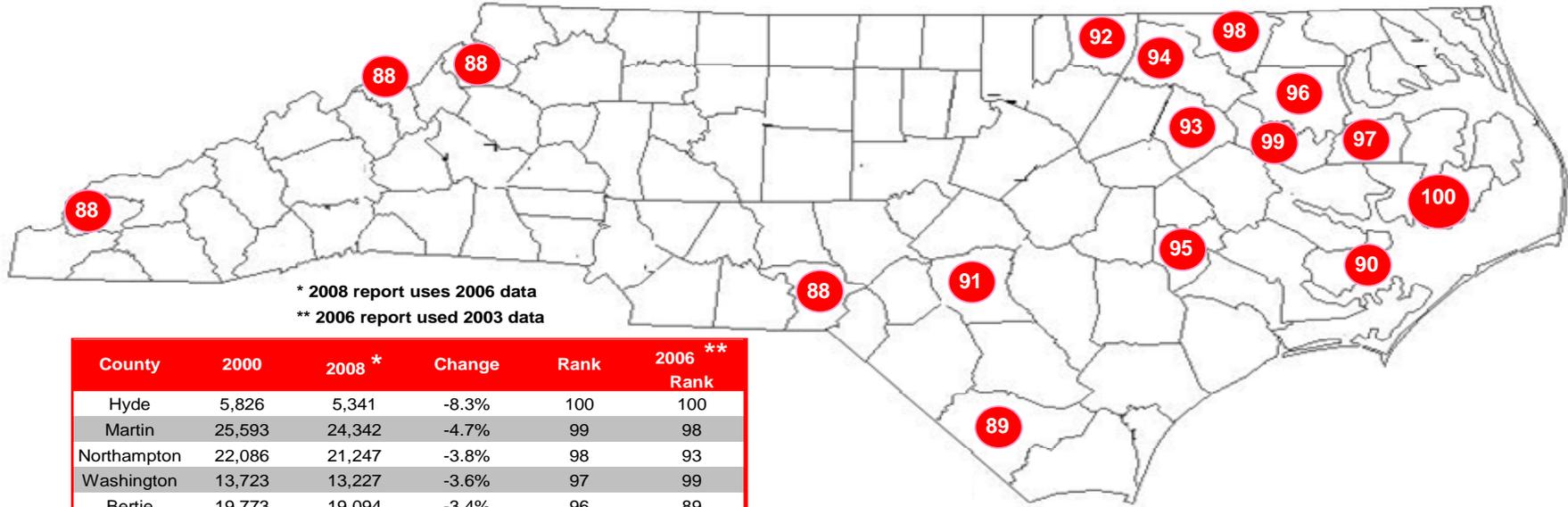
* 2008 report uses data from 2006

** 2006 report used data from 2003

Franklin dropped from 9th to 13th

Harnett dropped from 11th to 14th

Counties Losing Population in North Carolina, 2000-2006



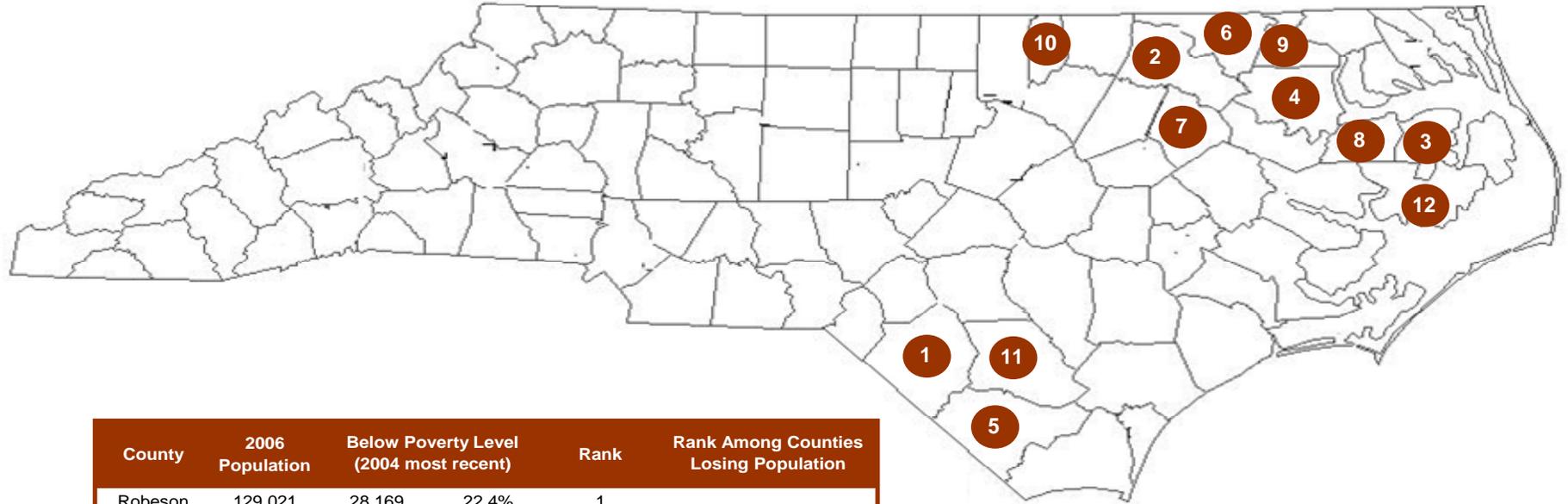
* 2008 report uses 2006 data
 ** 2006 report used 2003 data

County	2000	2008 *	Change	Rank	2006 ** Rank
Hyde	5,826	5,341	-8.3%	100	100
Martin	25,593	24,342	-4.7%	99	98
Northampton	22,086	21,247	-3.8%	98	93
Washington	13,723	13,227	-3.6%	97	99
Bertie	19,773	19,094	-3.4%	96	89
Lenoir	59,648	57,662	-3.3%	95	96
Halifax	57,370	55,521	-3.2%	94	94
Edgecombe	55,606	53,964	-3.0%	93	91
Jones	10,381	10,204	-1.9%	92	95
Warren	19,972	19,605	-1.8%	91	88
Cumberland	302,963	299,060	-1.3%	90	75
Pamlico	12,934	12,785	-1.2%	89	90
Columbus	54,749	54,637	-0.2%	88	84
Graham	7,993	7,995	0.0%	88	81
Mitchell	15,687	15,681	0.0%	88	70
Richmond	46,564	46,555	0.0%	88	79
Watauga	42,695	42,700	0.0%	88	76

Onslow moved from #97 to #77

Hertford moved from #92 to #70

Counties With Highest Percent of Population Below Poverty in North Carolina (2004)



County	2006 Population	Below Poverty Level (2004 most recent)	Rank	Rank Among Counties Losing Population
Robeson	129,021	28,169 22.4%	1	
Halifax	55,521	12,484 22.1%	2	7
Tyrrell	4,187	910 21.9%	3	
Bertie	19,094	4,026 20.6%	4	5
Columbus	54,673	11,067 20.3%	5	12
Northampton	21,247	4,400 20.2%	6	3
Edgecombe	53,964	10,924 19.9%	7	8
Washington	13,227	2,640 19.7%	8	4
Hertford	19,605	4,350 19.5%	9	
Vance	299,060	8,445 19.3%	10	
Bladen	12,785	6,283 19.2%	11	
Hyde	5,341	1,063 19.1%	12	1

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Budget and Finance

Although these terms are used in the private and public sectors, the functions are quite different. In both the public and private sector, budget generally refers to an itemized summary of estimated or intended expenditures for a given period of time, or a systematic plan for the expenditure of a usually fixed resource during a given period, or the total sum of money allocated for a particular purpose or period of time. In both sectors finance encompasses the science of the management of money and other assets, but the tools to exercise this science are very different. Unlike the private sector where there is an economic link between an increase in output and an increase in resources to create that output, this link is more tenuous in the public sector. On the one hand, government agencies frequently are expected to deliver an increased level of service without an increase in resources; while on the other hand, resource reductions are often difficult to achieve even in the face of reduced demand.

Current Environment

DHHS receives money through a bewildering array of funding streams, federal grants and appropriations. Each division has a budget officer who interfaces with centralized functions in the Secretary's Office, most notably Budget & Analysis and the Controller's Office. B&A and the Controller, in turn, work with finance units at the state level to route information, generate requests, make transactions and produce reports to keep the state and general public informed of DHHS's spending and priorities. All of these activities are monitored and validated and reported on by the Office of the State Auditor.

In managing this financial data flow, it is imperative that the department maintains a high level of interagency cooperation and communication to ensure that current information, work requirements and other demands are effectively and timely conveyed and that all agencies have adequate opportunity to participate in the budget management and development processes. In general, according to numerous interviews, DHHS has strong financial controls in place for the proper tracking of funds and expenditures.

Sometimes, the sheer size of DHHS is a disadvantage to obtaining needed funding from the state legislature. Too often, it is assumed that because the department has such a large budget, shortfalls will be made up and money can always be "found" to fill in the gaps. In the past, DHHS did have some ability to do this, but recent actions by the legislature have taken funds such as lapsed salaries off of the balance sheet, resulting in severely reduced flexibility. This has hurt the department's ability to find money each year to fund basic, recurring items such as utilities and DIRM operating expenses; but the effect goes well beyond to include most operational aspects of DHHS.

Key Operational Issues

The Office of State Budget and Management introduced Results Based Budgeting (RBB) for the 2007-09 Budget. The intent of RBB is to improve understanding of agency mission, goals, activities, impact and funding. There are many positive aspects to RBB:

- RBB supports the department's performance management initiatives;
- It represents an opportunity to present meaningful information about program purpose and impact to the legislature to direct discussions on funding; and
- It will provide historic information on expenditures and positions at the division level.

Traditionally, the lack of transparency in financial information due to an outdated budget structure makes it very difficult to determine where money is going and for what purpose. While DHHS is able to do this to the satisfaction of its auditors, an enormous amount of effort is expended. RBB will make this information clearer and provide more focus on the impact of spending these dollars. The systems merger of the Program Management Database, Sub-Recipient Monitoring and Contracts databases will provide a tool to make better judgments about how and where dollars are expended and whether performance objectives are being met. This, in turn, helps to inform management about spending priorities, funding overlaps, etc.

A common theme expressed in the divisions is the real and/or perceived funding inflexibility. This manifests in different ways, from the Office of Economic Opportunity, where federal grants mandate where and to whom dollars are to be directed, to Social Services, where funding inflexibility threatens to force the state into a national model that does not address specific needs in North Carolina (see the [DSS profile](#) on page 84 in Part II). To avoid such difficulties, various divisions are exploring waivers that would authorize targeted spending in such areas as Foster Care and Medicaid eligibility.

Sometimes restrictive funding is an illusion and results from over-interpretation of spending guidelines or a simple unwillingness on the part of a program manager to redirect or share funds. It is hoped that initiatives such as results based budgeting, program evaluations, performance management and IT consolidation will generate dialogue about creative, yet legitimate, use of funding streams.

As stated above, inadequate funding is a nearly universal complaint among divisions and offices. While this situation is not likely to change, some DHHS managers are taking positive steps to reduce the department's financial exposure. DMH, in particular, has placed restrictions on which grants/demonstration project opportunities can be pursued based on (1) priorities for assigning scarce human resources and (2) whether the short term opportunity will require state recurring dollars in the future. This change in focus from decentralized grant pursuit to long term sustainability ultimately will result in a better financial environment for DHHS and improved, stable services to recipients.

The Secretary has also expressed a desire to maximize resources by focusing on operational improvement and positive changes in how programs and services are delivered. The Office of Policy and Planning has led efforts in a number of divisions to achieve process improvement, demonstrating that working more efficiently is an effective way to make better use of limited dollars. Chief among these efforts is the centralized Criminal Records Check Unit, where process improvements resulted in reducing a fifteen week mail backlog to zero and total cycle time from six months to less than two weeks.

Divisions are increasingly refining how to monitor and measure vendor performance against contract requirements and are applying outcome based management practices to improve how programs and services are funded and targeted. Examples of these practices are found in Rural Health, where documented performance standards for NC health centers will buffer funding losses by providing an objective means of distributing available money, and in Child Development, where the division provides specific guidance to counties by requiring subsidy plans to be submitted and by establishing compliance ratings for counties.

Achieving Operational Success in Budget and Finance

With funding shortfalls identified as one of the top issues for the department, DHHS should take specific actions that will result in more money flowing in. These actions include pursuing waivers to increase the flexibility of federal dollars that are restrictive and that do not fully address specific needs in North Carolina; obtaining waivers to fund services to targeted recipients without imposing automatic eligibility for other programs and services; embracing the change to results based budgeting; and using tools such as

the Performance Management Database to improve the quality and substance of communications to state offices and the legislature and to ensure proper monitoring of programs and vendor performance as a way to maximize limited funds.

DHHS needs to take actions to make better, more efficient use of existing money such as: (1) increasing process improvement efforts in all divisions to improve operational efficiencies and streamline service delivery; (2) improving grant monitoring and training to ensure compliance with federal guidelines and to justify cost allocations; and (3) replace the knowledge base lost through retirements and attrition.

Finally, while recognizing that DHHS must pursue promising demonstrations that help to test new programs and innovative ways of service delivery, the department needs to prioritize and reduce grant taking that imposes unsustainable financial obligations on the state. To this end, management should identify and reduce the numbers of federal grants in DHHS that establish non-sustainable programs and services. These activities would be facilitated by improved systems to catalogue and track active or proposed grants in DHHS.

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Communications

***Communications* refers to all aspects of organizational communication up and down and across divisions within DHHS, including marketing, public relations and internal communications.**

Current Environment

In most organizations, communications is considered an employee core competency. In DHHS, it is more than that—it is fundamental to everything we do, from intergovernmental operations, to working with constituents, advocates and the general public, to program and service delivery. This section focuses mostly on the human element of communications, but it also touches on events occurring in other functional areas identified in this business plan.

DHHS has established strong external communications networks throughout the state. These networks are represented by a host of entities wherever programs and services are rendered, such as social service offices, LMEs, community care centers, health departments, independent living centers, vocational rehabilitation centers, district offices, and a host of other networks and providers too numerous to mention. External communications vehicles that link DHHS directly to the public include the NC Care Line and NCcareLink in the Office of Citizen Services, call centers in Medical Assistance, Mental Health and Social Services, and complaint lines in various divisions.

Customer Service has been a focus of DHHS for several years. There is an active customer service task force which recently developed a survey instrument designed to gather customer service performance information. Good customer service places a premium on good communications, and this is reflected in many of the policies, directives, task forces and work groups throughout the department. Various forms of electronic media—email, calendaring, teleconferencing, internet—supplement face-to-face communications and are used extensively throughout DHHS. Employees share information through on line newsletters produced by the department and by various divisions.

One of the most important means of communicating externally as well as internally is the DHHS website and all of the associated links to division, local, state and federal websites. An accessible “E-government” is increasingly expected among consumers and businesses that interact with government. Historically, DHHS websites and linkages proliferated in a relatively uncoordinated manner, resulting in information silos that have to be separately maintained and navigated. The amount of content is impressive, but the structure results in redundant information and maintenance efforts. These inefficiencies are costly for the state and frustrating for the average user who often struggles to find specific information on a particular topic.

The DHHS website has been transitioning under the leadership of the Office of Public Affairs to an intentions-based design that will organize information in a much more logical way than in the past. While divisions will maintain responsibility for content, significant changes are being made to navigation, appearance and accessibility. Information will be more readily accessed by all classes of users, including those with disabilities and Spanish language populations. Also, due to the array of different cultural backgrounds of North Carolina’s residents, the information is written at an eighth grade level.

In a department where daily activities are largely governed by rules, policies and federal/state regulations, communicating and ensuring understanding of such information is critical. Under the leadership of the Office of Policy and Planning, DHHS maintains an extensive on-line repository of department policies and directives, along with an effective review and approval process utilizing the expertise of policy owners and policy coordinators in every division and office. The Division of Medical Assistance has in place an effective Medicaid policy review process that functions in much the same way. Such processes provide for feedback, discussion and coordination that otherwise would prove difficult in such a large organization.

Key Operational Issues

Despite the effort and energy devoted to communications in the department, this business planning process revealed a number of opportunities for improvement. A key issue is how information is stored and managed. For a variety of reasons—some historical, some reflecting funding sources, some technical in nature—information tends to be held in silos; that is, information in one area is often unavailable—even off limits—to employees working in other areas, sometimes even in the same division. There are instances where this approach is appropriate, especially where federal or state statutes require restricted access. On the other hand, there are many more instances where restricting the flow of information impairs program or service delivery, encourages duplication of data gathering and storage, and otherwise increases the cost of operations while lowering productivity. This issue, which is further explored in other sections of this Business Plan, has emerged as one of the fundamental change opportunities in DHHS; that is, to establish a culture and a technical environment where information is more freely shared across division lines and where ownership is vested with the department and/or the state as opposed to individual divisions or programs.

If “information is power,” then “information sharing” is even more powerful. A number of senior managers have expressed frustration with the inefficient flow of information across division lines. Some have blamed this on organization structure; others say simply that the right people are not in the right room at the right time. Still others cite the technical environment, saying that even when desired information exists, it is unavailable for a variety of reasons including access restrictions, incompatible systems or terminology, or lack of adequate identifiers to verify data.

Beyond access, DHHS managers expressed the need for the department to make better use of information at hand. Some operations collect a large volume of complaint information, but fail to analyze it fully to aid efforts in early problem detection and resolution. Taking action in this area is the Division of Health Service Regulation, which obtained a one-time appropriation to upgrade its telephone complaint line to improve call data storage, analysis and response.

DHHS also needs to take a more formal approach to delineating and assigning responsibility for three traditional functional areas: Marketing, Public Relations and Internal Communications. To the extent that these roles are mixed, intended audiences may be underserved or may receive messages in inappropriate ways. A number of divisions express the need for their programs and services to be better marketed to the potential user community. The Division of Services for the Blind, for example, believes that there are a large number of potential beneficiaries who could be served if they were more aware of what the state offers. Lacking marketing resources within their own operations, some of these divisions wish to see this type of service provided by the Office of Public Affairs. This expressed desire for marketing resources (and specialized skill sets) is another example of how new business skills are being identified in the department and could contribute to greater success.

There is a need for divisions to be more proactive in shaping the public's knowledge of DHHS programs and services. This type of promotion will tend to increase public support of human services at the same time that it informs potential beneficiaries. DMH/DD/SAS, in particular, has spoken of the difficulty in conveying to the public and legislature the complexities of mental health transformation and its impact on local communities.

To a large extent, internal communications in DHHS reflects the department's decentralized and geographically dispersed structure. There is no coordinating body for internal communications, although some efforts have occurred through the Secretary's Customer Service Task Force via a focus on the internal customer. By delineating a special role for internal communications, DHHS can enhance the quantity and quality of shared information and establish more consistency in the messages being delivered and received.

Finally, in order to shape the message over time, the department must continually improve the way that it listens. In addition to the various networks, call centers, complaint lines and work groups, DHHS has obtained funding for a web-based survey tool to measure, understand and improve the quality level of programs and services. Clearly communications plans around major initiatives and issues are necessary. There is a saying that "The biggest problem of communications is the illusion that it has occurred." DHHS managers have identified lack of feedback as one of their main communications issues. Whether conducted formally through surveys, questionnaires or complaint analysis, or informally through simply listening better, feedback is a first step in making improvements, being more proactive, and generally doing more to achieve customer satisfaction.

Achieving Operational Excellence in Communications

There is more to communications than delivering a message. For communication of any sort to be truly effective, it should influence behaviors in some positive way. This is true whether the communication is to an internal audience about organization goals, program and service activities or process improvement. It is true in external communications when issues are explained to the public or potential service recipients are identified for targeted messages. This is why communications must be a core competency and requires a formal strategy for implementation.

One of the ways the department is working to achieve operational excellence in communications is by organizing the communications function (as defined in this business plan) to distinguish specific competencies and establish targeted resources for marketing, internal communications and external communications/public affairs. Part of this effort would be to increase and coordinate efforts between divisions and the Office of Public Affairs to market programs and services to potential recipients. Just as important is the need to formalize the internal communications function to enable strategic activity rather than ad hoc communications.

An important milestone for DHHS was the completion of the electronic survey tool initiated by the Customer Service Taskforce. While some divisions do not use the tool in its current form, features and functionality are being improved based on user feedback. The survey tool will be useful not only for soliciting input about DHHS performance, but also for general information gathering that will inform individuals responsible for program development and service delivery.

DHHS must also do more to share/consolidate call center resources to improve response and resolution to customer inquiries and improve how complaints are received, analyzed, acted on and resolved. While it usually is desirable to establish many portals of entry to the complex DHHS array of programs and services, sometimes these portals can diminish, not enhance, the public's ability to negotiate the

bureaucracy. Sometimes the phrase “no wrong door” means that there really are too many doors and the public is thus confused rather than better served.

Communications may also be inhibited by an inability to share information in databases across programs and/or divisions. The Office of the State Auditor is currently evaluating opportunities to do better data warehousing--this is a welcome step toward eliminating “information islands” statewide.

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Buildings and Facilities

Buildings and facilities refers to the management and use of all physical locations available to the organization, whether owned or leased, in such a way as to facilitate efficient delivery of services.

The Current Environment

DHHS currently owns hundreds of buildings throughout the state, most of which were constructed over a 150 year period between the late 1800s and the 1950s. These include hospitals, schools, rehabilitation centers and offices. In addition, DHHS leases over 200 properties. As the GIS derived map at the end of this section illustrates, DHHS has facilities throughout the state, greatly easing citizens' access to the department.

There are many positive things happening with DHHS buildings and facilities. A new state of the art psychiatric hospital in Butner is scheduled for occupancy this summer. Funding has been approved also for two new replacement hospitals and a combined new facility for the state lab and medical examiner. The planned partial closing of the Dorothea Dix hospital opens new possibilities for the use of the Dix campus. Also, the department has strong, professional leadership in its Office of Property and Construction that has made improvements in internal facility management processes.

Key Operational Issues

DHHS's old and outdated buildings pose many challenges to facilities management and are the source of frequent complains and requests from divisional staff. The scope of required renovations and repairs exceeds the state's ability to fund adequately. In many cases the buildings have out-dated designs that do not optimally support today's operations. The old buildings also present workplace environment quality issues. A work environment that is aesthetically unpleasant is not optimal for working and doing business and affects morale and public perception.

Additionally, there is much opportunity to improve the effectiveness of facilities utilization and staff locations. For example, much of the DHHS staff in Raleigh are scattered across the city. The "centralized" Controller's Office is in three locations. The Division of Medical Assistance exceeded capacity in its buildings on the Dorothea Dix campus and had to locate personnel at two off-campus leased offices. Even on the Dorothea Dix campus, personnel are scattered. The Division of Health Service Regulation has personnel in multiple buildings on the campus. This situation is replicated in other areas of the state. In addition to staff location, there is much opportunity to improve inventory management since warehousing and storage space could be used much more efficiently, for example, by implementing "just in time" practices that are standard today in many industries.

A significant challenge faced by the department in managing buildings and facilities is the layered oversight and review imposed by the state, which significantly reduces the department's flexibility and response time. Since funding is dictated down to the project level, it is very difficult to make necessary changes to project plans due to such occurrences as changes in the costs of materials or needed project revisions. Also, even minor changes in the spending plan and building costs have to be reviewed by numerous state agencies. Although OPC has responsibility for managing leases, it has little authority in the leasing process and in determining whether a property will satisfy the needs

of the department. Additionally, all leases, regardless of size must be reviewed by the Council of State.

Achieving Operational Excellence in Buildings and Facilities

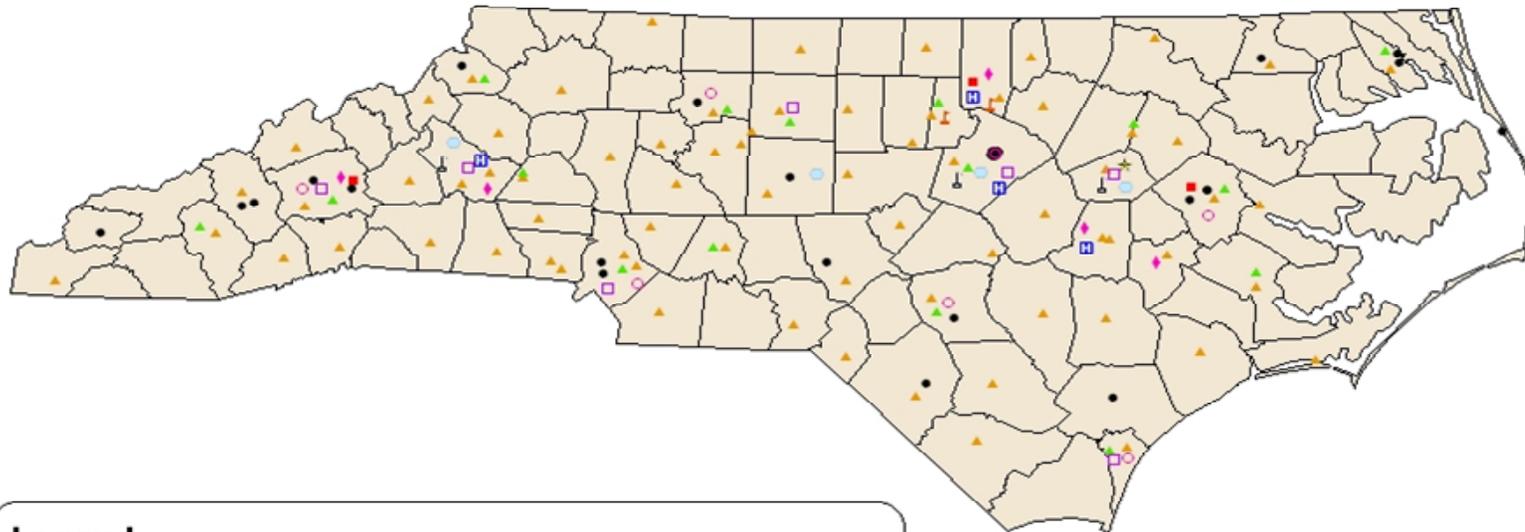
DHHS needs more flexibility in decisions about the use of capital funding. Money, time and resources could be saved if, instead of having funding dictated down to the project level, the department had the ability to manage capital budgets in response to changing conditions. The department has been successful in lobbying for revisions to administrative rules which has improved its ability to get construction projects completed in a timely and efficient manner; however, more changes are needed.

The scattering of personnel, old and outdated buildings, and lack of optimal co-locating across the state have negative impacts on business operations. One of these is the cost of travel both in terms of time and energy expense. More optimally locating staff would increase worker productivity and the effectiveness of communications. Identifying opportunities to consolidate personnel in common facilities across the state also has the potential to reduce facility costs, improve the quality of facilities and improve worker productivity. These issues also have a direct impact on efficiently managing the IT infrastructure. Given these impacts to operations and change opportunities at the Dorothea Dix campus, the department would benefit from an in-depth study of facility utilization from a business functions standpoint.

Along with a study on facility utilization, the department would benefit from a study on how inventory is managed. Automation in inventory management could greatly improve the efficient utilization of storage and warehouse space as well as the cost of having excessive inventory on hand. Additionally, the ability to utilize geographic information system technology would greatly assist management decision-making and be an additional safety factor in responding to emergency situations.

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North Carolina Department of Health & Human Services Division, Program, and Office Locations



Legend

- | | |
|-----------------------------------|----------------------------------|
| ■ ADATC | ▾ OES Schools |
| ○ Blind Services District Offices | ▣ Psychiatric Hospitals |
| □ Deaf Services RRC | ★ Special Center |
| ● EI Programs | ▲ Voc Rehab Living Sites |
| ◆ MHDDSAS Centers | ▲ Voc Rehab Local Offices |
| ⌞ MHDDSAS Schools | ● Other Program and Office Sites |

Part II: Division and Office Profiles

Executive Management

Current Environment

As the largest, most diverse department in state government, DHHS requires a strong and experienced executive management team to establish department goals and priorities, oversee division operations, and interface with decision makers elsewhere in government and the general public. In 2007, the newly appointed DHHS Secretary pledged to focus on services and how the organizational structure can be improved to ensure effective and cost-appropriate delivery to constituents.

The DHHS executive management structure includes the Secretary, a Deputy Secretary, an Assistant Secretary, the Director of Budget and Analysis, the Director of Governmental & Public Affairs, the General Counsel and other top leaders who meet regularly with their direct reports to coordinate department responsibilities. As needed, other DHHS staff is included in these regular meetings to discuss topics specific to their areas of expertise. The responsibilities of the executive management team are to direct operations and provide support services for the department's agencies and institutions to ensure that legislative and administrative policies are properly implemented to the benefit of citizens, clients, and employees and to promote health care access and self-sufficiency for underserved, low income and developmentally disabled people.

Like other departments in North Carolina, DHHS has struggled in recent years with limited federal and state funding to meet the demands of the state's growing population. In general, big ticket items have been covered, such as homeland security funding for emergency preparedness, Medicaid Management Information System (MMIS) projects, and mental health transformation. Other large projects such as the construction of new psychiatric hospitals are in process, and it is anticipated that funding for these on-going issues will be adequately addressed.

Funding for other operating expenditures has been more problematic and has required management to redirect and reallocate budgeted funds to pay for basic items such as utilities and computers. Other fund sources such as lapsed salaries have been emptied to return monies to the NC general fund, thus reducing DHHS's ability to pay for promotional increases, add new positions or address other unexpected costs. Since many state employees are already at a competitive pay disadvantage due to several years of little or no salary increases, it is becoming increasingly difficult to recognize, reward and recruit highly qualified personnel. State employee dissatisfaction over below-market wages is high and inevitably affects performance.

At times, the size and diversity of DHHS works against the department when legislators and others assume that management can address budget shortfalls in specific areas by reallocating existing funds. While this has been possible to some extent in the past, more and more budget flexibility has been eliminated, and it is increasingly difficult to identify basic operating funds for items such as utilities, facility upkeep, staffing needs and information systems. Additionally, there is great disparity between divisions that have money to invest in the information systems infrastructure and other divisions that have to rely on obtaining obsolete computers discarded from other state agencies when money can be "found". Aside from the obvious productivity and morale issues, these situations increase the cost of maintenance, security and support.

Key Operational Issues

Significant resources have been and are being expended in three major arenas: (1) mental health reform involving the statewide effort to transition a centralized, institutional care-based system to one of local service delivery and control; (2) physical infrastructure issues primarily involving new psychiatric hospital construction and future utilization of the Dorothea Dix campus in Raleigh; and (3) implementing a new Medicaid Management Information System (MMIS) that could not be completed with the previously selected vendor.

Mental Health Reform

State mental health reform has been widely publicized in the media, throughout state and local government entities, to service providers, mental health advocates and the general public. Some of the issues are covered in detail in the Division of Mental Health business profile. While the efforts thus far have met with limited success, DHHS executive management is committed to achieving the vision of improving the public's access to cost-effective care, choice in treatment and system accountability. To this end, DHHS has introduced new management, increased the dialogue with local management entities and the provider/user communities, and recommitted the necessary financial and human resources required to streamline the system.

Physical Infrastructure

As the DHHS organization has evolved, the employee base in the Raleigh area has become widely dispersed. Of the roughly 3,000 state employees in Wake County, about one third are located on the Dorothea Dix Campus, and the remainder are scattered at numerous locations in every corner of the county. This has created unsustainable logistical costs relating to facility leases and maintenance, redundant telephone systems and IT equipment, travel between locations for meetings, and delays in receiving mail and other time sensitive documents. Unquantifiable costs are incurred every day from poor communications and lack of accessibility to people or information. For example, the "centralized" DHHS Controller's Office operates out of three separate Raleigh facilities: the Albemarle Building in downtown Raleigh; the Spruill Annex Building on the Dix Campus; and the Oberlin Road facility near Cameron Village. Planned changes to alleviate this situation have been put on hold pending the closing of Dix Hospital and the availability of that space for other uses. Closing the Dorothea Dix psychiatric hospital represents an opportunity for DHHS to review all of its physical location issues and develop a plan for consolidation on the Dix Campus. While public debate may influence how the Dix property is ultimately used, co-locating DHHS operations on the campus is a high priority.

MMIS

In 2004, the Centers for Medicare and Medicaid Services (CMS) mandated that the State of North Carolina replace its 30-year-old technology used to manage its Medicaid system. The MMIS is the largest multi-year contract in North Carolina and is currently being prepared for re-bid following a canceled contract with the previously selected vendor. Extensive management oversight is required due to the complexity of this project; fortunately, significant benefits will result once a new system is implemented. According to MMIS management, DHHS expects that there will be a \$1 million per month reduction in monthly operating and maintenance costs for the replacement MMIS. At the same time, the latest technology will enable better and faster service delivery while improving the quality and quantity of information needed to manage the Medicaid system and improve efficiencies.

Other Issues

Funding—Executive managers in DHHS see a need for more consolidation of the budget function to facilitate consistency and communications. In addition, they believe more emphasis should be placed on acquiring sustainable funding for current programs and services rather than expanding services through

time limited grants that will require state funds to implement or sustain. Part of this emphasis is a need for training and oversight to ensure that employees understand federal guidelines and restrictions, especially since DHHS regularly loses expertise through attrition, and to ensure that management approval is gained prior to the pursuit of grants.

Records Management—DHHS has created an internal work group to identify methods to better retain and manage permanent correspondence and transmittals that will serve to document actions, decisions and agreements among the various public and private entities interacting with the department. This will not only preserve information and institutional knowledge but will also aid the department when questions are raised about funding decisions. Ideally, both electronic and paper documents would be stored and managed through a central database using scanning technology and indexing.

Technology Utilization for Service Delivery—Executive management sees the need for new technology to facilitate service delivery, to access information, to allow service providers to handle larger caseloads, and to improve collaboration among divisions in delivering programs and services. Recognizing that the federal government is driving greater collaboration through budget reductions and giving the responsibility to the states to block grant money, DHHS will encourage collaboration by keeping the discussion on “how we (divisions and offices) mutually serve clients.” This includes embracing a more “client centered” philosophy that focuses on the client (customer) more than on programs, and it includes adoption of an enterprise approach not only in developing technology solutions but in all business applications of the department. Improved collaborative use of technology is being facilitated by the year old IT Governance Committee, created as a result of the 2006 Business Plan. And, the Program Management Database (PMD) will continue to play a role in the analysis and review of service delivery, to foster collaboration between programs and to provide transparency for the public.

Human Resources—As a result of information identified in the 2006 Business Plan, the department sponsored a work force conference to quantify pending work force demographic changes and to identify solutions to position DHHS for these changes and to plan for the work force of tomorrow. With employment retirement eligibility looming at 25% over the next eight years, a very competitive job market for available staff, and the image of government jobs as lower paying and offering fewer opportunities for advancement, DHHS and other state agencies will be at a disadvantage without detailed HR planning and policy adjustments.

Prevention—Finally, DHHS sees the potential for across-the-board benefits by increasing the focus on preventative measures while maintaining rehabilitative care. Recent information from the Prevention Task Force of the NC Institute of Medicine shows that North Carolina spends a greater percentage of its gross state product on health care than is spent nationally (13.8% versus 13.3%), but fares poorly in overall health rankings. The Task Force set an overarching goal of developing a North Carolina Prevention Action Plan to help guide the Division of Public Health and community organizations in prioritizing their prevention efforts. This effort, along with other efforts to provide a medical home, case management and better care management through the Rural Health Centers will play an important part in preventing more severe health consequences and in containing the rising costs of health care.

Key Indicators for Success

Status of Past Indicators

1. More rapid progress moving from solution identification to implementation--especially in instances such as NCFAST where we have the opportunity to establish more collaborative

capability among the 100 counties, better enable case management, increase the productivity of county and regional workers, and better serve the public.

Status: DHHS has implemented an Information Technology Governance Board that approves or denies new project proposals while providing centralized oversight of on-going projects.

2. Improve communications at all levels within DHHS and externally with and among the counties, local providers, advocates and residents.

Status: In addition to a host of initiatives detailed in office and division profiles (see index), DHHS has developed an electronic survey tool which will be used by all department agencies to assess customer satisfaction and gather other information, both internally and externally.

3. Achieve pay equity in the marketplace so that DHHS can better compete for the talent needed to advance operational and programmatic excellence.

Status: DHHS has adjusted new hire and existing pay rates for various categories of hard-to-recruit skills such as nursing and information systems. In addition, the department has been a leader in converting job classification structures under the state's career banding initiative.

Current Indicators

Indicator	03-04	04-05	05-06	06-07	07-08
Improve fiscal and programmatic accountability by adopting a risk based approach that minimizes the number of audit findings.	-	-	-	-	-
Retention of DHHS skilled workforce as evidenced by reduction of annual voluntary turnover rate for the department.	9.84%	9.75%	10.53%	8.86%	-
Time to develop next generation of products/process cycle time, focuses DIRM's attention on improving processes, which ultimately results in the improved cost effectiveness of IT products and services.	Average project duration for new products and services				-
Number of uninsured adults, with incomes below 200% of the federal poverty level, who are provided a medical home, care coordination, and primary care services.	-	-	29,995	33,253	-

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Division of Aging and Adult Services

Mission: To promote the independence and enhance the dignity of North Carolina’s older adults, persons with disabilities, and their families through a community-based system of opportunities, services, benefits, and protections that offer choice, and to help ready younger generations to enjoy their later years.

Vision: North Carolina’s older adults, adults with disabilities, and caregivers will be confident in knowing about and accessing needed supports and services, as well as opportunities for civic engagement.

The Current Environment

In order to support the growing number of aging and disabled adult North Carolinians requiring assistance, the Division of Aging and Adult Services (DAAS) needs to expand the options and availability of home and community-based services and protections and strengthen caregiver supports. To accomplish this, the division has three strategic focuses: value collaboration with other divisions and agencies, promote seamless access to services, and become more proactive in advocating for expanded resources for the aging and adult services network.

DAAS recognizes that it is necessary to work with other divisions and agencies in efforts to meet the needs of aging and disabled adults. This can be a challenge given the focused nature of funding streams and associated information systems. In addition to participation with the Long Term Services and Supports Cabinet, DAAS has embarked on several initiatives to identify opportunities and to foster collaboration. These include, for example, collaboration with:

- DIRM, to complete conversion of the Aging Resources Management System (ARMS) into a web-based application for provider reimbursement and client tracking—with use of an expanded client registration form to collect more information for outcome measures
- DIRM, to secure participation in the DHHS Common Name Database System as a important feature of the division’s continued performance outcome measurements work
- Office of Long Term Services and Supports, to integrate responsibility for Aging and Disability Resource Connections when the Office received the federal Systems Transformation grant
- Office of Citizen Services, in securing statewide coverage for NCcareLINK by encouraging participation by Area Agencies on Aging (AAAs) as regional hubs
- Office of the Attorney General and others, to expand Victims Assistance Program for persons who have been victimized by consumer fraud
- Division of Public Health and others, to begin the federally funded evidence-based Chronic Disease Self-Management program that is initially involving 46 counties
- NC Association of County Directors of Social Services and others, to expand the Special Assistance (SA) In-Home Program (an alternative to placement in an adult care home for SA/Medicaid recipients) to 91 counties and 2200 allocated slots.

Identifying such opportunities for collaboration will continue to be a focus.

Hand in hand with collaboration is a desire for “no wrong door” for aging and disabled citizens accessing needed services and supports. Seamlessness of access is a goal at the local/county level as well as at the state level. Achieving this will require improved use of technology, improved coordination of funding sources, and promotion of self-directed/consumer-directed care. It will also require support for new

models of service delivery such as the Adult Protective Services Clearinghouse Model and continued support for training of human services workers.

To respond to the challenge of increasing demand and stagnant funding, DAAS is identifying ways of being more proactive in addressing the needs of older and disabled adults and promoting their continued involvement as contributing members of society. The work of its Adult Protective Services Task Force and the support of healthy aging through its Livable and Senior-Friendly Community initiative are examples. One key component of becoming more proactive is having access to relevant data and statistics for planning, development, evaluation and dissemination of effective practices. It is also a priority of the division to have a greater ability to establish and track performance outcome measures.

Two examples of its work toward this end include: (1) the division's adaptation of a tool for tracking progress in policy and systems change (i.e., Progress Check, being piloted with the division's Family Caregiver Support Program); and (2) the division's presentation to the General Assembly of its recommendations for a comprehensive study of the aging of the state's population (consistent with Senate Bill 448, Section 2 of S.L. 2007-355).

Key Operational Issues

North Carolina is currently in what could be called “the calm before the storm.” While the growth of the senior population is relatively negligible this decade (except among the oldest old) it will explode over the next 20 years. By 2030 it is projected that 75 counties will have more persons age 60 and older than 17 and younger. As expectations and demands grow and issues become more complex, there are enormous pressures on division personnel—as there are among personnel at the local level.

The growing retirement of experienced personnel within the DAAS workforce presents a serious issue for the years ahead—especially if the division and its local partners are not able to recruit and retain suitable replacements. For example, up to 50% of the directors of county departments of social services are projected to retire over the next five years. The workforce issue for the division is compounded by the inequity that still exists among a significant number of professional positions, especially in the aging services side of our business.

Support for the importance of promoting livable and senior-friendly communities continues to grow—but without resources to do so and in some cases, the loss of resources. The U.S. Administration on Aging is promoting the “Choices for Independence” initiative with a three-prong emphasis: (1) increasing seamless access to information and services through Aging and Disability Resource Connections; (2) promoting healthy aging through evidence-based programs; and (3) supporting consumer choice through consumer-directed services. The division is involved in all three areas.

To effectively be proactive through data analysis and tracking performance measures and to be effective at collaborating and promoting the “no wrong door” approach, the division must have more seamless access to and involvement in various systems and data within the department such as NCFast. Since these resources often reside outside of DAAS, it can be challenging at times to access them. It can also be a challenge for the division to get involved with large department-wide IT initiatives because DAAS's stake in such systems is not always immediately recognized, and its available funds to help support such ventures is limited.

Another component of being proactive is seeking ways to sustain initiatives proven to be very effective that are originally funded by short term grants. For example, Project C.A.R.E. is a demonstration project that is proving very effective at delaying the placement of persons with Alzheimer's disease or other

dementia into institutions. However, it is funded by a time-limited grant. Unless additional funds are identified, it will not continue. The work with developing Aging and Disability Resource Centers presents a similar concern.

Key Indicators for Success

Status of Past Indicators

S.A.F.E. Program—Strategic Alliances for Elders in Long Term Care)

The program was honored by the Southeastern Association of Area Agencies on Aging in 2007 as an outstanding model. In Salemburg, 106 law enforcement officers completed the training provided through the North Carolina Justice Academy.

Long Term Care Ombudsman Volunteers

Currently, there are 1,168 trained community advisory committee members who have volunteered 37,614 hours visiting nursing homes and adult care homes. The division's long term care volunteer program continues to be one of the most active programs in the country.

Support of Family Caregivers

DAAS will increase the capacity of communities to provide support to family and friends to continue care giving for older adults at home. Success will be measured by: (*As of January 17, 2008)

- a. The number of caregivers served (target is to increase by 2% annually) - 15,599*
- b. The percentage of caregivers served who are caring for someone with dementia - 42%*
- c. The percentage of caregivers indicating that services 'helped a lot' in making them a better caregiver -75%*
- d. The percentage of caregivers indicating that services 'definitely' enable them to provide care longer -60%*
- e. Leveraged funds (goal is to grow leveraged funds by 2% annually) - \$357,489*
- f. The number of counties participating and the number of people served by the Special Assistance In-Home Program:- 91 counties; 2,200 slots allocated - 1,371 filled and 829 pending; 1,503 persons served*
- g. The NC Alzheimer's Demonstration Program, Project C.A.R.E. ("Caregiver Alternatives to Running on Empty") continues to increase the quality, access, choice, and use of respite and support services to low-income rural and minority families caring for a person with dementia at home or within a hospital setting. As a result, Project C.A.R.E. has effectively increased the capacity of targeted communities to provide dementia-specific caregiver support.
 1. From July 2004 through June 2007, Project C.A.R.E. served over 1300 dementia caregivers. This represents a 54% increase in families served through Project C.A.R.E. when compared to the first three year demonstration grant period (July 2001 - June 2004).
 2. From July 2004 through June 2007, respite services were provided to client families through 95 local respite care providers. This represents a 51% increase in provider contracts when compared to the first three year demonstration grant period (July 2001 - June 2004).
 3. Since the program's inception in 2001, the Project C.A.R.E. service area has been expanded from 6 to 14 counties.
 4. According to recent surveys, 95% of respondents reported that Project C.A.R.E. services helped them with a wide variety of care giving issues. Approximately 92% of client families reported that Project C.A.R.E. services allowed them to

provide care at home longer, and 94% rated their satisfaction with the overall program above average or excellent.

5. The Alzheimer’s Disease Demonstration Grants to States Program is the primary funder of Project C.A.R.E. to date. The Division contracts with Mecklenburg County Department of Social Services and the Western Carolina Alzheimer’s and Related Disorders Chapter to provide outreach, care management, and community based direct care services. These federal funds have been leveraged through grants provided by private foundations (i.e., Sisters of Mercy, Kate B. Reynolds, United Way and Centura Bank) as well as supplemental funds provided by local Family Caregiver Support Programs.

Senior Centers

There are 164 senior centers in 98 counties. Of these 164 centers, there are 8 senior centers in development in Regions B, F (3), I, L (2) and P. There are 53 Centers of Excellence (32%) and 6 Centers of Merit (3%). In addition, 95 people have graduated from the Ann Johnson Institute, a DAAS management training program for senior center managers and leaders.

Age-in-Place

The Home and Community Care Block Grant (HCCBG) is the primary program funded through the Division of Aging that provides community based services to at-risk older adults in their homes. During SFY 06-07, older adults received in-home services as follows:

Home Management	3,577
Personal Care	3,988
In-Home Respite Care	557
Institutional Respite Care	52
Group Respite Care	70
Senior Companion	78
Home Delivered Meals	17,617 (of these, 16,622 have 2 or more ADL limitations)
Home Improvement	1,344
Adult Day Services	1,086
Transportation Services	12,993
Care Management	<u>203</u>
Total Service Needs Met:	41,564

Current Indicators

Indicator	03-04	04-05	05-06	06-07	07-08
DAAS expenditures for services that support community-based long term care	-	-	96.7%	97.6%	-
Growth in number of clients served in the state/county Special Assistance In-Home program	-	-	10.8%	44.5%	-
Change in cumulative number of clients receiving Home and Community Care Block Grant services	-	-	-3.3%	1.4%	-

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Division of Child Development

Mission: Promote and support high quality early care and education to build a stronger social and economic future for North Carolina.

Vision: DCD will lead the nation, providing a stellar start for NC's children.

The Current Environment

DCD's vision of the future includes an array of strategies to encourage more outcome-based programs for children and coordination of a seamless early childhood education community throughout the state. National studies indicate that early parental involvement and effective learning activities are strong indicators of success for children as they progress through elementary, middle and high school.

DCD is already recognized nationally for its star rated license system that ranks child care centers and family child care homes on a 1-5 star scale based on program standards and staff education. This innovative program has provided incentives for raising the quality of child care through educational certification of staff and equivalency exams, as well as examination and improvement of the classroom environment for preschool children. DCD is currently completing the process of transitioning all licensed child care facilities from a three-component license to a two-component license which will provide a better measure of the quality of care being provided in each facility.

Key Operational Issues

The Division implemented a performance based work plan in the Subsidy Services Section during SFY 06-07. Staff collected data regarding accuracy and error rates related to the administration of the Subsidized Child Care Program by each county DSS agency. This information was used to target training and technical assistance provided to county departments of social services to address problem areas. The Section also implemented a monitoring plan which allows for programmatic and fiscal monitoring of each DSS agency every three years to determine compliance with the Subsidized Child Care Program policies. All of these efforts were implemented in an effort to assure policies are applied correctly so that as many families as possible can be served with the funding available to the Program.

DCD is challenged by inadequate funding to meet necessary demands for services and programs. The demand for subsidies is increasing along with the increase in low income families. At the same time, the cost of care is rising due to increased public/parental expectations for higher quality care. One way that DCD is addressing these financial challenges is by seeking funds through the economic development and business and financing communities rather than only through parent fees and state subsidies. In addition, DCD is increasingly outcome focused and attempts to achieve the greatest return for all its expenditures. For example, DCD offers specific guidance to counties by requiring subsidy business plans to be submitted and by establishing compliance ratings for counties.

Technology plays a major role in the success of the division. DCD field staff improve their effectiveness and efficiency through better use of electronic data; therefore, initiatives are underway to improve the overall IT environment, including mobile access. Enhancements to internal database systems will enable DCD sections to work more seamlessly to track and promote provider education—which in turn will contribute to maintaining or increasing rated license scores. DCD has also made extensive use of teleconferencing to communicate issues quickly and consistently across the state.

An expanding population in North Carolina affects child care in numerous ways: Beyond more staffing to address sheer numbers, there is a need for more bilingual teachers as well as teachers who are trained to care for special needs children who were unable in prior years to participate in group care. To help providers cope with larger and more diverse child populations, DCD will continue to seek expansion funding for staff increases and training, and will explore other options for applying advanced technologies to maximize staff resources.

Challenges to effective service delivery include:

- An increase in the number of Spanish and other foreign language speaking families in North Carolina.
- The need to improve and increase the inclusion of children with special needs in licensed child care facilities.
- Maintaining continued affordability of quality care and support for families in need of subsidized child care services.
- Addressing the loss of infant and toddler care slots.

Key Indicators for Success

Status of Past Indicators

1. By 2008, NC will achieve a 10% increase in child care centers earning a score of three or higher in both program and education licensing standards.
 - At the beginning of SFY 06-07, 44% of child care centers earned 3 points in both the program and education components; as of 12/31/07, 54% are at that level of quality.
2. By 2008, DCD will serve an additional 5% of the (2006) eligible unserved subsidized child care population.
 - Increased subsidy costs (3% in 06-07) have prevented expansion of service.
3. By 2008, DCD will better protect children by increasing the number of child care monitoring visits performed by regulatory consultants by 30% annually.
 - Since legislative change in 2005, regulatory staff has focused on the transitioning of child care programs from the 3 component rated license to a 2 component system. This has included making TA visits, holding provider meetings, presenting workshops and other methods to ensure that providers are aware of the potential impacts on their programs. These activities have been given priority during the last eighteen months. As the transition preparatory work comes to an end, now that the change has been implemented regulatory staff will work toward increasing the number of monitoring visits while continuing to ensure a smooth and timely process for providers.
4. By 2008, the statewide average of county subsidy compliance scores will be 95%.
 - As of March 2007 (end of DCD performance cycle) 91 of 94 local purchasing agencies (LPA) had an accuracy rate of 90% or higher and 74 LPAs were at 95% or above. The goal for the 07-08 performance cycle is to increase the accuracy rate of all counties to 95% or higher.

Current Indicators

The three most critical measures for the Division's success for primary customers are:

Indicator	03-04	04-05	05-06	06-07	07-08
Percent of high quality (3-5 star) child care programs in NC (Note: transition from 3 to 2 component license beginning in 2006-07)	68%	68%	69%	72%	65%
Number of children receiving non-Smart Start subsidized services in 3, 4 or 5 star-rated licensed facilities	119,130	126,606	126,473	131,421	-
Percent of child care programs with 3 points or more in the education component of the rated license	-	43%	45%	50%	56%

Note: The percentages listed above are point-in-time measures from December of each first calendar year (03, 04, 05, 06, 07).

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Division of Health Service Regulation

Mission: The Division of Health Service Regulation regulates medical, mental health and group care facilities, emergency medical services and local jails. We ensure that people in the care of these facilities are safe and receive appropriate care. We make certain that medical facilities are built only when there is a need for them.

Vision: DHSR regulatory work promotes the development and safe provision of health care services and is conducted in a fair, professional and competent manner.

The Current Environment

In 2007, to better convey its role in helping to improve the quality and delivery of health care through regulatory review and consultative practices, this division changed its name from the Division of Facility Services to the Division of Health Service Regulation (DHSR).

The DHSR provides regulatory oversight for the state's many health related facilities and institutions including but not limited to plan reviews for facility construction, licensure and certification, and maintaining a health care personnel registry of training and competency for healthcare personnel. DHSR actively inspects nursing homes, hospitals, mental health facilities, adult care facilities, ambulatory surgical centers, home health agencies, hospices, clinical laboratories, renal dialysis centers, rural health clinics and a number of other programs, ensuring that providers are following state and, where applicable, federal standards. DHSR is chartered to enforce federal and state regulations regarding licensure and certification of certain healthcare facilities. Although improvement of quality of care is of concern, it has remained secondary to the regulatory role.

The majority of DHSR employees are nurses, social workers, and other medically trained individuals such as pharmacists and dietitians, most of whom support the inspection processes. In addition to the medically trained personnel, DHSR employs engineering and administrative talent, certifies and trains Emergency Medical Services (EMS) personnel, administers the Certificate of Need program, and inspects county, municipal and regional jails throughout North Carolina.

The division's work load has increased dramatically in recent years due to population increases and aging as well as government actions that stimulate new facilities and services. The North Carolina legislature has been responsive to DHSR needs while increasing the scope of state regulation. Session Law 2005-276, effective July 1, 2007, required annual state inspection of all adult care homes and 24-hour residential mental health, developmental disability and substance abuse services facilities. In addition, the law also required inspections every three years of all licensed home care agencies.

Session Law 2007-323, provided DHSR more staff to:

- Better regulate jail and detention centers (2 positions)
- Provide for faster review times for health care facility construction projects (8 positions in FY07-08 and 8 additional positions requested for 08-09)
- Conduct investigations of providers subject to the Health Care Personnel Registry Act (12 positions)
- Implement a rating system (beginning January 1, 2009) for adult care homes based on rules adopted by the N.C. Medicare Care Commission (2 positions)
- Better administer the Certificate of Need program (6 positions)

In addition, de-institutionalization of mental health services into community settings will have an impact on DHSR as adult care homes and mental health facilities deal with the transfer, discharge and influx of new residents, and as new care facilities are established in local communities.

Effective January 2007, DHSR voluntarily added to its web site (<http://www.ncdhhs.gov/dhsr/>) a listing of fines and penalties imposed against adult care homes since 2006. The listing is updated on a monthly basis for public viewing (<http://www.dhhs.state.nc.us/dhsr/acls/adultcarehomefines.html>).

Key Operational Issues

DHSR operates in an environment where there are competing interests on all sides, from CMS and federal guidelines, to providers, patients and advocates. Balancing all of these interests while fulfilling a regulatory mandate is a difficult proposition. DHSR would like to establish quality improvement programs (QIPs) in all licensed facilities/agencies, have staff to monitor the QIPs routinely with the ability to quickly identify and correct compliance problems prior to the occurrence of adverse events and prior to major regulatory action.

Because regulation is usually understood to define minimum standards of care, DHSR recognizes that any definition of *quality* in regulated facilities has to mean more than an absence of citations. As a result, the division has attempted to distinguish the quality and regulatory roles by offering separate training and consultation to facility personnel and county inspectors/social workers. This work is necessarily limited due to shortages of qualified personnel and the necessity for state inspectors to concentrate on regulation and compliance.

The division has been working with the Office of Long Term Services & Supports (LTS) to create a career ladder for unlicensed health care workers to address recruitment and retention issues in facilities and agencies. This initiative is referred to as the Win-A-Step-Up Program. In addition, DHSR has also been working with the LTS office in the development of better jobs/better care initiatives that will offer provider incentives for internal improvements to the management of the care of their clients aimed at improving overall care.

More and better use of technology will be a major factor in DHSR's ability to maintain and improve its performance in response to growing demands for services. Much of the DHSR systems environment consists of mandated federal databases such as the Automated Survey Processing Environment (ASPEN). This system is used by DHSR to track all deficiencies initially cited by nursing home surveyors. While DHSR does not have authority to make changes to federal systems, investments are needed to upgrade state and local systems. Most of these systems, such as the Master Facility File (MFF) that is heavily used by DHSR, are old legacy systems that are no longer supported by software vendors. The only technical support capability for many of them resides with a few DIRM employees or individuals contracted by DIRM.

An example of where the MFF is used and where new technology would have a dramatic impact is in the annual license renewal process. Currently, the process is labor intensive and takes months to complete. A thick packet containing information printed from the MFF is mailed across the state to thousands of facilities, which are asked to verify that the information is correct. These forms are returned to DHSR where a temporary employee hired for roughly three months enters changed or new data into the system. Final documents are then printed and licenses mailed out. This whole process could be tremendously simplified and cost reduced by enabling the licensure information to be updated via secure internet access. It was hoped that this type of technology improvement, along with the risks posed by old legacy systems,

could be addressed through the MMIS project. With cancellation of the previous contract, work has ceased. Considering the uncertainties surrounding DHSR’s involvement with any new version of MMIS in the future, it is critical for DHSR and the department to establish a strategy to eliminate or mitigate risks posed by these legacy systems.

More immediate opportunities exist for DHSR to make better use of laptop and tablet computers to improve and streamline the inspection process so that information can be recorded directly instead of being transcribed from handwritten notes. Laptops would also give instant access to regulatory language and other information that would be of value in documenting surveys and investigations. Such an approach is being piloted in the federally funded programs.

Key Indicators for Success

Status of Past Indicators

Previously, DHSR listed a number of objectives such as tracking completion of annual inspections for 24-hour mental health, developmental disability and substance abuse services facilities; tracking completion of annual inspections of adult care homes; tracking completion of every three year home care inspections; tracking completion of jail inspections; and tracking time frame for health care facility construction reviews. While these activities will continue to be tracked, DHSR has identified more meaningful success indicators that will be measured in the future.

Current Indicators

Indicator	03-04	04-05	05-06	06-07	07-08
Licensed nursing home surveys and complaint investigations conducted within the federally established timelines. ¹	-	-	-	-	0.0 %
Annual quality of care surveys conducted of all licensed adult care homes and residential mental health facilities.	-	-	-	-	0.0 %
Health care construction review times not more than 6 weeks from receipt to completion (goal now 50%, will go to 100% when fully staffed).	-	-	-	-	0.0 %
Patient encounters with licensed Emergency Medical Service (EMS) providers result in conformance with the standard of care established by the North Carolina College of Emergency Physicians' protocols (the standard is 98%).	-	-	-	-	0.0 %

¹Nursing home surveys are conducted every 9-15 months; complaints filed against nursing homes are investigated in the applicable two day, ten day or 45 day established requirement. Data is collected quarterly and reported annually.

Division of Medical Assistance

Mission: To provide access to high quality, medically necessary health care for eligible North Carolina residents through cost-effective purchasing of health care services and products.

Vision: The Division of Medical Assistance (DMA) will efficiently manage Medicaid and NC Health Choice for Children to ensure that cost-effective health care services are available to all eligible persons across the state.

The Current Environment

The Division of Medical Assistance manages the Medicaid and NC Health Choice for Children programs for the State of North Carolina.

Medicaid provides certain low-income persons who meet state and federal eligibility requirements with access to medical services. During state fiscal year (SFY) 2007, more than 1.7 million NC residents including children, the aged, blind and disabled, and persons eligible to receive federally assisted income maintenance payments (i.e. Work First, Supplemental Security Income (SSI), State/County Special Assistance, etc.) received services through Medicaid. Current funding is received from federal, state and county governments, but the county share of program costs is being phased out over the next two years.

NC Health Choice for Children provides children in families whose incomes exceed the Medicaid eligibility level with access to comprehensive health care coverage with little or no cost sharing required. Enrolled children receive similar coverage as provided to children of state employees and teachers, with the addition of vision, hearing and dental benefits.

Major initiatives designed to improve programs and services, productivity, operations and related measurable progress are:

- New Multi-payer Medicaid Management Information System (MMIS).
- Community Care of North Carolina (CCNC) expansion. Continued linkage of CCNC and North Carolina Health Choice (NCHC), as well as linkage of the aged, blind and disabled population with medical homes through CCNC.
- Medicaid coverage of independent foster care adolescents.
- Pharmacy program enhancements. SmartPA is a tool to adjudicate prior authorization requests online in real time. CyberAccess is another tool that will allow providers access to clinical alerts and pharmacy/medical data on their patients. Additionally, there will be enhancements to the pharmacy prior authorization and claims reporting system through CyberFormance.
- Continual system improvements within Program Integrity.
- Provider enrollment improvements through National Provider Database (NPD).
- Evidence based best practice clinical coverage policies.
- Contract documentation that includes monitoring requirements and expected deliverables.
- Disproportionate Share Hospital (DSH) Program.
- Business Continuity Plan and privacy policies.
- Quality management through Quality, Evaluation and Health Outcomes Unit (QEHO)
- Strategic planning through Strategic Planning, Assessment and Research Team (SPART).
- Continuance of Community Support Services controls.

Key Operational Issues

The number of individuals who are eligible for NC Medicaid has grown during the past eight years by an average of approximately 4.6% per year, slowing to 2.3% during SFY 2007. During the same eight-year timeframe, the percentage of North Carolina's population that is Medicaid eligible has averaged 17.31%, increasing to 18.98% during SFY 2007. Last year the Division served approximately 1.2 million residents each month, with the largest group of Medicaid enrollees falling into the Pregnant Women and Children category (41%), followed by AFDC-related (27%), Disabled (16%), Aged (9%), Qualified Medicare Beneficiaries (3%) and several smaller categories, as has been the case for many years.

Sixty percent of Medicaid enrollees are female and forty percent are male. The difference in the categories for white and black enrollees is only five percent, at thirty-nine and forty-four respectively. All other race categories comprise seventeen percent of those enrolled. In terms of age, most beneficiaries are between 5 and 20 years of age (37%), followed by 21 to 64 (32%), 0 to 4 (21%) and 65 and over (10%).

Expenditures for Medicaid program services (i.e. medical services) increased almost 51% from SFY 1998 to SFY 2002. During the five year period from SFY 2003 to SFY 2007, Medicaid expenditures grew 36%. While the growth in the Medicaid budget appears to be slowing, the program still accounts for approximately 15% of the General Fund operating budget and continues to consume much of the state's limited resources each year. County governments have struggled with the budgetary requirements for the Medicaid program. During the 2007 Session, the General Assembly enacted legislation to begin a gradual phase-out of the county portion of the non-federal share of Medicaid program funding. As this process continues, it is difficult to predict the degree to which this phase-out will contribute to future growth trends in Medicaid spending.

All state Medicaid programs are susceptible to any (downward or upward) change in the national, state or local economy. Equally significant factors that could affect DMA's ability to provide programs and services include:

- Rising cost of health care services
- Rising cost of malpractice insurance
- Major industry closings and layoffs
- Natural disasters
- Natural aging of our state's population—including in-migration of retirees
- Growing number of immigrants and seasonal/migrant workers in NC
- Policy decisions at the state and federal level that alter Medicaid coverage categories, as well as the eligible population

Furthermore, trends at the federal level threaten to increase the financial burden of each state with respect to its Medicaid program, and could shift the proportions of health care costs borne by consumers, as well as negatively influence the health care workforce. Specifically, two components of Medicaid involving federal reimbursements, disproportionate share hospital (DSH) payments and upper payment limit (UPL) arrangements, have been reduced by billions of dollars in recent years. As a result, all states are bearing a greater share of total Medicaid expenses.

The federal government has also proposed regulatory changes in other key programs, including targeted case management, school-based services, rehabilitative services option and graduate medical education, which may significantly impact our service delivery and covered populations. DMA will actively

monitor federal proposals and respond to any applicable public comment periods to inform federal oversight agencies regarding the impact on North Carolina's Medicaid program.

Other challenges faced by the division include:

- Development of a new MMIS – Continued operation in a legacy claims processing system poses daily challenges. System limitations make some legislative directives virtually impossible to implement in a timely manner. For example, a number of new programs will require the division to collect premiums. The current MMIS does not have the necessary functionality, making timely implementation of the new system imperative.
- Continued demand to implement sophisticated cost sharing requirements for various program and eligibility groups. Until recently enrollee cost sharing was limited to nominal co-payments for selected services. However, the DMA is currently trying to determine how to implement other cost sharing mechanisms, including premiums, deductibles and coinsurance. In addition to the system challenges mentioned in the previous item, these approaches also have the potential to impact provider and recipient behaviors. Determining the appropriate balance to ensure proper utilization of services is a significant challenge.
- Managing program expenditures and utilization of Community Support Services and other mental health enhanced services categories.
- Growth in NC's aged, blind and disabled (ABD) population – Population growth in general among Medicaid eligibles has increased the demand for Medicaid funded services. Although the elderly and disabled represent 26% of Medicaid beneficiaries, the combined group accounts for 65% of total expenditures. Managing the high cost ABD population is and will continue to be a significant challenge as the state's population continues to age.
- Rising cost of prescription drugs – The volume of prescription drug claims has decreased due to Medicare Part D coverage, however the per unit costs covered by Medicaid continue to grow.
- Unfunded mandates from the federal and state level impact the success of programs and services. This practice continues to stretch staff and funding beyond the limits of budgetary control/operational efficiency
- Provider concerns regarding inadequate reimbursement rates (specifically failure to maintain rate adjustments that cover their continually increased costs of doing business, as well as anticipated federal changes which may reduce the amounts approved for reimbursement) have created difficulties in maintaining existing enrollment and encouraging new enrollment amongst providers in certain disciplines, most notably dentists.

Key Indicators for Success

Status of Past Indicators

Much of the division's future success is likely to depend upon how successful the department is in implementing the multi-payer MMIS. Timely implementation is critical to the Medicaid program, and DMA expects immediate pressure by policymakers to build upon and enhance the core system. DMA previously identified goals in the areas of budgetary control, management rather than regulation,

quality improvement, accountability, customer service, public image and job satisfaction. While these goals will continue to serve as top priorities, DMA also will begin to measure success through additional indicators that provide greater impact to the public.

Current Indicators

Indicator	03-04	04-05	05-06	06-07	07-08
Improve outreach and program coordination to maximize the enrollment rate and participation in Community Care of North Carolina.	-	-	-	77%	-
Health Status of Beneficiaries - improve care to Medicaid patients by increasing consistency of provider performance and promoting the adoption of best practices.	-	-	-	-	-
Service payments to providers are appropriate and within the context of current policies to meet the essential health care needs of Medicaid beneficiaries.	-	-	-	-	-
The rate of enrollment in Medicaid of eligible families with incomes below 200% Federal Poverty Level (FPL).	-	-	-	-	-
The rate of enrollment in NCHC of eligible children with incomes below 200% Federal Poverty Level (FPL).	-	-	-	-	-
Percentage of North Carolina Health Choice (NCHC) linked to a Carolina Community North Carolina Primary Care Physician	-	-	-	23%	-

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

Mission: North Carolina (NC) will provide people with, or at risk of, mental illness, developmental disabilities, and substance abuse problems and their families the necessary prevention, intervention, treatment services, and supports they need to live successfully in communities of their choice.

Vision: NC residents with mental health, developmental disabilities, and substance abuse service needs will have prompt access to evidence-based, culturally competent services in their communities to support them in achieving their goals in life.

The Current Environment

The Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) is the largest division in DHHS with over 12,000 employees working throughout the state at its headquarters in Raleigh, four large psychiatric hospitals, three developmental disabilities centers, three alcohol and drug abuse treatment centers (ADATCs), three neuro-medical centers, and two residential programs for children. As the NC population continues to grow, so too does the need to provide for an increasing number and more diverse group of residents who require significant medical and behavioral support.

In 2001 the North Carolina General Assembly enacted sweeping legislation to reform the public mental health, developmental disabilities and substance abuse services system. The legislation fundamentally altered the role of the division and the area authorities—entities of local government that at the time of the enactment of the legislation functioned as the primary providers of services outside of state institutions. The legislation sought to increase accountability in the system by separating service delivery from management oversight, to improve consumer's access to services, and to increase consumer and family participation in the management of the service delivery system. To accomplish these goals, the legislation required area authorities, now known as Local Management Entities or LMEs, to change their focus from service delivery to system management and to develop an alternative array of private providers to deliver services. In order to increase efficiency and gain economies of scale, it also targeted a reduction in the number of LMEs to no more than 20 by 2007. The legislation also required a reorganization of the division, which was accomplished in 2003.

The effort to transform the mental health system in NC has had a profound impact on the way DMH/DD/SAS operates, both internally throughout DHHS and externally with LMEs, providers, partners, and recipients of services. The skill sets needed to manage the system at the state and local level are significantly different from those required in the old system. With the growth of the private provider community, the need for standardization of functions, processes and products, and the need for automated, electronic means of sharing information, has increased exponentially.

The reform legislation and the U. S. Supreme Court's ruling in the case of *Olmstead vs. L.C.* are also having a profound impact on the state facilities. The legislation and the Supreme Court decision emphasize the preference that mental health, developmental disabilities and substance abuse services are delivered in community settings, rather than in large institutions. There will continue to be a need for state facilities, but their role and the populations they serve are changing. A clear example of that is the change currently being implemented in the state-operated Alcohol and Drug Abuse Treatment Centers (ADATCs). Providers have been successful in increasing capacity in community-based substance abuse rehabilitation programs, but they have not been successful in developing community-based detoxification

services, particularly for individuals with significant medical complications. In recognition of that reality, the model for the ADATCs is being changed from 28-day rehabilitation facilities, to providers of acute and sub-acute detox services for particularly challenging individuals.

Some of the division's aging facilities require renovation so extensive that they will be rebuilt in their entirety. The new hospital under construction in Butner will replace two of these aging psychiatric hospitals: Dorothea Dix in Raleigh and John Umstead in Butner. The General Assembly recently approved special indebtedness funding to replace the other two hospitals in Goldsboro and Morganton before the end of this decade.

In helping to transform the MH/DD/SAS environment in NC, the division is leading the effort to assist LMEs to evolve from their traditional role as direct service providers to managers of community services with the following responsibilities:

- Developing local business plans and strategic planning, including ensuring that consumers and family members and other community partners are engaged in planning and implementation
- Ensuring prompt access to services through 24/7/365 screening, triage and referral functions
- Building service capacity through provider development efforts
- Collecting data and evaluating outcomes to address gaps in services, the quality of services, and the effectiveness of providers
- Providing care coordination to ensure continuity of care for high cost and high risk consumers

Accomplishing these objectives requires division employees to expand and enhance their own core business skills as adjuncts to the traditional programmatic areas of expertise. Performance based contracts have been developed and are evolving to document and measure each LME's success in implementing the new responsibilities. The number of LMEs has decreased by 15, but the division continues to encourage LMEs to identify ways to achieve greater efficiency and economies of scale. Many LMEs have completely divested of service provision, and others continue to deliver only a small handful of services.

Internally, DMH/DD/SAS is dealing with many of the same challenges faced by other DHHS divisions. A fundamental inability to recruit, retain and adequately reward employees has left the division with a shortage of operational and programmatic expertise at all levels. Where current employees are near retirement (which is the case with virtually all of the senior staff in the central office and in the institutions) the division has been unable to put together an adequate workforce plan due to state requirements concerning non-competitive pay grades, classifications, salaries and reward systems. The result is that the division struggles to compete in the marketplace for the best and brightest.

Key Operational Issues

Local Management Entities: Transformation continues at the local level through 25 local management entities (LMEs). During SFY 2007, DMH prepared a one-year performance contract for SFY 2008 that defines required LME functions, measures of performance and funding. The contract for SFY 2008 replaces the LMEs' local business plan, as the previous scope of work, with a standardized scope of work for all LMEs. DHHS and each LME signed the performance contract in the fall of 2007 including addendums addressing the specific relationships between each LME and the state-operated facilities in their region.

Providers and Services: Since March 20, 2006, when new services approved by the federal Centers of Medicare and Medicaid Services were implemented, the number of private providers of services has continued to grow. Using standardized processes, LMEs endorsed providers of these services who were then enrolled by the Division of Medical Assistance (DMA) for reimbursement for Medicaid eligible

clients. In the spring of 2007, DMA and DMH conducted analysis of service patterns of one of the new services—community support—and then followed with audits and post-payment reviews of high-volume providers of that service. In addition to imposing sanctions on providers who inappropriately used the service, other actions are underway to reestablish the balance of service capacity across the state to meet the needs of consumers more appropriately.

State Operated Services: In 2006, the division started the conversion of the O’Berry Center, the Black Mountain Center and the Special Care Center into neuro-medical centers. In addition, considerable progress has been made with the construction of the new Central Regional Hospital at Butner with anticipated occupancy in the summer of 2008. The new hospital will serve patients currently served at Dorothea Dix Hospital and the John Umstead Hospital.

Strategic Plan: In June 2007, the division published a three-year strategic plan as required by legislation for SFY 2008, SFY 2009 and SFY 2010. That plan includes five strategic objectives, each of which is defined further with action steps and milestones and with measures of success regarding consumer outcomes and system performance. The strategic objectives include:

- Establish and support a stable and high quality provider system with an appropriate number and choice of providers of desired services.
- Continue development of comprehensive crisis services.
- Achieve more integrated and standardized processes and procedures in the MH/DD/SAS system.
- Improve consumer outcomes related to housing.
- Improve consumer outcomes related to education and employment.

Baseline measures of consumer outcomes and system performance have been identified or are being developed for each of these objectives. See the Division’s web site for a copy of *Transformation of North Carolina’s System of Services for Mental Health, Development Disabilities and Substance Abuse, the State Strategic Plan: 2007-2010*.

Workforce Initiative: The NC Commission for MH/DD/SAS and the division undertook a joint effort during 2007 to recommend strategies for addressing workforce issues within the field in collaboration with DHHS and other state partners. These recommendations are in response to the considerable current and projected workforce issues experienced by the entire public MH/DD/SAS system in particular and as part of the overall health care system in general as North Carolina’s population and demand for services change.

The Office of State Budget and Management projects a 7.5% population growth (651,000+) for North Carolina from 2005 to 2010. This means that the number of people seeking MH/DD/SAS will continue to grow and will stress human and financial resources. Ideally, DMH/DD/SAS endorses a policy of budgetary increases based on population growth and inflationary increases, especially at the community level (similar to how public school funding is viewed).

Continued productivity and patient care is jeopardized by chronic under funding of operations that has resulted in aging equipment, a lack of preventative maintenance, and underutilization of technology in both facilities and division offices. A striking example of this is that DMH/DD/SAS facility employees are working with obsolete, hand-me-down computers discarded by another state department. A more egregious example of the inability to address current industry standards in technology is apparent in the problems the division’s institutions are facing in complying with the new Medicare Prospective Payment System for psychiatric hospitals and new Medicare Part D prescription drug billing protocols. The General Assembly approved the issuance of \$20M in special indebtedness to begin to develop the

necessary technology for the new hospital being built in Butner, but funding will not be sufficient to complete the project, let alone implement the new system in the other division facilities.

Financial investment in technology is required to address other issues such as:

- The state institutions currently do not have systems that most inpatient facilities find critical to ensuring quality clinical care by having real-time access to clinical information at the point-of-care. The only place that consumer data on ancillary services is compiled for consumers served in DMH/DD/SAS state facilities is in paper medical records.
- Inability of the division, LMEs and providers to communicate and transfer patient information effectively due to outdated information technology and information systems. No standard data system is in use at the LMEs, and the electronic medical records that some LMEs have developed independently do not interface with other LMEs or with the state facilities. The inability to communicate seamlessly regarding “shared” consumers exacerbates the problem of a lack of integration between state facilities and community services.
- Sharing of information/data on consumers being served by multiple public agencies to coordinate services and funding more efficiently. Some states are developing systems that allow a provider of service to submit a combined bill to the state for all services rendered and the state’s payment system identifies the specific “pots” of money that can pay for each service. NC is years away from being able to do this since there is no way of knowing at the state level which consumers are receiving services from multiple agencies.
- Inefficient, labor-intensive work systems that rely on manual and paper processes.

These problems can only be solved by investing in modern information systems, clinical care and client management/billing systems and new tele-medicine technologies; and then integrating these systems to improve consumer outcomes, information sharing and revenue recovery. DMH/DD/SAS has requested additional funding for computer hardware and software and replacement or upgrade of automation and clinical care and client management systems in state facilities. These investments would allow DMH/DD/SAS to participate more fully in the national movement to electronic medical records, documentation and electronic billing.

The division was a partner in DHHS’s efforts to secure a new Health Information System (HIS). HIS will provide a means for capturing, monitoring, reporting and billing services provided in local health departments, Child Development Service Agencies and the State Laboratory of Public Health. While HIS is not a solution for state facilities operated by DMH/DD/SAS, it could largely solve the information issues faced by LMEs and the local community providers. However, the decision has now been made that DMH/DD/SAS will not continue to be involved in this effort at this time. Since 75% of the LMEs use the software vendor that has been chosen as the platform for HIS, the division is still hopeful that this project may eventually be beneficial to LMEs and the division.

Lack of understanding of the complexity of the undertaking of transformation of the entire system and how long it would take to implement the required changes has caused some support to waiver. To the extent that the unique needs of the MH/DD/SAS community are understood, that support will increase. Some of the communications priorities listed by DMH/DD/SAS leadership are:

- Restructuring a web site that traditionally targeted the LMEs but must become more consumer and provider friendly.
- The division collects many data in the quality management section, but reports are too detailed and are not understood well by important constituencies. This information must be simplified so that decisions, actions, and priorities are better understood by all.

Other forms of outreach will be explored to better articulate the MH/DD/SAS vision to the public.

In some cases, better management practices have been identified that address funding and resource shortages. For example, the division has placed restrictions on which grants/demonstration project opportunities can be pursued. This was done for two primary reasons. It was decided that it was not prudent to devote scarce human resources to projects that do not contribute to achieving the core transformation goals of the division. In addition, many of the federal grants obtained in the past established programs that were funded in the short term but required recurring state funding to continue. This often resulted in a lack of sustainability. By reducing the number of grants and demonstrations pursued, the division is better able to guarantee the continued success of ensuing programs and services.

Performance based measurement is being applied to all contracts, not just those formed with the local management entities. The contract process—including how contracts are organized in the division—also represents opportunity for cost savings by improving contract language and speeding up approvals. This and other administrative processes are being reviewed to reduce the unnecessary layers of management review within the division, within the department, and from other areas of state government, and ensure that each working step represents value added to achieving the end objective.

Despite the great need for investments in facilities and technology, by far the most important key to success in DMH/DD/SAS is the ability to invest in people. Success in implementing reform of the MH/DD/SAS system depends on leadership and support at the executive and legislative levels of government. An important measure of this support is the recognition that highly trained, highly motivated people are needed to devise, administer and deliver critical services. Creative solutions are needed so that the division can become more competitive in the marketplace for professionals who are hard to recruit and retain. In many cases, the personnel system places nearly all job value on clinical skills and education. As job requirements evolve in the reformed system, so too must the state's personnel system evolve to account for and value non-clinical skills such as business, finance, quality and process improvement, and many of the other competencies that are now essential throughout the workforce.

Finally, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services will continue to obtain commitment at all levels of state, county and local government to fulfill its mission and promise to “...provide people with, or at risk of, mental illness, developmental disabilities, and substance abuse problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice.”

Key Indicators for Success

Status of Past Indicators

In 2006, the Division began publishing reports on the performance of the system, including the Semi-Annual Statewide System Performance Report and the quarterly Community Systems Performance Indicators reports. The DHHS-LME Performance Contract sets compliance standards and target goals for each LME on a number of performance measures. Quarterly reports track LMEs' compliance and achievement of the targets as spelled out in that document. As examples, some of the key indicators focus on access to care, timely engagement, admissions and re-admissions to state operated facilities, treated prevalence and community provider capacity.

In addition, information about outcomes for consumers is captured in the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS). NC-TOPPS captures key information on current episodes of treatment for consumers of mental health and substance abuse services. NC-TOPPS

aids in evaluation of active treatment services and provides data for meeting federal performance and outcome measurement requirements. It supports LMEs in their responsibility for monitoring treatment services in each LME's catchment area. In addition, NC-TOPPS facilitates the DMH/DD/SAS and LMEs and their provider agencies in quality improvement efforts.

Mental health and substance abuse consumers' perceptions of the care they receive are captured in an annual Consumer Survey, developed by the Mental Health Statistical Improvement Program. This national survey has been conducted in North Carolina for seven years.

North Carolina also participates in the National Core Indicators, a collaborative effort among participating National Association of State Directors of Developmental Disability Services (NASDDDS) member state agencies and the Human Services Research Institute (HSRI). The goal is to develop a systematic approach to performance and outcome measurement for consumers with developmental disabilities.

Reports from all of these initiatives provide extensive information about the status and progress of the operation and transformation of the system and its impact on consumers' care. See these reports on the Division's web site at: <http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm>.

1. To increase provider capacity and service availability across the state in an equitable manner in order to meet the needs of consumers.

As of December 3, 2007, there were a total of 2,133 endorsed providers, an increase of 994 percent since January 4, 2006.

Strategy 1.1. To develop a long range plan to determine service needs, service availability and gaps in service. See: Long Range Plan by Christina Thompson and Andrew Broskowski, December 2006 on the Division's web site at: <http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm>

Strategy 1.2. To facilitate the recruitment and enrollment of qualified providers.

Ongoing collaboration between the division and the Division of Medical Assistance (DMA) has resulted in a process for endorsing providers by LMEs and enrolling providers with DMA to provide and be reimbursed for services approved by the Center for Medicare and Medicaid Services. Providers that meet requirements are now fully endorsed and enrolled. In addition, joint efforts between the division and DMA have involved (1) provision of Accessing Care Training for LMEs and providers, and (2) audit and post-payment reviews of providers of Community Support services.

2. To provide greater standardization of management and service delivery at all levels to ensure consistency and quality of practices, including screening/triage/referral, person-centered planning, local management entity (LME) and provider oversight and data requirements.

Standardization of processes and procedures is one of the five strategic objectives in the division's three-year strategic plan. Accomplishments to date include:

- A uniform screening, triage and referral form implemented August 2006 for use by all providers. This form provides data on all individuals who access the system. See: <http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm#forms>
- Standardized person-centered plan forms and manual implemented July 2006. See: <http://www.ncdhhs.gov/mhddsas/pcp.htm>
- Standardized provider endorsement policies and procedures -- Implementation Update #33 (9/10/07) and policy revisions (12/3/07). See:

<http://www.ncdhhs.gov/mhddsas/stateplanimplementation/providerendorse/index.htm>

- Standardized LME-Provider Contract and LME-Provider MOA have been implemented.
- DHHS/LME Performance Contract spells out refined measures and reporting mechanisms and processes regarding sharing of client data. See:
<http://www.ncdhhs.gov/mhddsas/performanceagreement/index.htm>
- Standardized processes for service authorizations and claims processing and payment have been developed.
- The Frequency and Extent of Measuring (FEM) tool that is required in the DHHS-LME Performance Contract has been developed and published. Training has been provided to LMEs. This tool enables LMEs to determine the frequency and extent to which individual providers must be monitored and provides a score for publication locally.
- Quality management training for LMEs, providers, and Consumer and Family Advisory Committee members in the collection, documentation and use of data for management of services.

Activities currently underway include:

- Provider monitoring tools and manual are entering pilot testing phase for implementation 6/30/08.
- Processes for referral and continuity of care of consumers across a variety of service types and providers including community-based and state operated facilities.
- Defining how system-wide consumer outcomes and system performance measures will be used for planning and system improvement.
- Contract with Mercer to assess LME functions as implemented in 25 LMEs and to recommend ways to standardize or otherwise streamline these functions.

3. To establish a statewide utilization review process for state-funded services with standardized procedures and formats.

Two activities are underway as follows, yet it is important to recognize that recent legislation supporting single stream funding to LMEs affects how this indicator will be implemented.

- 1) Contract with Mercer to assess how LMEs currently carry out the UM/UR function with state funds and to recommend ways to standardize or otherwise streamline this function.
- 2) Based on the DHHS-LME Performance Contract, tools are under development for the division's ongoing monitoring of LME functions, including UM/UR for stated-funded services.

4. To complete the new central regional state psychiatric hospital to replace aging facilities at Dorothea Dix and John Umstead Hospitals.

Construction of the new Central Regional State Psychiatric Hospital is nearing completion. Recent events have delayed occupancy for 60 days to allow an assessment of the safety of certain structures for patients. The DHHS Secretary has undertaken strategies to assess the status and take needed actions. In addition, plans are underway to replace Cherry and Broughton hospitals given the age of these facilities.

5. To renovate the first of four units at O'Berry Center and obtain certification as a specialized developmental disabilities nursing facility to meet the growing service demands for this population in the eastern and central regions of the state.

The name of skilled nursing facilities has been changed in statute to neuro-medical treatment centers

as the first step in this process. The O'Berry Center (currently an ICF-MR facility) has begun the transition of the physical plant and staffing changes to qualify as a neuro-medical center by 2010.

Longleaf and Black Mountain centers are both certified as skilled nursing facilities and serve the appropriate population. Staffing and program changes are occurring to fully implement these centers as neuro-medical treatment facilities. See: Communication Bulletin #78 State Operated Services on the Division's web site at <http://www.ncdhhs.gov/mhddsas/announce/index.htm>.

6. To increase capacity to provide 84 acute beds at the ADATCs to divert involuntary substance abuse commitments from state psychiatric hospitals into more appropriate treatment.

Currently, progress differs at the three ADATCs:

- Walter B. Jones opened the 24 acute bed unit August 2007.
- Progress on the construction of the J. F. Keith unit:
 - July 2006—All drawings complete; ready to go to bid. Architect's final estimate places project cost at \$850,000 over budget. Cannot go to bid. Drawings sent to Office of State Construction for review.
 - Fall 2006—Office of State Construction submits outline of corrections/changes needed to plans. Work placed on hold until decision regarding funding made.
 - December 2006—Joint Committee on Governmental Operations approves DHHS plan for additional funding.
 - February 2007—Architects begin to address concerns raised by Office of State Construction review in fall 2006.
 - August 2007—Construction began.
 - August 2008—Projected completion date is August 28th.
- R. J. Blackley has been operating 20 acute beds. They have been unable to increase to the proposed 30 beds due to an ongoing psychiatrist shortage. As soon as this staffing situation is resolved, it can operate the final 10 acute beds.

7. To develop and implement a culturally competent workforce development plan for the service system that addresses the needs for the service system throughout the state.

In a joint effort, the division and the NC Commission for MH/DD/SAS has prepared a Workforce Development Initiative report that provides recommendations for addressing the current and future shortages and requirements for a quality workforce for the public MH/DD/SAS services system. This report is due for publication in May 2008. In addition, the division's Cultural Competence Advisory Group has been reconvened to meet every other month in 2008.

8. To develop and implement a recruitment, recognition and retention plan for the division that informs and involves staff and ensures adequate leadership for the future.

Division management continues discussion with DHHS Human Resources, especially regarding leadership of state-operated facilities and the effect of training and education requirements on increasing applicant pools.

9. To communicate effectively with all stakeholders.

In addition to the following strategies to communicate with stakeholders, the Division has conducted six town hall meetings, four videoconferences, and 10 Accessing Care training events for over 2300 attendees. Regular communication with stakeholders is provided through Communication Bulletins

and Enhanced Services Implementation Updates. These written communications can be found on the division's web site. In addition, the division published 10,000 copies of a consumer friendly version of the State Strategic Plan for 2007-2010.

Strategy 9.1. Establish an external advisory group of stakeholder organizations to obtain their guidance and advice on division policy and practices.

The External Advisory Team comprised of representatives from public partners was established January 2006 to provide a regular, recurring forum to discuss and provide input on policy matters related to transformation and operation of the public MH/DD/SAS system. The team meets monthly and provides input on various policies, rules and the strategic plan. In addition, the State Consumer and Family Advisory Committee as established by statute provides guidance and advice to the division on policy and practices at its monthly meeting.

Strategy 9.2. Revise the division's public web site to better inform and engage stakeholders and to be user friendly for diverse populations.

The division has completed a revision of its public web site following DHHS guidelines.

Strategy 9.3. Produce an annual report for the division to be communicated to constituents and publicized through the web site.

The division published annual reports for SFY2005 and SFY2006 and is in the process of developing the annual report for SFY2007. The annual report is distributed in hard copy and on the division's web site.

Current Indicators

The three performance indicators identified below reflect indicators of system performance rather than specific outcomes for consumers. There is current emphasis on transformation of the system and the need to monitor closely that the components of the system are operating as intended. Increased system performance in turn will bring positive outcomes for consumers. Plans for the future include refinement of measures of consumer outcomes currently measured by NC-TOPPS for mental health and substance abuse and National Core Indicators for developmental disabilities. As these are refined, the measures in the Business Plan and the PMD will come into alignment for consistency.

Indicator	03-04	04-05	05-06	06-07	07-08
Increase the use of community-based crisis services to reduce short-term crisis care (a stay of 1-7 days) in state-operated psychiatric hospitals	-	-	-	55 %	-
Increase the number of adults and children served with substance abuse problems by increasing the capacity of substance abuse services	-	-	-	43,740	-
Increase the percent of MH/DD/SAS providers accredited by an approved national accrediting body using December 2007 as the baseline	-	-	-	3.9 %	-

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Division of Public Health

Mission: To promote and contribute to the highest possible level of health for the people of North Carolina.

Vision: To add years of quality life for NC citizens and to eliminate health disparities.

The Current Environment

The NC DPH is responsible for overseeing operations of 85 local health departments and operating programs to protect the health of the residents of NC. A wide range of North Carolina Public Health programs and services on both the state and local levels combine to protect and improve the health of the people who live and work in North Carolina. North Carolina Public Health is community health. Disease prevention, health services and health promotion programs protect entire communities, not just individuals from risks such as communicable diseases, epidemics and contaminated food and water. The division works daily to reduce the impact of chronic and oral diseases.

National rankings offer a relative comparison among states and serve as an indicator for establishing priorities. Nationally, North Carolina ranks 40th in premature deaths and 36th in overall health. The state's poorest rankings are in smoking and obesity (in both teens and adults), diabetes, stroke mortality, infant mortality, HIV, and projected Pan Flu deaths. North Carolina's highest ranking is in childhood immunizations, with the third highest immunization rate in the country.

Key Operational Issues and Opportunities

Health promotion initiatives such as Smoke-Free places legislation, an increase in the tobacco tax, and the Eat Smart Move More campaign reduce health risks and promote healthy choices. Chronic disease programs such as stroke awareness, the stroke registry, provider training in stroke care and an expanded Breast and Cervical Cancer program are helping to address the leading causes of death.

The Child Health Initiative is bringing together expertise and resources from many partners working to improve the school nurse ratio, focus on reducing infant mortality, and promote advances in immunizations. The Early Intervention program is successfully addressing evaluation and service needs for young children. Public Health is leading an initiative to address child maltreatment.

Initiatives such as the antiviral stockpile, and the development and testing of preparedness plans in all local health departments will ensure North Carolina's capacity to respond in an emergency. Increased HIV/AIDS drug eligibility and mandatory and routine HIV testing will enhance the care of infected patients, and provide the resources needed for early detection and reduced infection rates. The capability in the State Laboratory is expanding to cover testing for infectious diseases and other conditions.

The new Health Information System (HIS) will be fully implemented by the end of 2008. The initial implementation of HIS will replace the functionality of the current Health Services Information System (HSIS) that has been operational since 1983. The HIS will provide an automated means of capturing, monitoring, reporting and billing services provided in local health departments, Children's Developmental Service Agencies (CDSA's), the State Laboratory for Public Health and environmental

lead investigations for the Division of Environmental Health in the Department of Environment and Natural Resources (DENR).

Under a multi-state collaborative project, a new WIC system is planned for roll out in SFY 2010-2011. The new system will replace an obsolete information system and provide functionality to enhance service delivery and program management in the WIC nutrition program. The NC Electronic Disease Surveillance System (NC EDSS) is a centralized system for disease reporting that will significantly improve the timeliness, reliability and accuracy of reportable disease in North Carolina. The Laboratory Information Management System (LIMS) is a system for submitting and reporting lab results electronically that will facilitate enhanced processes at the state lab.

Expanding partnerships in health initiatives involves working with partners at the local, state and federal levels. Bringing the expertise and resources of partners such as the Institute of Medicine and the NC Medical Society will enhance the division's capacity to affect positive change on a broad scale. Across the state, community-focused initiatives are targeting the elimination of health disparities. Expanded capacity in the Healthy Carolinians program supports Community Health Assessments and local partnerships.

The population of North Carolina is increasingly diverse, with a particularly high increase in the Hispanic population. Significant health disparities persist in the state. African Americans have higher death rates from heart disease, cancer, HIV, diabetes, homicide and stroke, compared to Whites. The African-American infant mortality rate is more than twice the rate for Whites. Hispanics in North Carolina have higher death rates for motor vehicle injuries and homicide and a higher percentage with no health insurance, compared to non-Hispanic Whites.

The increases in our aging population will drive demand for services to meet the specific needs of the elderly. Collaborations are emerging with other agencies, and evidence-based programs are evolving to support areas such as chronic disease self-management. The Public Health Task Force 2008 used the theme 'Foreseeing and Enabling the Future'. The Task Force recommendations are shaping DPH's priorities in the areas of Essential Public Health Services, Chronic Disease, Healthy Children and Families, Communicable Disease and Preparedness, and Finance.

Within five years, Public Health will have a statewide fully implemented accreditation program and implementation of a voluntary national model for state and local accreditation. The Public Health Accountability program will be institutionalized for state and local public health. The impact of the accreditation and accountability programs will be evidenced by standard capacity to deliver core functions consistently across the state.

A new facility is being built to house the State Laboratory jointly with the Office of Chief Medical Examiner. Current facilities are cramped and do not provide consistent electrical power, climate control and space configuration to ensure reliability, efficiency, accuracy and safety. The new building will provide a well-planned space with adequate capacity to support increases in workloads, test volumes and the complexity of testing methodologies and instrumentation.

Health Status

The state's most significant health challenges are in smoking and obesity (in both teens and adults), diabetes, stroke mortality, infant mortality and HIV. Reducing the impact of these challenges requires a multifaceted approach, including prevention, education, chronic disease management and advocacy.

Preparedness

The state must ensure full preparedness for all hazards and ensure the capacity to respond to and recover from disasters or other threats to the public's health. Planning, field testing and interagency coordination are essential functions in ensuring preparedness.

Health Information

Public Health practice relies on data to identify conditions, assess impacts of both threats and interventions and to assess performance. The availability of timely and accurate information is an on-going challenge.

Workforce

Workforce challenges are increasing as more workers are reaching eligibility for retirement, creating a steady loss of experience and institutional knowledge. The division is challenged to retain qualified and trained staff, particularly in highly marketable skill sets. Recruitment is difficult within the state salary schedule. The division is developing strategies to attract and retain qualified staff.

Emerging Threats

Emerging diseases and health threats will continue to pose challenges. Surveillance is essential in identifying outbreaks. Programs must adapt to meet emerging needs and changing priorities.

Key Indicators for Success

Status of Past Indicators

1. Addressing Women's and Children's Issues

- a. The statewide school nurse to student ratio will be 1:1175 based on the expansion budget request for 100 new school nurse positions in 2006-07 and 250 positions in each of the next four (4) years. DPH is working toward the national goal of 1:750. (Baseline: 2004-05 school year ratio was 1:1593)

Status: The North Carolina General Assembly provided an appropriation to the Division of Public Health for the School Nurse Funding Initiative in July 2004, beginning with the school year 2004-05. At this time the school nurse to student ratio was 1:1897. The Initiative provided funding for 80 permanent school nurse positions and 65 positions for a two year period at \$50,000 per position. The permanent positions were funded through an annual state appropriation of \$4 million, and the two year positions were funded through the Maternal and Child Health Block Grant at \$3.25 million for each of the two years. During these two years the ratio improved first to 1:1593 and then to 1:1571. In July 2006, the General Assembly assured that the 65 time limited positions would be permanent, and appropriated funding bringing the total to 145 full time school nurse positions supported through this Initiative. In July 2007, additional funds were appropriated for an additional 66 school nurse positions. These school nurse positions began during the 2007-2008 school year and have improved the ratio to 1:1280. It is anticipated that an additional 181 nurses will be needed each year for the next four years and 182 in the fifth year in order to meet the goal of one school nurse to every 750 students.

- b. The universal vaccine program will be 100% funded for all vaccines routinely recommended by the U.S. Advisory Committee on Immunization Practices (ACIP).

Status: The program is currently funded at 67% for all recommended vaccines for children. The additional 37% will be requested in the expansion budget.

- c. 20,000 patients (women and men) will be served under the family planning waiver and the number of low income patients (women and men) receiving family planning services by county will increase by 10% in 80 counties. (Baseline year: 2004).

Note: Low income patients include those persons in need of publicly financed family planning services (i.e., Medicaid, Family Planning Waiver, Title X) and served by all providers (public and private) in a county during a calendar year.

Status: For Waiver Year Two (October 1, 2006 through September 31, 2007), there were 49,393 individuals enrolled in the Family Planning Waiver program (41,520 women and 7,873 men). Of this number, 16,085 individuals received Family Planning Waiver services (15,955 women and 130 men) through Waiver Year Two. Between 2004 and 2007, the total number of family planning patients provided services by health departments declined from 135,760 to 129,375 (-4.7%). When examining individual counties, 16 of the 100 counties increased their individual caseloads by over 10% while 17 showed increases of less than 10%.

- d. The early intervention program will meet the goals on its State Performance Improvement Plan associated with enrollment into and transition out of the program and timeliness of service planning and delivery. The Plan is designed to move the state forward in meeting federal compliance requirements for the Infant-Toddler Program.

Status: The early intervention program has met the goals on its State Performance Improvement Plan associated with enrollment into and transition out of the program. Regarding timeliness of service planning and delivery, the program has made significant improvement, and is currently at 92% compliance; the target goal is 100%.

- e. There will be 450 medical practices actively participating in the “In the Mouths of Babes” (IMB) dental preventive services (including fluoride varnish) and providing a total of 400,000 dental preventive services cumulative since 2000.

Status: Accomplished as of September 2007, 452,132 cumulative dental preventive services have been provided since 2000.

2. Addressing Epidemiological Issues

- a. The HIV/STD Prevention and Care Branch will increase the number of persons tested annually by publicly funded test sites for HIV infection by 15%. (Baseline: 120,000 per year).

Status: Accomplished. The 2007 total number of such tests was 150,758, an increase of 26%.

- b. AIDS Drug Assistance Program eligibility will be increased to 250% of the federal poverty level. Current eligibility is 125%, the lowest in the United States (US).

Status: Accomplished. Rule 10A NCAC 45A .0202 Determination of Financial Eligibility was amended on October 1, 2007 to allow this increase.

- c. 100% of local health departments will have completed and exercised a local All Hazards Response Plans to include the Pandemic Flu Plans.

Status: Accomplished. All 85 Local Health Department Pan Flu Plans or Pan Flu annexes to All Hazard Plans were reviewed by the University of North Carolina's Center for Public Health Preparedness and North Carolina's Division of Public Health for content and consistency with State Pan Flu Plans. All but one Local Health Department have exercised their plan.

- d. DPH will have initiated construction of new state public health laboratory facilities and a new state medical examiner facility.

Status: Accomplished. The new facility housing the State Public Health Laboratory and the Office of the Chief Medical Examiner is currently in the design phase with groundbreaking anticipated by late 2008. Completion is planned for 2010-2011.

3. Preventing and Controlling Obesity and Chronic Disease Issues

- a. All NC schools and hospitals will have 100% tobacco free campuses for students, patients, staff and visitors 24 hours/day, seven (7) days/week.

Status: As of August 1, 2008, all school campuses are smoke free. Currently, 75% of the hospitals in NC have adopted a 100% tobacco-free policy for their campuses.

- b. NC will have an annual state wide surveillance system for child health indicators.

Status: The surveillance system, named CHAMP (Child Health Assessment Monitoring), has been launched as a demonstration project but needs funding for full implementation. The CHAMP survey was developed in the fall of 2004 and implemented in January 2005. CHAMP is the first survey of its kind in North Carolina to measure the health characteristics of children ages 0 to 17. Eligible children for the CHAMP survey are drawn each month from the BRFSS (Behavioral Risk Factor Surveillance System) telephone survey of adults (ages 18 and older). All adult respondents with children living in their households are invited to participate in the CHAMP survey. One child is randomly selected from the household, and the adult most knowledgeable about the health of the selected child is interviewed in a follow-up survey. All questions about the selected child are answered only by the most knowledgeable adult. CHAMP surveys will be revised each year to meet the child health surveillance needs of North Carolina.

- c. The public and decision-makers will be educated about the public health impact of increasing the cigarette tax by at least 75 cents, or 75% of the national average.

Status: The current excise tax is .35 cents and the national average is \$1.11. The division will continue to educate the public and key decision-makers.

- d. 100% of NC school districts will provide 30 minutes of daily physical activity for all students in grades K-8. (No baseline data currently available.)

Status: Policy issued by the NC Department of Public Instruction currently requires 30 minutes of daily physical activity. DPH continues to work with School Health Advisory Committees (SHAC) to fully implement the requirements statewide.

4. Implementing Accreditation of Health Departments

- a. 50% of the local health departments will be accredited.

Status: Currently 40% of the local health departments are accredited. By the end of 2008, DPH anticipates having 53% of local health departments accredited.

- b. The state DPH will be accredited using a state-established accreditation program.

Status: In Feb. 2007, NC successfully completed the first state level accreditation in the nation. DPH and Environmental Health (in DENR) jointly participated in a pilot accreditation process for state health departments during 2006-2007. The division completed a self-assessment based on the standards during September - November, 2006 and prepared for a site visit in February, 2007. Although DPH is not yet an accredited state health department, information about this pilot is being used to inform the development of a national accreditation process for state health departments, led by the newly appointed Public Health Accreditation Board.

5. **Strengthening Technology**

- a. Updates to the following IT systems under the PHIN:

- 1) **NC Electronic Disease Surveillance System (NC EDSS)** – part of the national system to electronically report diseases and conditions of public health significance.

Status: TB component is fully functional and other diseases will be operational mid 2008.

- 2) **Vital Records (VR)** - A system that will improve birth and death registration processes.

Status: Implementation is planned by the end of 2008.

- 3) **Laboratory Information Management System (LIMS)** – electronic system for submitting and reporting laboratory results.

Status: Projected for implementation by mid-2008.

- 4) **Health Information System (HIS)** - A replacement of the outdated Health Services Information System (HSIS). HIS will provide a means for capturing, monitoring, reporting and billing services provided in local health departments, Children’s Developmental Services Agencies and the State Laboratory of Public Health.

Status: The HIS is projected to be fully implemented in 2008.

- 5) **State Agency Model (SAM)** for Women Infants and Children (WIC) program

Status: The planning phase concludes in 2008. Full implementation will be completed in 2010-2011.

Current Indicators

Indicator	03-04	04-05	05-06	06-07	07-08
The vaccination rate among children 19-35 months of age	-	-	-	-	-
Infant mortality rate (deaths per 1,000 births)	-	-	-	-	-
Percentage of adults who are obese	-	-	-	-	-

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Division of Services for the Deaf and Hard of Hearing

Mission: The Division of Services for the Deaf and the Hard of Hearing (DSDHH) serves individuals who are deaf, hard of hearing, deaf-blind or speech-impaired, their families, and communities in North Carolina (NC) by enabling them to achieve equal access, effective communication and a better quality of life.

Vision: Every person who is deaf, hard of hearing, deaf-blind or speech-impaired in NC has equal access to those community and human services that are provided to all individuals in the community.

The Current Environment

Through seven regional centers and central staff located in Raleigh, DSDHH provides direct services to individuals, private and public agencies, medical and health care facilities, community organizations, educational institutions and businesses. These services range from direct assistance and training to access advocacy, counseling, communications and information dissemination, and interpreter skills development.

One out of eight North Carolinians, or just over one million people, experience some degree of hearing loss. By 2030, there will be about 2 ½ million residents with hearing loss, with many more of them experiencing hearing loss at relatively early ages. This rapid growth of the customer base stresses resources at all service levels and has created high demand for staff with specialized knowledge and skills.

In February 2005, NC became the first state in the nation to establish an ongoing, statewide program to distribute hearing aids to eligible low-income NC residents. The division is a national leader in other areas such as marketing and communications. Counterparts in several states have cited the division's media campaign and outreach activities as a model in terms of market penetration (e.g., 90% of the 35+ NC television markets) and effectiveness (e.g., utilization of social marketing practices to better reach target audiences) in creating awareness about service availability.

Key Operational Issues

As the population of individuals with hearing loss grows, the need for improved technology will be an increasing factor in core business operations. Systems are needed to track telecommunications and other assistive technology equipment that has been authorized or distributed to customers. Because effective communication access by customers is critical, a process needs to be in place to assure the division's technological resources are kept commensurate and compatible with the technology commonly used by their customers. Effective case management will require information coordination within the division and across DHHS divisions such as Vocational Rehabilitation and Services for the Blind. Operational efficiencies can be enhanced through better internal coordination with DHHS offices such as Budget and Analysis, Human Resources, Property and Construction, and Information Resource Management.

Non-competitive salaries and specialized skill requirements have forced DSDHH to expand out-of-state recruiting and have severely impacted the division's ability to fill critical vacancies. This not only impacts programs and services, but also impacts the capacity of the division to operate efficiently because available resources are frequently diverted to deal with emergencies and other short-term issues. Further, the small size of the division's management hinders its capacity to be consistently responsive to operational demands at all levels.

Staffing shortages impact service agencies as well as state offices so that there is an ongoing struggle at all service levels to maintain an adequate knowledge base from year to year; therefore, training occupies more and more of the resource capacity of the division. This includes supervisory and business management training for managers, interpreter training, training for providers of communications access equipment, customer service and client assessment training, and teaching service providers how to work with individuals with diverse needs.

The division has taken on a number of projects that will have positive effect in the near term:

- The ESS Replacement Project managed by DIRM is a joint project between DSB and DSDHH to replace a legacy database system that is currently used for application processing /payment processing/tracking of many DSDHH services. This project will continue into 2008-2009.
- An internal Telecommunications Equipment Distribution Program (TEDP) project for scanning processed TEDP applications to reduce paper retention and allow for online lookup of processed applications for equipment is on target to be completed mid-2008.
- An internal bandwidth increase project for all DSDHH offices to allow for direct video communications for ASL (American Sign Language) conversions and for better access to VRS (Video Relay System) operators for all staff is on target to be completed in six of our seven locations by mid 2008. As part of this project, an internal video conferencing server also is being planned for mid-2008 for desk to desk video conferencing to allow all staff, deaf and hearing, to communicate more easily. This will allow for more equal communications access for our deaf, hard of hearing, and hearing staff. This system will also be used for interoffice meetings and training sessions.
- An internal project connected to the bandwidth and video conferencing project is looking at remote ASL evaluations as well as remote mentoring of interpreters-in-training. This will allow staff at each of our locations to participate in real-time evaluations of SLPI (Sign Language Proficiency Interviews) as well as distance mentoring, thus reducing travel and allowing better use of our limited staff resources for this need. This will also include video processing needs associated with the services DSDHH provides.

Key Indicators for Success

Status of Past Indicators

By 2008:

1. The division's media campaign will maintain a 90% penetration of the 35+ NC television markets and a 50% penetration of the 35+ radio markets.
 - Actual result: Penetration was not measured since a media campaign was not undertaken until late in 2007. Since there is a direct correlation between the frequency of ads and requests for services, the campaign was purposely muted so as not to overwhelm limited staff resources; however, to help handle calls, the division has established a formal agreement with the Office of Citizen Services to provide CARELINE support.
2. The number of clients served per year will increase from 2,500 to 3,500.
 - Actual result: 3,757, an increase of 14.5% from SFY06 to SFY07
3. The number of agencies served per year will increase from 1,400 to 2,500.
 - Actual result: 1,575 (However, the number of agency staff served by the division increased)

4. The number of hearing aids (one per individual) distributed per year will increase from 1,010 to 3,000.
 - Actual result: 4,141

5. The number of individuals served by the division's Telecommunications Equipment Distribution Program (TEDP) will increase from 2,000 to 8,000.
 - Actual result: 7,343

Current Indicators

Indicator	03-04	04-05	05-06	06-07	07-08
DSDHH - number of clients served	-	2,521	3,280	3,757	-
DSDHH - number of agency staff served at such agencies as social services, healthcare, law enforcement, emergency alert/response and the judicial system.	-	3,058	4,075	4,177	-
DSDHH - Total number of Adaptive Telecommunications Equipment (TTY's, electronic speech aids, Telecoil hearing aids, weather radios, etc.) approved for distribution ¹	-	1,913	5,263	7,343	-

¹The Telecoil Hearing Aid Distribution Program was implemented for FY 06-07 which resulted in the substantial increase from 05-06 to 06-07. The measure accounts for equipment approved for distribution since actual distribution to clients can take 2-3 months (due to manufacturer lead times, need for professional instruction on use, etc.) and may span across 2 fiscal years.

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Division of Services for the Blind

Mission: To enable people who are blind or visually impaired to reach their goals of independence and employment.

Vision: DSB will be known across North Carolina as the leader in providing employment and independent living services for people who are blind or visually impaired.

The Current Environment

As DSB strives to be a leader in enabling people who are blind or visually impaired to reach their goals of independence and employment, it is imperative that the division focuses on a few key areas. As the vision statement indicates, one key item necessary for success is getting the word out to individuals who need the services offered by DSB. It is not uncommon for individuals receiving DSB services to comment that they wish they had known about DSB sooner. These comments are often made by families who have children with significant vision loss who could have benefited from DSB services as the children transitioned from school to other training or employment. Or, from adults who lose their vision and were not aware of the services that the division could provide to help them develop independent living skills and continue to work. For this reason, a central part of the DSB plan is to market its services, with a particular emphasis on minorities and retirees.

Also central to DSB success is improving employment opportunities for people who are blind or visually impaired. The division will focus on three areas in order to accomplish this goal: (1) becoming recognized as the leader in the use of and in having expertise about assistive technology for those with vision loss; (2) broadening relationships with employers; and (3) identifying training that will provide skills that match the needs of the job market and encouraging those served by the division to pursue training.

Assistive technologies are a critical element in helping blind and visually impaired North Carolinians to work and live independently. These technologies are constantly advancing and changing, which requires DSB staff to keep abreast of technology that is available as well as being experts in the use of the technologies. DSB works closely with vendors to maintain and build expertise.

Formerly DSB appealed to the goodwill of employers to hire blind and visually impaired employees. DSB now positions itself as a source of good employees who can meet the needs of employers. This requires educating and building relationships by marketing to employers.

As the economy of North Carolina changes, the types of jobs available are shifting to more service and professional jobs. This means that DSB must ensure that vocational rehabilitation specialists are qualified to train people in the skills needed in the current job market. DSB is constantly evaluating its programs, services and staff knowledge to determine what changes should be made in order to meet the needs of the consumers seeking employment as well as the business community that hires DSB constituents.

Key Operational Issues

DSB faces some challenges to operate effectively. One of these is the ability to recruit and retain qualified rehabilitation Counselors. This proves challenging for three reasons: (1) the pool of qualified candidates is small; (2) the Rehabilitation Act of 1973, as amended, sets a high education standard for people employed in rehabilitation counselor positions; and (3) DSB has a difficult time competing with

other employers, particularly private sector agencies, for the limited number of qualified candidates for counselor positions.

DSB has begun the process of replacing the Electronic Services System, an early 1990-era database which is now outdated. The ESS serves several purposes including (1) processing authorizations and invoices paid for services to consumers and (2) tracking data on individual consumers served which is used to generate program reports at the state and federal level. The new system will be web-based, providing easier access from remote locations and by those who use adaptive technology.

Another challenge is found in working with other state agencies and departments to ensure that their initiatives which impact on DSB staff or consumers are accessible, particularly when forms or other electronic formats are used. DSB has a number of employees with vision loss who use assistive technology and are very independent in performing all aspects of work within the division when good access is available. However, any initiatives that do not employ accessible formats will create major operational difficulties for the staff which will ultimately have an impact on the consumers served.

Key Indicators for Success

Status of Past Indicators

1. By 2008, the average wage of visually impaired individuals who have successfully achieved their employment goals through services received from the North Carolina Division of Services for the Blind will increase by 15%.
 - While there has been a slight increase in wages for consumers who have been successfully employed since 2005, DSB has not yet met this goal. With the addition of assistive technology (AT) staff and increased training opportunities for AT staff, more consumers will be placed in technology related jobs.
2. By 2008, the number of visually impaired individuals who will be receiving services from the DSB Independent Living Program, will increase by 8%.
 - There has been an 8% increase in the number of consumers served in the Independent Living Rehabilitation Program since 2005.
3. By 2008, the North Carolina Division of Services for the Blind will increase statewide staff communication, as measured by ninety-five percent of staff indicating “a positive improvement” by survey.
 - A survey will be conducted in 2008 to determine staff satisfaction. While DSB has been getting positive feedback from supervisors at quarterly meetings, a planned video conferencing system available in all our district offices to use for training and meetings has not been approved. In addition to improving communications, such a system would reduce travel expenses and increase the capacity of our limited training staff.

Current Indicators

Indicator	03-04	04-05	05-06	06-07	07-08
Increase in wages for consumers	\$329	\$353	\$332	\$354	-
Increase in the number of consumers served in Independent Living Program	-	7,869	7,870	7,686	-
Increase out reach activities	-	-	-	143	-

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Division of Social Services

Mission: The Division of Social Services (DSS) is committed to providing family centered services to children and families to achieve well-being through ensuring self-sufficiency, support, safety and permanency.

Vision: All programs administered by the Division of Social Services will embrace family centered practice principles and provide services that promote security and safety for all.

The Current Environment

With few exceptions, North Carolina's social services system is state supervised and county administered. The federal government authorizes, provides regulations and funding for programs in each state while the state provides funding, policy, technical assistance and support. Actual delivery of services and benefits to customers is performed by the 100 county departments of social services and non-profits across the state.

While Child Support services are primarily provided by county departments of social services, services in 28 counties are provided by 16 state operated Child Support Offices and in 9 counties, the Child Support Program is administered by another county entity or is privatized. Refugee Services and some family support services are provided by non profits across the state.

DSS provides program supervision, policy, training, technical assistance and consultation to the county staff and non profits that work in the following program areas:

- Child Protective Services
- Family Preservation and Support Services
- Foster Care Services
- Adoption Services
- Food Stamps
- Low Income Energy Assistance
- Crisis Intervention
- Refugee Assistance
- Work First
- Child Support Services (organization and additional DSS responsibilities explained above)

Despite almost uninterrupted economic expansion in NC over the past decade, DSS, like other DHHS divisions, facilities and schools, is increasingly stressed by a rapid growth in a demand for services that has not been matched by increases in funding or resources.

Since 1990, NC population has grown from 6.6 million to nearly 9 million, and is projected to be about 9.5 million by 2010.¹ This population growth has been fueled by a robust job market, particularly in construction and high tech, as well as by a growing number of seniors who view the state as an attractive retirement locale. These developments have expanded the tax base and benefited a large majority of North Carolinians, but other dynamics have had negative impacts that trigger social service intervention.

¹ <http://www.ncruralcenter.org/databank/datasheet.asp?topic=Population>

While the traditional industries of textiles, furniture and tobacco retain importance in the state, these industries have been struggling due to global competition. Displaced workers in these industries are generally not trained for the type of work available in the state's growth areas such as biotechnology, pharmaceuticals, computer software and hardware, electronics, tourism and construction. Even if training were not an issue, jobs may not be geographically accessible to displaced workers who have little or no resources to relocate.

Still other factors have influenced the need for social services in NC. The state has experienced an increase in single parent families, an increase in teens that do not complete high school, and an increase in children who have difficulty speaking English (not just Spanish speakers, but other languages as well). Substance abuse, particularly methamphetamine use, manufacture and domestic violence remains a concern. Energy and fuel prices have skyrocketed for everyone, but especially impact low income families and individuals. Finally, due to its large military population, NC has experienced a large number of deployments and deaths during the gulf war that impact families and the economy in military communities.

Key Operational Issues

Because of the significant operational issues and opportunities that are impacting DSS, strategies have been developed and are being implemented to address them. In the area of child safety, opportunities are available to improve the quality of service at point of delivery.

The Multiple Response System (MRS) is an effort to reform the entire continuum of child welfare in NC, from intake through placement services. MRS has been implemented in all 100 counties. The reform is based upon the application of family centered principles of partnership through seven strategic components:

1. Collaboration between the work first family assistance and child welfare programs
2. A choice of two approaches to reports of child abuse, neglect or dependency
3. A redesign of in-home services
4. A strengths-based, structured intake process
5. Coordination between law enforcement agencies and child protective services for the investigative assessment approach
6. Implementation of child and family team meetings during the provision of in-home services
7. Implementation of Shared-Parenting meetings in child placement cases

Through MRS, families will experience seamless access to services as they are transitioned from one to another by a single caseworker. Providing these services to families will require social workers to work non-traditional schedules, continuously engage community partners, and view family members as equal partners.

There has been a philosophical shift facilitated by MRS system reform process. Communities' have an increased responsibility to develop and maintain support services for families to insure that children are safe, healthy and their wellbeing needs are met. Due to an increased focus on strong community partnerships, communities are challenged to work together to build strong community. Increasing Work First Participation Rates will indicate that some of the most vulnerable and overburdened families have the skills and abilities necessary to work and contribute to meet the basic needs of their family. Ultimately, families who have jobs and work will become economically self-sufficient which is the primary outcome for all Work First participants.

While DSS experiences chronic restrictions in federal funding for many programs, the division has a good record in streamlining policies and process for county social services employees to increase efficiencies and make better use of available dollars. Other small technology changes also help, such as the use of debit cards in Child Support Enforcement, expansion of web-based services and electronic court services. Despite these efforts, reduced and restrictive federal and state funding are major concerns across the DSS spectrum.

Finally, it is increasingly difficult to fill vacancies in DSS with qualified individuals. Due to the nature of NC's county administered system, experienced employees from counties are ideal choices for many of the division's vacancies. However, state pay schedules and benefits have not kept pace with many county social service agencies. This results in vacancies remaining open for extended periods while the jobs are posted often multiple times. This lag time results in increased workloads for those remaining staff who are attempting to continue the work of the division.

In summary, DSS is aggressively pursuing innovative approaches to case management, performance measurement and community involvement. While of necessity many of the division's actions are reactionary, they are increasingly focused on prevention by attempting to influence behavior patterns. Examples are evidence-based program administration where decisions are made on outcome evidence rather than statistical or anecdotal information; and strengths-based structured input where familial strengths are identified and used as building blocks for improvement. Many of these innovative clinical approaches are enhanced – even dependent – upon improved, seamless information access throughout the social services network.

Key Indicators for Success

Status of Past Indicators

Child Support Enforcement

- Collections increased by 6% over the previous year.
- Completed implementation of arrears collection contract with a private vendor through the AG's office.

Family Support and Child Welfare

- Youth aging out of foster care with a support system continues to be challenge. LINKS is the state's outcome-based program, which allows counties to use a flexible spending approach to design services to meet the unique needs of youth aging out of foster care. County DSS engage youth in a variety of skill development and vocational activities which supports their transition into adulthood. Youth also work within their community to identify at least 5 caring and responsible adults who are involved with their life outside of professional relationships.
- Through the implementation of MRS, the state has effectively reduced the rate of repeat maltreatment. In addition to the human benefit of reduce child abuse, such an approach is cost effective. Through the reduction in repeat child maltreatment, entry into the foster care system is reduced. Caring for children in custody of the state is an expensive and ineffective means to ensure child safety. Through the provision of services to children and families placement of the children is less likely, thus saving the state the more costly service of foster care.
- Children in families where substance use is prevalent continues to be a risk factor for child abuse and neglect. Accessing mental health services for these children and families is a concern. The Division has clearly increased its ability to identify and assess cases more accurately through the use of Structured Decision Making tools. Early identification of mental health and substance problems has the potential to assist counties in putting services in place that are needed.

- Seventy percent of all counties have developed community protocols through their Drug Endangered Children (DEC) teams or through other pre-existing community teams. Counties have increased their awareness and are better prepared to address issues concerning the use and manufacture of methamphetamine.
- More than 3,500 DSS child welfare staff were provided training in the strategies of MRS associated with CPS in 2007. Training was provided to community partners which supports an ongoing process part of our effective partnerships focus.

Food and Nutrition Services

- The National Average for Payment Accuracy was 96.16 percent. North Carolina exceeded the National Average.
- The performance measures for last year were:
 - Program access/participation rate of 64.16% (September 2006).
 - Payment accuracy rate of 97.17% (September 2006).
 - Application processing timeliness rate of 96.66%.
- North Carolina earned bonus funding in 2006 for application processing timeliness in the amount of \$2,072,590, and also received bonus funding for Payment Accuracy in the amount of \$4,021,638.

Current Indicators

Indicator	06-07	07-08
Child Support Enforcement		
• Total Collections	-	-
• Percent of Cases Under Order	-	-
• Current Support Collection Rate	-	-
Family Support and Child Welfare		
• Reduction in the number of children in the foster care program by achieving permanency	-	-
• Improved retention and recruitment of child welfare staff	-	-
• Increase in local/community programs which provide support services to families	-	-
• Improve the Work First Participation Rate	-	-
Food and Nutrition Services		
• Exceed the national average for payment accuracy and improve division numbers	-	-
• Improve program access/participation rate	-	-
• Improve application processing timeliness	-	-

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Division of Vocational Rehabilitation

Mission and Vision

Mission: To promote employment and independence for people with disabilities and link them with the resources they require through customer partnership and community leadership.

Vision: North Carolinians with disabilities will live and work in the communities of their choice with economic and other supports available to help them achieve and maintain optimal self-sufficiency and independence.

The Current Environment

As the Division of Vocational Rehabilitation (DVR) strives to assist individuals with disabilities in meeting their vocational and independent living needs, they face many challenges. Among these are the increase in the percentage of the population that is disabled, the changing needs of the job market, increasing clientele with limited English proficiency, and changes in the way citizens expect to access information and support.

To address these challenges, DVR has established six core values that drive all programs and service delivery. These are:

1. Balancing regulatory compliance with valued outcomes as perceived by customers
2. A service mindset as the foundation for success
3. Limiting regulatory burden on direct service staff and external customers
4. Evidence based decision-making
5. A high involvement culture
6. A performance based culture

In addition to these core values, customer and relationship management play an integral part for all programs of the organization. DVR continues to analyze the value being provided by the services being offered through the division. They are also adapting the way they deliver services in order to offer a continuum to accommodate consumers needs. This includes developing more self service options by using web-based and other technologies to produce:

- More effective outcomes and therefore more satisfied consumers
- Lower costs
- Increased organizational capacity
- Staff spending a higher % of time using expertise with consumers who need it and can benefit from it most
- A more integrated approach that incorporates all players in the VR process (employers, vendors, referral sources, other agencies)

By implementing these core values and customer focus, DVR is committed to being performance and strategy driven and having a culture of continuous improvement and change.

The Division of Vocational Rehabilitation Services has begun implementation of several initiatives to further the commitment to continuous performance improvement throughout its organization. These efforts are required in order to meet the need for individualized services while managing staff

recruitment/retention issues and a rapidly changing job market affecting the outcomes for the individuals with disabilities served.

Dual-Customer Approach: In FY 2007, Vocational Rehabilitation Services successfully piloted an approach to job placement that emphasizes the needs of job seekers with disabilities and those of prospective employers. This dual-customer approach emphasizes the employer's need for qualified workers, and that Individuals with disabilities represent qualified applicants who can meet these needs.

A new database, the Employment Management System, allows counselors and Business Relations Representatives to track employers, qualified applicants, job openings and placements as a part of the placement initiative.

Human Resource Initiatives: Since January, 2005 DVRS has offered a paid internship program to graduate students in rehabilitation counseling programs. The Division has worked with 107 paid interns and of those, 31 interns were hired. DVRS is tracking the retention rate of these employees in order to determine if the internship positively influences retention.

A New Manager Mentoring Program began in February, 2008 as one strategy to counteract continuous staff turnover and the shortage of qualified rehabilitation professionals as defined and required by the Rehabilitation Services Administration which is the federal agency administering the public vocational rehabilitation program and other related programs under the Rehabilitation Act. The purpose of the pilot is to shorten the learning curve for new managers, build self-confidence, provide support in addition to what they receive from their managers, and assist with workforce planning.

In 2007 DVRS placed 4 ads on the CareerBuilder.com website to see if that would improve our recruitment efforts. Only 4 of those slots have been used to date and 9 employees were hired as a direct result of using CareerBuilder.com. DVRS will be renegotiating another agreement as soon as the last slot is expended.

Recruitment and Retention Committee: DVRS has a statewide recruitment and retention committee that meets quarterly to review recruitment and retention statistics, develop plans of action, and track the result of those actions.

The role of "recruiter" within the Division's Human Resources area has been redefined. The recruiter assists hiring managers with rewriting vacancy announcements to increase the pools of qualified candidates; talking to applicants about other vacancies DVRS has in addition to the one they have applied for; sourcing new avenues for advertising positions, and providing statistics to target recruiting difficulties.

In addition, a new position classification, *Human Service Coordinator*, has been developed which allows counselors more time to better manage their caseloads. This new position will decrease the dependency on the number of rehabilitation counselors with master's degrees needed in the future because of the shrinking supply of candidates, assist with recruitment of professional staff with either unrelated master's degrees or bachelors degrees, and maintain service delivery to consumers at the current level, if not better. The Human Service Coordinator positions also provide a career ladder for bachelor-degreed employees in the field of vocational rehabilitation to retain employment with DVRS.

Comprehensive Assessment Tool for the Independent Living Rehabilitation Program (ILRP): This pilot tests use of a comprehensive assessment tool comprised of valid and reliable survey instruments to measure functional limitations of consumers of the ILRP before and after services. From 09/07 to 02/08, 195 people were assessed before services began; of which none has completed services at this time. The

change in measured functional limitations of consumers will be part of the overall program evaluation of ILRP services impact and effectiveness.

Disability Determination Services (DDS) Electronic Procedures Initiative: This initiative will expand the implementation of the electronic processes to additional levels of claims processing beyond enhancements presently being incorporated in the current electronic processing of *initial* claims and *reconsideration* claims (claims resubmitted for reconsideration following initial claim denial).

Strategic Planning: Planning and review of policy and programs continues with a new emphasis. The Director is making sure that the direct service providers (VR Counselors, Engineers, Support Staff and Business Relations Representatives) have input on all issues and an opportunity to question procedures and policy that are not helpful. The Executive Leadership Team reviews issues and provides guidance and implements needed changes statewide. Providing quality services, effective communication, excellent customer service and access to information for both internal and external customers is the priority for this initiative.

Outreach and Expansion: DVRS has expanded programs that serve individuals with traumatic brain injury, individuals for whom English is a second language and education to staff regarding these issues. The Multicultural Work Group has completed a two year project reviewing data regarding diversity and made recommendations to the Executive Leadership team for inclusion in strategic planning. The Division has been asked to present at numerous national conferences to share unique approaches to employment (micro enterprise/self-employment) and development of partnerships with advocacy agencies. The Division sustains many positive long-term relationships with advocacy groups and councils appointed by the general assembly.

Key Operational Issues

Due to a high turnover rate among Division staff, the staff often covers multiple caseloads and has a very large workload. In addition, many of the entry-level and manufacturing jobs historically available within the state's economy are no longer available for individuals with disabilities. This combination of current trends requires a shift in staffing patterns, improved technology and innovative approaches to job placement for individuals with disabilities

To enable DVR to attain its organizational strategy, there are several factors related to operational needs. To begin with, management in the division needs easy access to their data for analysis and decision support which is critical for evidence based decision making and an outcomes focus. A concerted effort has been made to remove any procedural barriers that prevent management and staff from receiving data and analysis of the data in a timely manner.

A second critical operational need is external access to DVR information resources. This is for both external partners and DVR field staff. For the former, DVR needs the ability to make available to external partners some information resources while protecting others. DVR field staff need to access information resources as if they were sitting at a desk in the main office. The field staff needs this level of access even while utilizing computers and networks that are not managed by DVR (such as rehab counselors who are located in schools).

For the Independent Living Rehabilitation Program (ILRP), customer demand is expected to increase as the baby boomer generation ages. Most ILRP services involve home visits, community involvement and outreach; therefore funding to support this must be available. ILRP counselors need laptop computers

with access to the internet so that forms can be completed at a consumer's home and uploaded to the data system.

In order to conduct assistive technology (AT) assessments and provide effective AT services, the North Carolina Assistive Technology program administered by DVRS must have the capacity to download and install demonstration software applications *and* maintain a secure environment. Also, staff need access to the statewide computerized database for assistive technology programs without interference from pre-established firewalls and other security mechanisms.

In order to provide counselors and other direct service personnel with the time needed to provide placement and excellent customer service, the case management and information system must be updated. Although, there have been many positive changes in the current system, there are still areas that are burdensome to the counselors and require an inordinate amount of work to utilize. A more modern, flexible system would address this need and allow rapid implementation changes that are required by the Rehabilitation Services Administration.

DVR is also very aware of the special needs that persons with disabilities have in utilizing information technology resources. For example, web pages need to work well with screen readers used by those who are visually impaired. Another example is instant messaging, which is an excellent communication tool for people who are deaf or hard of hearing.

The need for assistive technology services also continues to grow at a rapid pace as well as the technology changes regularly occurring in the assistive technology arena. Keeping staff trained and current on new equipment is necessary to continue to provide the best services. Furthermore, additional staff skilled in various skill sets is essential to providing the quality services necessary. The North Carolina Assistive Technology Program must continue to partner with private entities to expand resources across the state.

New strategies have been utilized to make client purchases more efficient within the parameters of state purchasing requirements. In addition, customer service initiatives contribute to increased staff morale and collaboration. IT services maintains close communication with DIRM in order to address the IT needs cited above.

Another operational need is in the recruitment and retention of qualified staff. Federal requirements have raised the educational requirements for core staff of DVR and the need for staff with a second language skill, including sign language, is increasing. State salary classifications and requirements, lack of competitive salaries, and lack of faster processes to change these areas create a difficult workforce issue for the division.

Disability Determination Services, which has reporting ties to DVR, is a leader in the nation in its recent transfer to a paperless environment for processing Social Security Insurance (SSI) claims. NC DDS was chosen as a pilot because of its reputation for having effective processes and openness to change. The new system and accompanying reengineered processes have been a big success. Together they have resulted in increased worker efficiency, improved customer service, and access to more meaningful data for management analysis of processes.

In NC, all SSI determinations can be adopted by Medicaid, which in many cases prevents duplicate processing of SSI and Medicaid claims. However, in NC, Medicaid claims can be filed separately or without an SSI claim at all. These Medicaid claims cannot be processed with the new electronic system and associated processes. This creates duplication in systems and processes which reduces efficiency and creates staffing problems.

Key Indicators for Success

Status of Past Indicators

Rehabilitation Services Administration (RSA) Outcomes:

1. Number of individuals who achieve an employment outcome during the current performance period compared to the number of individuals who exit the VR program after achieving an employment outcome during the previous performance period.
RSA Performance Level: To exceed previous year
NC DVRS, FFY 2007: 6,271 (-993)
NC DVRS, FFY 2006: 7,264 (-1,478)

 2. Of all individuals who exit the VR program after receiving services, the percentage who are determined to have achieved an employment outcome
RSA Performance Level: 55.80%
NC DVRS, FFY 2007: 47.15%
NC DVRS, FFY 2006: 38.46%

 3. Of all the individuals determined to have an employment outcome, the percentage who exit the VR program in competitive, self or Business Enterprise Program employment with earnings equivalent to at least the minimum wage.
RSA Performance Level: 72.60%
NC DVRS, FFY 2007: 100.00%
NC DVRS, FFY 2006: 99.66%

 4. Of all the individuals who exit the VR program in competitive, self or Business Enterprise Program employment with earnings equivalent to at least the minimum wage, the percent who are individuals with significant disabilities.

RSA Performance Level: 62.40%
NC DVRS, FFY 2007: 71.82%
NC DVRS, FFY 2006: 65.78%

 5. The average hourly earnings of all individuals who exit the VR program in competitive, self or Business Enterprise Program employment with earnings equivalent to at least the minimum wage, as a ratio to the state's average hourly earnings for all individuals in the state who are employed.

RSA Performance Level: 0.52 Ratio
NC DVRS, FFY 2007: 0.51
NC DVRS, FFY 2006: 0.49

 6. Of all individuals who exit the VR program in competitive, self or Business Enterprise Program employment with earnings equivalent to at least the minimum wage, the difference between the percentage who report their own income as the largest source of economic support at the time they exit the VR program and the percentage who report their own income as the largest single source of support at the time they apply for VR services.

RSA Performance Level: 53.00 Mathematical Difference
NC DVRS, FFY 2007: 65.05
-

NC DVRS, FFY 2006: 66.00

7. The service rate for all individuals with disabilities from minority backgrounds as a ratio to the service rate for all non-minority individuals with disabilities.

RSA Performance Level: 0.80 Ratio

NC DVRS, FFY 2007: 0.97

NC DVRS, FFY 2006: 0.97

DVRS met the criteria of four out of seven of the performance indicators instituted by the Rehabilitation Services Administration. Although four indicators were passed, federal regulations require the completion of the two primary indicators related to Standard I, Employment. DVRS implemented a program improvement plan in order to improve performance on the standards and indicators.

State Outcomes:

1. Number of individuals receiving services who reported a high level of satisfaction with VR Program services.
Status: For the past fiscal year, 67.80 percent of individuals receiving services reported a high level of satisfaction with VR Program services.
2. Retention of Rehabilitation Counselors
Status: Retention of Rehabilitation Counselors continues to present a challenge. Several Human Resources initiatives are in place to address this issue.
3. Recruitment time for deaf and hard of hearing caseload
Status: The length of time required to recruit counselors for the deaf and hard of hearing caseloads has decreased during the last year. Outreach to members of the deaf community including presentations to advocacy groups and forwarding information regarding open positions has been effective. DVRS is receiving assistance with referrals of qualified applicants. The recruitment time for support positions has not improved.
4. Use and implementation of Evidence Based Decision Making
Status: Use and implementation of Evidence Based Decision Making is incorporated into many aspects of the Division's operational procedures. This includes committees, staff meetings, and management decisions made to resolve the cited challenges we are currently addressing.

Independent Living Services:

1. The number of individuals with significant disabilities living more independently after receiving IL Program services as determined by an Independent Skills Assessment administered at the start and completion of each Independent Living Plan (ILP)
Status: The number of individuals with significant disabilities living more independently as a result of having received IL Program services, as determined by an Independent Living Skills Assessment administered at the start and completion of each Independent Living Plan (ILP). This measure is associated with a recently initiated pilot project of a comprehensive assessment instrument to determine consumer needs and measure program impact once services are completed. As of the December 31, 2007, pre-service data is available for 155 individuals and no data yet to report for post-services.

2. Number of individuals who report having access to services needed to improve their ability to live more independently
Status: 2,060
3. The number of individuals prevented from moving to institutions, and who move out of institutions into community-based settings
Status: 419
4. Number of individuals receiving services who reported a high level of satisfaction with IL Program services
Status: Ninety percent of respondents (1854) receiving services who reported a high level of satisfaction with IL Program services

Disability Determination Services:

1. Maintain DDS initial claim average processing time within 7 days of the national average
Status: Case processing time: 78.0 days
2. Achieve annual decisional/documentation accuracy rate of at least 93% as measured by SSA
Status: The accuracy rating for this period is better than the region and national average
3. Maintain performance standards mandated by the exit plan for the Alexander Court case for Medicaid claims (no more than a 70 day average processing time and completion of at least 90% of claims in 70 days)
Status: Maintenance of the Alexander threshold: 95.7%
4. Maintain an annual cost per case that is less than the national average
Status: Cost per case is less than the regional average
5. Retention of Disability Examiners
Status: Retention of Examiners had improved: FFY07 attrition rate of Examiner staff was 15.3% compared to FFY06 21.6%
6. Recruitment of qualified medical staff
Status: Recruitment of Medical Staff: 5 doctors and 5 psychologists were hired during FFY07

Assistive Technology Services:

1. Percentage of customers satisfied with program services
Status: Percentage of customers satisfied with AT Services = 99.98%. This is based on 3394 respondents out of 7324 people surveyed or a 54% response rate. A breakdown of the level of satisfaction of those responding is as follows:

Highly Satisfied:	83.35%;
Satisfied:	10.31%
Satisfied Somewhat:	6.30%
Not at all Satisfied:	0.02%
2. Percentage of customers who achieved improved access to and/or acquisition of assistive technology

Status: Percentage of customers who improved in access to and acquisition of AT Services = 99.99%. This is based on 2288 decision makers out of 4187 customers who received services or a 58% response rate. A breakdown of those making a decision is as follows:

Made a decision that AT would be helpful: 97.59%

Made a decision that AT would not be helpful: 2.40%

The customer total includes a high number who received services but did not make a decision about AT.

Current Indicators

Indicator	03-04	04-05	05-06	06-07	07-08
The percent of persons with employment disabilities, ages 16-64, employed in some sector of the labor force (goal = at least 16.81%).	-	-	-	16.81%	-
The percentage of persons with disabilities who have difficulty dressing themselves, remembering, or going outside the home, ages 16 or older, living in institutional group quarters (goal = not to exceed 8.67%).	-	-	-	7.50%	-

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NC Council on Developmental Disabilities

Mission: To ensure that people with developmental disabilities and their families participate in the design of and have access to culturally competent services and supports, as well as other assistance and opportunities, that promote inclusive communities.

Vision: Building Bridges to Community

The Current Environment

The North Carolina Council on Developmental Disabilities (NCCDD) is a 34 member gubernatorial appointed body and is part of a network of organizations created by federal law (PL 106-402), the Developmental Disabilities Assistance and Bill of Rights Act, to promote the best services and supports for persons with developmental disabilities. The purpose of the N.C. Council on Developmental Disabilities is to promote access to and participation in the design of culturally competent community services, individualized supports, and other forms of assistance and opportunities that enhance self-determination, independence, productivity, and integration and inclusion into the community for individuals with developmental disabilities and their families. This is done through conducting systemic change, capacity building and advocacy activities that are consistent with a participant and family-centered, comprehensive system, and coordinated array of services, supports and other assistance, in the areas of (1) employment; (2) community living; (3) prevention and child development; (4) self-determination; (5) health care; (6) recreation; (7) transportation; (8) education; (9) housing; and (10) system coordination and community education.

As a result of a comprehensive Five Year State Plan development process, a number of developments were identified that provide direction for statewide quality assurance/quality improvement activities and priorities in the coming five years. In the 18 listening sessions held across the state to help develop the NCCDD Five Year State Plan, the following quality improvement concerns and recommendations emerged as clear priorities:

1. More comprehensive data (such as service delivery, waiting list information and performance outcome measures) is needed to effectively plan, evaluate and advocate for services;
2. Consumers are seeking more active roles in planning and monitoring services;
3. From a local perspective, consumers perceive fragmentation and lack of coordination between providers, local management entities and other agencies.
4. Consumers are seeking adequate choice in providers and more qualitative information about available providers.
5. Consumers are seeking opportunities to develop new leadership; build a stronger grassroots, self advocacy movement; and increase the base of knowledge about legal & human rights related to responsibilities.

The listening sessions also identified as priorities community living, assistive technology, healthcare and justice system issues for people impacted by developmental disabilities in NC. While NC is making progress in creating more opportunities for services in the community, the progress is slow.

NC's over-reliance on services in group homes and institutions is out of step with contemporary policy and practice, as supported by the US Supreme Court's Olmstead ruling. The NCCDD seeks, under the plan, to advocate that the state DD authority initiate long-range planning for census reduction in both the developmental centers and the state's ICF-MR/DD group homes. Such work should be concomitant with renewed efforts to make participant directed supports available statewide. Constituents also voiced

concerns with the justice system. If encounters with the justice system occur and developmental disabilities are not appropriately addressed, the result is often unequal treatment.

Improved access to health care was also identified as a priority. NCCDD has made use of two nationally recognized health resources. The Area Health Education Centers provide training to physicians, dentists, registered nurses and other health-care professionals. Educational opportunities include those for family practitioners regarding issues related to young adults with developmental disabilities. The Cecil G. Sheps Center for Health Services Research has also played a role in improving health care access related to persons with developmental disabilities by providing practical and comprehensive input into policy development. NCCDD has also released funds in the area of wellness, promoting a pro-active, consumer-centered approach to healthy living.

Additionally, access to evaluation, professional support and education of individuals in the use of their newly acquired assistive technology equipment is unavailable in most parts of the state.

Key Operational Issues

Each year the NCCDD fulfills its responsibilities by distributing nearly \$1.4 million in federal funds for projects and activities. These projects and activities vary widely in scope. Grantees may be state or local advocacy organizations, grassroots disability groups, state or local governmental agencies or such diverse community groups as churches, transit systems or local schools. Most of the NCCDD funds are given out competitively through Requests for Applications (RFAs). An RFA contains a concept that the NCCDD would like to see implemented and asks the potential grantee to describe, in an application, how that concept might be implemented. RFAs are published annually in the NCCDD's newsletter, "Bridges to Community." This publication is widely distributed in the state.

The NCCDD also provides a limited amount of funds on a non-competitive basis. Throughout the year, unsolicited ideas for possible NCCDD activities that are consistent with goals and objectives within the Council's State Plan may be received from agencies and organizations. The NCCDD, prior to further action, may approve these conceptual ideas for potential development and implementation. The requirements for development and implementation of these potential grants are the same as the competitive grants.

Key Indicators for Success

Status of Past Indicators

1. **Employment:** Through council projects, people get and keep employment consistent with their interests, abilities and needs.
Status: The third and final year of NC Network for Organizational Change (NCNOC) was comprised of 20 community rehabilitation programs; these supported 1,163 people to begin working in the community, an improvement from only 797 a year ago. The percentage of individuals previously served in rehabilitation programs who are now working in the community slightly decreased from 53% to 49%. On average, individual wages increased from \$6.41 to \$6.54 per hour, approximately \$1.00 more than the Federal Minimum Wage for the time period.
2. **Education:** Through council projects, students reach their educational potential and infants and young children reach their developmental potential.

Status: The Council released a Request for Applications for an inclusive, post-secondary education initiative in the amount of \$150,000 for year one of a three-year project. UNC-Greensboro was selected to implement the project.

3. Housing: Through council projects, adults choose where and with whom they live.
Status: During the past year NCCDD played a key role in the overall development of a “Housing Primer” on affordable, accessible housing geared towards people with ID/DD. The NCCDD assisted in the dissemination of over 1,000 “Housing Primer” books to local self-advocates and cross-disability, grassroots organizations statewide.
4. Health: Through council projects, people are healthy and benefit from the full range of needed health services.
Status: The Mountain Area Health Education Center (AHEC) project continued to improve ID/DD skills training for medical professionals through its “mini-fellowship” program. Interagency workgroups met throughout the year to develop action plans. All three projects moved toward sustainability; the dental project received appropriations (\$200,000) from the NC General Assembly. The Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) project provided training, TA and materials about the Medicaid EPSDT program (Health Check). The grantee, the National Health Law Program, provided trainings for parents and professionals from community agencies. Sixty-five people participated.
5. Child Care: Through council projects, children and families benefit from a range of inclusive, flexible child care options.
Status: Greater awareness of the Council, its goals and projects, was accomplished through production and dissemination of a newsletter describing the work of NCCDD and highlighting accomplishments.
6. Recreation: Through council projects, people benefit from inclusive recreational, leisure, and social activities consistent with their interest and abilities.
7. Transportation: Through council projects, people have transportation services for work, school, medical and personal needs.
Status: Both Council staff and Council members participated in NC Department of Transportation’s (NCDOT) statewide conference and provided valuable disability awareness information to workshop attendees. Later in the year, staff and council members participated in NCDOT’S annual driver recertification and training session and provided follow-up sensitivity training to over 150 para-transit bus drivers. Over the past year, additional NCCDD Council members have been placed on transportation coordinating councils.
8. Quality Assurance: Through council projects, people have the information, skills, opportunities, and supports to live free of abuse, neglect, financial and sexual exploitation, and violations of their human and legal rights, and the inappropriate use of restraints or seclusion. Quality assurance systems contribute to and protect self-determination, independence, productivity, and integration and inclusion on all facets of community life.
Status: The Council provided funding for presentations at seven conferences across the state. These presentations addressed topics on housing, self-advocacy, supported employment, un-served and under-served populations, minority health, youth leadership, provider capacity, systems change and policy development. These presentations, workshops and seminars were conducted by regional and national experts who provided the innovative and unique perspectives on each topic to a variety of stakeholders.

9. Community Supports: Through council projects, individuals have access to other services available or offered in a community, including formal and informal community supports that affect their quality of life.

Status: The four aging projects concluded their three-year grant period by meeting or exceeding all goals set forth in their respective grants.

Current Indicators

The nine points listed above will remain as current indicators.

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Office of Economic Opportunity

Mission: The mission of the Office of Economic Opportunity (OEO) is to administer grant programs that provide opportunities for low-income individuals and families to become self-sufficient through the provision of financial resources to community action agencies, limited purpose agencies and other community-based organizations for programs that will substantially reduce the number of citizens in our state who are living in poverty.

Vision: The OEO will be a leader in providing grant opportunities and technical assistance to local subrecipients which will result in strategies and projects that better address the causes, conditions and problems of poverty in North Carolina.

The Current Environment

As an administrator of three major grant programs, OEO directs federal resources to provide training for and ensure contract compliance of nearly 200 community-based organizations (CBOs) throughout the state. The Community Services Block Grant (CSBG) Program funds CBOs (primarily Community Action Agencies) to provide a range of services designed to assist low-income people to attain the skills, knowledge and motivation necessary to achieve self-sufficiency. The Weatherization Assistance Program (WAP) and its companion Heating and Air Repair and Replacement Program (HARRP) fund CBOs to help low-income families reduce energy usage and costs while promoting health and safety. The Emergency Shelter Grants Program (ESGP) provides funds to local homeless shelters primarily for operations support, with a relatively small amount available for prevention and other services.

The 2006 American Community Survey, released in September of 2007 by the U.S. Census Bureau estimates that 10.7% of the state's families and 14.7% of all state residents had income for the previous 12 months that was below the federal poverty level. The need is increasing along with the costs of providing services. The funding level of most programs is not keeping pace with the need or the rising costs. Another factor affecting the current environment in which OEO works is homelessness since providing shelter must include the availability of supportive services. The OEO coordinates its activities with other DHHS agencies, particularly the Division of Social Services since both manage programs to improve the ability of low-income families to reduce the impact of rising energy costs.

Key Operational Issues

A small number of OEO employees administer nearly 200 contracts with CBOs, shelters and other non-profit organizations. OEO has embraced performance based contracting but at times is frustrated with implementation. Specifically, OEO struggles with a contract timeline that requires performance data to be submitted well in advance of contract expiration dates. Our review of applications and contracts for the upcoming year must be completed and approved before performance for the current year can be fully evaluated. In addition, a majority of the recipients, working as non-profits, represent the only vehicle for assistance in the communities where they operate, especially in rural areas. Further complicating OEO's performance expectations is the high level of turnover among subrecipients that results in lost expertise and interrupted services.

In order to balance tight funding levels with identified needs, OEO would like to promote program efficiencies by funding fewer subrecipients which cover larger service areas. However, OEO is constrained by federal regulations that determine which subrecipients receive funding, and the only mechanisms to accomplish program efficiencies are increased accountability, training and education. The federal government is encouraging most agencies receiving ESGP funds to participate in a Homeless Management Information Network—in NC this is known as the Carolina Homeless Information Network

(CHIN). CHIN is a centralized data collection tool that will aggregate client level information, and affected ESGP agencies will be required to participate in this by the beginning of SFY 2008-09. Similarly, agencies providing CSBG and WAP programs have been encouraged by OEO to participate in the Accountable Results for Community Action (AR4CA) web-based case management and reporting system developed within the Community Action Agency network.

OEO staff provide and/or arrange training on a variety of specialty areas—everything from conducting energy audits and combustion inspection to mechanical ventilation installation, empowerment skills for family workers, and strategies for effective CAA management. Accountability efforts include participation in the CSBG Information System (CSBG/IS) and the national Results Oriented Management and Accountability (ROMA) system. The CSBG/IS is used to describe the activities of CSBG eligible organizations and how they promote self-sufficiency, family stability and community revitalization. The NCROMA initiative, instituted in 2001, is OEO’s vehicle for enhancing accountability within the community action network by supporting, reporting and using outcome measures.

Operationally, OEO would benefit by electronic invoicing and online business transactions. Efforts are underway to convert forms and funding requests to accomplish this. Because the contract process is so time consuming and labor intensive, reform of departmental procedures and further automation would benefit the division. Additionally, continuing to be effective as an agency depends on two things: (1) the ability to attract and retain good staff and making sure they have training as needed to keep skills up to date and (2) continuing to build partnerships with and among grantee agencies.

Key Indicators for Success

OEO revises key indicators as needed to remain responsive and accountable both to the department and OEO’s constituents. The key indicators currently in place are responsive to the requirements of the program funding sources. Past key indicators and current indicators are similar and the measurement results are summarized below.

Indicator	03-04	04-05	05-06	06-07	07-08
CSBG					
• The number of low-income families rising above the poverty level	-	790	761	810	-
• The number of participants obtaining employment	-	1,407	1,320	1,306	-
• The number of jobs with medical benefits obtained	-	561	609	577	-
• The number of participants completing education/training programs	-	597	578	571	-
• The number of participants securing standard housing	-	984	598	621	-
• The number of participants provided emergency assistance	-	2,365	2,423	2,636	-
ESGP					
• The number of individuals provided shelter per year.	-	45,031	41,290	41,966	-
HARRP					
• The number of heating/air systems repaired / replaced	-	1,297	1,033	1,720	-
WAP					
• The number of dwellings weatherized	-	3,696	3,456	3,808	-

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Office of Education Services

Mission: The mission of the North Carolina Department of the Health and Human Services (NC DHHS) Office of Education Services (OES) is to provide quality, comprehensive, developmental and educational opportunities for eligible students ages birth to 21 and their families so that students can develop the skills necessary to lead productive lives-- vocationally, socially and personally--resulting ultimately in the achievement of their highest potential for independent and successful lives.

Vision: The vision of OES is to be a state and national leader in providing early intervention and education services to children who are deaf and/or blind by ensuring that those children have the educational, communication, and technological tools to reach their highest potential.

The Current Environment

The OES is in a unique position within DHHS to provide education to students in a variety of settings that include birth to three years old for Early Intervention, birth to five years old for Governor Morehead Preschool, three to 21 years old in the Resource Support Program, and five to 21 years old in the residential schools. At the schools students have access to the NC Department of Public Instruction Standard Course of Study and Life Skills curricula.

The OES performs the functions of a central office within a school system and an office within DHHS. In fact, OES is the central office for the DHHS Local Education Agency (LEA) and the OES director is the superintendent for the LEA. The DHHS Secretary functions as the School Board for the DHHS LEA. OES makes every effort to keep educational issues at the forefront of DHHS and proactively communicates with other divisions, offices, facilities and schools. Being proactive keeps everyone in the loop and offers opportunities to provide input to initiatives affecting the beneficiaries of department programs and services.

Already recognized as a national leader for early intervention with deaf and hard of hearing children, OES plans more regional service delivery and employment of highly qualified teachers, providing continuing staff development to ensure that teachers are able to instruct students with multiple disabilities to further improve their effectiveness.

Key Operational Issues and Opportunities

OES continues to work with the DHHS schools and programs to focus on the recruitment and retention of highly qualified staff. Through collaboration with the Office of State Budget and Management, vacant educational positions can now be hired at the M-0 level to ensure funds for hiring teachers with more experience and higher levels of education. The office is committed to making DHHS schools desirable places to work where staff feel valued and rewarded. OES emphasizes leadership opportunities and encourages teachers to pursue National Board Certification. However the need for more competitive supplements exists and the inability to provide hiring incentives similar to the other school systems in the state negatively impact recruitment and retention efforts.

Early Intervention for children who are deaf and hard of hearing and the Governor Morehead Preschool services for visually impaired children continue to serve more children and their families each year. Early identification, improved awareness and growing relationships with service providers all contribute to more referrals. New teacher positions in these programs over the past two years have been filled which reduced the teacher loads to a more reasonable level. However, as more children and their families require services, qualified providers continue to be a need. Teachers are working to diversify their communication modality expertise and both programs encourage teacher advancement through the National Board Certification process.

New school improvement plans must be in place before the start of the 2008-2009 school year. OES and instructional leadership are reviewing the mission, vision, and major goals of the organization, including Early Intervention, outreach, and the Governor Morehead Preschool. As a result, School Improvement Plans at the residential schools will include the new OES mission and vision and more progressive initiatives aimed at eliminating achievement disparities for deaf, hard of hearing, deaf/blind, and visually impaired students. By working to share resources, better use of technology and collaboration will lead to even more opportunities for student success.

OES is impacted by the increase in students with multiple disabilities and mental health diagnoses, the increase in the Hispanic/Latino population and the increase in transportation costs. These factors require OES to evaluate changes to the service delivery. To ensure students with the greatest needs who require the most restrictive environment are served residentially, OES may increase the length and type of summer programming so that students receive a wide variety of services. In conjunction, OES plans to enable more students to remain in their home schools through the use of outreach services and assistive technologies. This requires OES to increase outreach to public schools and staff.

Services will increase through the Governor Morehead Preschool birth to five year old visually impaired children and their families and by collaborating with the school systems, more services will be provided to deaf and hard of hearing three to five year olds. More efforts in outreach for deaf and hard of hearing students as well as collaboration with schools and school systems across the state will provide more regionalized services to these students. Outreach efforts and services for visually impaired students will provide direct services to students, families and professionals, building greater capacity in schools. In the residential schools, emphasis on the Governor's Learn and Earn program will be provided so that all graduates leave with the knowledge and skills needed to experience success in a global economy.

Safety on residential school campuses and for all itinerant teachers continues to be a constant challenge. Education for staff as well as gatehouses at the schools, the use of Lobby Guard, and improved communication systems, especially for emergency notification, are all critical parts of the effort to provide safe and secure environments for students and professionals.

The needs created by the changing demographics of blind, deaf/blind, deaf, and hard of hearing students in NC presents a fluid dynamic in programs and schools. Communication options chosen by families' vary widely and staff should be culturally sensitive to students and their families. If staff are trained in cultural sensitivity and provided more Spanish language interpreting services, they can partner more with the parents to educate them on their role.

Finally as experts in the education of blind, deaf, and hard of hearing students, OES is seeking to partner with schools and school systems. OES is working to articulate clearly the role of DHHS in sensory impairment education. The Resource Support Program and the outreach component of Governor Morehead School are taking the lead in this endeavor.

Key Indicators for Success

Status of Past Indicators

- **All professional early intervention staff will become proficient in one (1) oral and one (1) visual communication method for children who are deaf or hard of hearing.**

Measure: Currently, about 46% of these teachers are proficient in both one oral and one visual communication method. The goal for the end of 2007 is for 85% to be proficient. The goal for 2008 is 100%.

Status: As of February, 2008, many teachers in the Early Intervention Program for Children who are Deaf and Hard of Hearing have achieved this goal. The percent of teachers proficient in both has risen to 48%.

- **By their graduation, students in the residential schools for the deaf and blind will be able to use multiple technologies to support their communication needs in a global environment.**

Measure: By 2008, all seniors access assistive technology to meet 100% of their Individualized Educational Program (IEP) goals.

Measure: By 2008, all seniors on a diploma pathway will pass the computer skills test (which is a high school exit standard).

Status: As of February, 2008, both of these goals have been met by all three schools at 100%.

- **Children identified with vision or hearing needs will begin receiving early intervention services by the age of six (6) months.**

Measure: By 2008, 100% of children referred by the age of six (6) months will receive services.

Status: Currently, all children referred by the age of six months begin receiving services immediately. However, OES cannot control the referral ages of children from other agencies.

- **All teachers in kindergarten through grade 12 will attain a level of professional credentials commensurate with or exceeding the highest state and national standards, including dual licensure or National Board Certification as appropriate.**

Measure: By June 30, 2006, all DHHS teachers who need High Objective Uniform State Standard of Evaluation (HOUSSE) credentialing to meet the “No Child Left Behind” criterion of highly qualified will be complete.

Measure: By 2008, all DHHS teachers with career status will have a licensure status of highly qualified.

Status: These goals have been met.

- **OES programs will seek to explore and replicate, with needed adjustments, nationally recognized initiatives in communication and life skills areas that will meet the changing needs of hearing and visually impaired children.**

Measure: Each year, OES will review at least one research-based, nationally recognized program/approach to meet the changing needs of students in communication and in life skills.

Status: OES schools have been involved in a five-year reading grant administered by the NC Department of Public Instruction. This grant is aimed at gathering data about which research-based reading programs positively impact students with sensory disabilities. NCSD is involved in teaching reading through Reading Foundations (K-2 portion of the Wilson Reading Method) at the moment and will implement Wilson as their students move through the 2nd grade level of Foundations. GMS currently has 3 students receiving instruction in the Wilson reading method through a contract tutor. There is one teacher at NCSD who just completed the Wilson training who will implement that training with her students soon.

Current Indicators

Indicator	07/08	08/09
Number of deaf, hard of hearing, and visually impaired students served through outreach services	700	
Increase the availability of appropriate technology devices to deaf and hard of hearing children ages birth to three and visual impaired children ages birth to five (percentage)	25%	
Number of students who matriculate from the residential schools to employment or higher education	12	

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Office of Rural Health and Community Care

Mission: The Office of Rural Health and Community Care (ORHCC) assists rural and medically underserved communities and populations to develop innovative strategies for improving health care access, quality and cost effective delivery.

Vision: The ORHCC will be a national leader in improving the health of North Carolina's rural and underserved people as determined by the Federal Office of Rural Health Policy.

The Current Environment

Founded in 1973 as the Office of Rural Health Services, the ORHCC provides technical assistance to rural health centers and small hospitals in rural and medically underserved communities. Since its inception, the office has established 85 community-based rural health centers throughout the state. The office also recruits health care providers to work in rural and medically underserved communities, averaging approximately 138 placements over the past nine fiscal years and provides grants for rural and community health centers. These services are accomplished by a staff of 40 program and administrative specialists located in Wake County and through the issuance and monitoring of approximately 500 current contracts with a total value exceeding \$29 million (these totals include loan repayment incentives).

In its [January/February 2006 issue](#), the *North Carolina Medical Journal* published a collection of articles entitled, "Contemporary Issues in Rural Healthcare." In this issue, ORHCC was prominently named as a pioneer in forging community and state partnerships for healthcare in rural and underserved areas.

The office is the lead agency for demonstrations in the delivery and financing of health care for the department. Presently, ORHCC is spearheading Community Care of North Carolina (CCNC), a national model for Medicaid-managed care. CCNC is a collaborative effort between the state and key Medicaid providers such as physicians, hospitals, health departments, departments of social services and other community organizations. The objectives are to (1) increase access to care, (2) promote community-based systems of care, (3) achieve enhanced patient care management, and (4) improve quality and cost effectiveness. Currently, over 750,000 Medicaid patients are enrolled in the program. Nineteen staff from the Division of Medical Assistance (DMA) support the continued development and expansion of CCNC, providing Medicaid expertise where needed.

ORHCC has been very successful in helping small Critical Access Hospitals build alliances with larger, regional hospitals. This initiative increases the range of services for smaller hospitals, enhances reimbursement, and often allows them to remain open. Currently, there are 23 Critical Access Hospitals operating in North Carolina.

Through the Medication Assistance and Review Program, the ORHCC provides software and technical assistance to 132 sites throughout North Carolina to assist providers to obtain prescription drugs for their clients. This program utilizes the pharmaceutical manufacturers' free prescription drug programs for low income, uninsured residents. The annual value of free prescription drugs delivered by the 132 sites is approximately \$56 million. The office is collaborating with the Division of Mental Health on an expansion of the system to include mental health patients throughout the state.

The ORHCC is the lead agency for the NC Farmworker Health Program. This program combines federal and state support to provide for outreach, enabling, medical, and dental services for migrant and seasonal

farm workers in North Carolina. Currently, the office provides grant funding to 14 health care sites that serve as access points for the state's migrant fee-for-service program.

Key Operational Issues and Opportunities

North Carolina faces an acute shortage of primary care medical providers, especially in its rural areas. This year, it is expected that population growth will exceed the growth in number of physicians. This projection is further compounded by an aging workforce; many physicians who were successfully placed in the 1970s and 1980s are reaching retirement age. The number of medical and dental providers will have to expand to meet the expected shortages. In response, ORHCC has begun a process of expanding recruitment efforts by requesting additional dollars for provider incentives and recruitment staff. Additionally, ORHCC will work with local management entities (LMEs) in support of state mental health reform through recruiting needed psychiatrists and others trained in psychiatric services. In SFY 06/07, \$1 million for psychiatric recruitment was funded through the General Assembly to attract and retain qualified psychiatrists throughout the state with an emphasis placed on rural and underserved populations. To date, 18 psychiatrists have been placed in needed areas. Mental health services are critical to the comprehensive care delivered to underserved residents.

Continued federal funding restrictions will increase ORHCC's emphasis on seeking grants to acquire funds from new sources. In addition, documented performance standards for all of its grantees will provide an objective means of distributing available funding.

To respond better to critical health needs in rural and underserved communities, especially the growing number of uninsured residents, ORHCC must maintain active involvement and adjust programs and services to meet changing needs. The biggest obstacle remains lack of funding. Last year, ORHCC funding fell \$1.5 million short of requests from rural health centers which have seen their indigent care load increase dramatically in the past few years, thus necessitating some difficult funding decisions. At a time when successful recruitment is more important than ever, all incentive funds (used to relocate physicians and help them pay off education loans) were exhausted only five months into SFY 06/07.

Service delivery will be affected by a variety of demographic trends:

- Immigration, whether legal or through unlawful entry, expands the uninsured population, creates a need for language translation services, and exacerbates the risk for poor health outcomes in minority populations.
- General unemployment and a decrease in industry in rural areas also expand the uninsured population and to some degree cause migration within the state from rural to urban areas.
- Aging population, population growth, growth in the uninsured, decrease in industry in rural areas, unemployment, decrease in primary medical care providers present a host of significant challenges.

Key Indicators for Success

Status of Past Indicators

ITEM	SFY 05-06	SFY 06-07
To maintain a national ranking of #1 in total placements of health care providers in rural areas ¹	141	149
To maintain a national ranking of #1 in family physician placements in rural areas ¹	40	34
To maintain a national ranking of #1 in dentist placements in rural areas ¹	38	37
To maintain or improve a national ranking of #4 in maximizing federal contributions to rural health programs ²	\$2,642,065	\$2,713,742
To improve from #2 to #1 a national ranking in the % of Rural Disproportionate Share hospitals enrolled in 340B drug pricing ³	85% (24 of 28)	100% (28 of 28)
To maintain a national ranking of #1 in the percentage of counties participating in community-based care networks for Medicaid eligibles	92%	100%

¹Source: 3R Network Evaluation: Membership Activities Report, January 2005

²Source: National Rural Health Association and the National Organization of State Office of Rural Health, FY2003 or FY 2004

³Source: Office of Rural Health Policy

Current Indicators

Indicator	06-07	07-08
Primary Care Provider Recruitment		
<ul style="list-style-type: none"> Percentage of recruited providers placed in designated shortage areas. Through increased funding for incentives, the office expects to maintain its #1 national ranking in total placements of health care providers in rural areas. 	83%	-
Psychiatrist Recruitment		
<ul style="list-style-type: none"> Number of psychiatrist placements with incentives 	9	-
Continued Care for the Indigent and Uninsured		
<ul style="list-style-type: none"> Number of uninsured adults, with incomes below 200% of the federal poverty level, who are provided a medical home, care coordination, and primary care services 	33,353	-
* Quality Improvement and Savings for Medicaid		
<ul style="list-style-type: none"> Cost savings to the Medicaid program through Community Care NC is based on the annual report from Mercer Actuarial Services 	\$154 M	-

* SFY 06-07 results available in summer 2008

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Division of Budget & Analysis

Mission: The Division of Budget and Analysis (B&A) provides leadership and support to DHHS and division management through (1) the development, execution and modification of the department's operating budget, (2) the research and analysis of issues that impact the department's budgets, plans and programs, and (3) development of innovative solutions to challenging problems.

Vision: The Division of Budget and Analysis will enhance its capacity to serve as a cohesive group valued for innovative delivery of quality support services to the secretary and the agencies that comprise the department. In achieving this vision B&A will empower employees to continuously improve the quality of services; foster innovative workplace efficiency; promote communication and awareness of the division's role and services department-wide, and forge effective partnerships between the division and its stakeholders.

The Current Environment

B&A plays an important role in two-way communications among the divisions, the DHHS secretary and state level functions such as State Budget, Fiscal Research and the legislature. Working with DHHS management, B&A assists in prioritizing assignment of available funds. B&A will also make recommendations to agencies when it determines that common budget sources or program objectives would facilitate program merger or rationalization.

The effect of economic trends that influence the ability of the state to collect tax revenues has a considerable impact upon DHHS programs and services. A recession or static economy reduces the ability of the state to collect additional tax receipts. Inflationary pressure and an expansion in demand for services (often prompted by recession) create demand for additional revenue. The net effect is the need to constrain program growth in some areas and reduce program size and scope in other areas. The budgetary impact of these influences creates a substantial burden on work load and a commensurate change in working relations with divisional budget and program offices.

Key Operational Issues

Good communications, including a common understanding of the information requested and presented, is essential for B&A to accurately collect, analyze and deliver information. The division relies on formal and informal feedback that will improve communications at both the front end with agencies and at the back end with external stakeholders. Lack of feedback is itself an indicator of poor communication, thus B&A's objective is to break down this kind of communication barrier and actively solicit dialogue.

B&A's role is traditionally reactive in that the division collects data in response to formal requests and legislative mandates. As a result, information often is gathered and disseminated on short deadlines which can have a negative effect on accuracy and quality. Through experience and good business practices, B&A can be proactive by anticipating requests and giving people as much time as possible to respond. From this perspective, B&A supports a broadly owned information structure both at the state and department level that would facilitate accurate and rapid information access.

Key Indicators for Success

Status of Past Indicators

Through informal surveys after major tasks or events, Budget and Analysis will assess performance in the following areas:

1. Effectiveness of communication and technical assistance provided to divisions and offices within the department.
2. Clarity, quality and usefulness of output from divisions and offices.
3. Clarity, quality and usefulness of the output provided by B&A to the secretary that results in the secretary's ability to make informed decisions.

Output and information provided to the secretary will be timely to allow the secretary sufficient time to effectively evaluate the output.

Results of the informal surveys will be utilized to continue to refine efforts to improve delivery of quality support services to the secretary and the agencies that comprise the department.

Current Indicators

Current indicators will remain unchanged in the current plan.

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Office of Housing and Homelessness

Mission: The mission of the DHHS Office of Housing and Homelessness (OHH) is to reduce fragmentation of housing/homeless efforts within the department, increase the capacity of the state and local agencies to maximize existing housing and supportive service resources, and to more effectively engage the affordable housing industry to expand supported housing opportunities for our constituents.

Vision: The vision of OHH is that constituents live in decent, safe and affordable housing with access to the supports they may need to live in communities of their choice.

The Current Environment

The role of the DHHS Housing Coordinator is to ensure a unified and evidence-based approach to housing and homeless issues across the department, and to enhance departmental coordination on housing and homeless issues with external entities, including councils, workgroups, media, advocacy groups, local service organizations, other state agencies, and the governor's office.

As the DHHS Secretary's housing representative, the Housing Coordinator leads and guides the divisions and offices of DHHS in the development of policy and strategies to address housing needs for DHHS clients and ensure synchronization of services across division lines, and represents the department in state and federal housing policy and planning initiatives.

Key Operational Issues

As the affordable housing crisis deepens across the country primarily due to cut backs in federal housing assistance funding, the unmet housing needs of DHHS constituents, particularly persons with disabilities, low income elderly and families continue to grow. According to the latest census information, 459,009 renter households and 590,517 owner households, in North Carolina were paying more than 30% of their income on housing; meaning over 1 million households of 3.4 million households in the state were cost burdened, or spending more than they could afford on housing. In addition, thousands of people in North Carolina are affected daily by the problem of homelessness. North Carolina is working to meet the temporary and long-term needs of its homeless residents. The state's goal is to largely eliminate homelessness through a [10-Year Plan](#) and through similar plans being adopted by communities throughout the state.

The 10 Year Plan is the work of the North Carolina Interagency Coordinating Council for Homeless Programs. This body advises the Governor and the Secretary of the North Carolina Department of Health and Human Services on issues affecting people who are homeless or at risk of becoming homeless.

Housing Credit Targeting Program

Since 2002 NC Housing Finance Agency has partnered with DHHS to facilitate the integration of persons with disabilities and the homeless in Housing Credit properties. The Qualified Allocation Plans (QAP) for 2002 and 2003 offered substantial bonus points to developers that agreed to target 10% of their projects' units to these populations. The 2004 QAP changed the 10% set-aside to a requirement for all owners; this policy has remained in place for subsequent QAPs. In 2003 and 2004, Housing Credit developers could also earn bonus points by building twice as many accessible units than required under fair housing standards. These apartments also include curbless showers and allow for parallel toilet

transfers. Starting in 2005 these design features are required for all Housing Credit properties and there are now over 500 such units among funded projects in North Carolina.

Property owners must demonstrate a partnership with a local human service agency, the Lead Agency, which is outlined in a Targeting Plan. The Lead Agency works with local disability service agencies, the Housing Support Committee, to develop a collective process for referring tenants and making their services available to qualified tenants. The lead agency role was designed to facilitate access for eligible tenants regardless of who provides supportive services, while protecting confidential information about diagnosis or treatment needs. As a result, units are open to persons with a full range of disabilities who are receiving services from a full range of providers. In addition, individuals in targeting plan units can change providers without having to relocate.

There are three fundamental aspects of the targeting plans' principles: (1) disability neutrality at all stages of the referral process, (2) not allowing landlords to require acceptance of services, require compliance with treatment plans, or have any other non-standard lease provision, and (3) individuals receiving services based on eligibility from a variety of programs, none of which depend on where they live.

Local Housing Support Committees were originally designed to connect referral agencies to the Housing Credit properties; however, these committees have proved to be beneficial beyond these purposes. Committees provide a forum for human service providers who typically may not cross paths to interact, learn about each others' programs, other housing opportunities and collaborate on meeting tenant needs. The Housing Support Committee have also proved to be a resources for property managers seeking guidance related to non-targeted unit tenants, as local human services agencies can also provide a menu of services and supports available to all tenants in the properties.

The Key Program

Starting with properties awarded in 2004, DHHS and NCHFA also established a project-based operating subsidy, the Key program, for the 10% set-aside units in Housing Credit properties. Key pays the difference between what a tenant on SSI income can afford to pay toward their housing cost and the cost of operating the unit. Key assistance is also designed as a bridge subsidy; residents must document their status on the Section 8 waitlist. The requirement maximizes the number of households benefiting from Key assistance by facilitating tenants' transition to permanent, portable federal assistance if it should become available.

Housing Credit units are subsidized and thus already more affordable than market rate units, therefore the average per-unit monthly expense of \$222 under the Key Program is only two-thirds of the monthly rent subsidy in NCHFA's project-based Section 8 portfolio and substantially less than the average cost of tenant-based vouchers. The result of units being set aside and Key Program assistance being available is the creation of approximately 250 units targeted and affordable to persons with disabilities in North Carolina each year.

Prior to the implementation of the 400 Initiative funding (March 2007), there were 921 targeted units in funded Housing Credit properties; 458 units were completed and certified for occupancy. The occupancy rate for targeted units was approximately 93%. Another positive outcome is community integration and distribution around the state. Targeted units are part of 141 Housing Credit properties, with an average of seven targeted units per property. These properties are or will be in 56 counties across North Carolina.

The DHHS –NCHFA partnership was expanded in 2006, 2007 and 2008 with onetime capital funding and \$5.7 million in recurring funding for the Key Program. This expansion will fuel a rapid expansion of the number of assisted households. A Targeting Program evaluation study is underway to evaluate the

program and document that the investment in the Key Program is justified by improved consumer outcomes and reduced costs in other areas. This will be an important tool in advocating for further expansions and is due June 2008.

ICCHP

The ICCHP support many efforts including:

- Improving and Targeting Homeless Data Collection including the development of a state wide collaborative, Carolina Homeless Information Network (CHIN), to meet HUD mandates for homeless data collection.
- Developing a Balance of State Continuum of Care where effort 61counties accessed funding in the competitive federal funds. This Balance of State effort, combined with additional technical assistance provided to the other 13 continua resulted in a record amount of funds for North Carolina this past year.
- Implementing the SOAR (SSI/SSDI Outreach, Access, and Recovery) Initiative aimed at significantly improving the rates with which eligible homeless people successfully apply for SSI and SSDI. To date trainings have been completed in 11communities across the state.
- Piloting the Homeless Mental Health Initiative In partnership with the Interagency Council on Coordinating Homeless Program (ICCHP), the Division of MH/DD/SAS has awarded funding for three pilot Housing Support Teams to provide housing support services to persons who are homeless and have a history of cycling through publicly funded systems.
- Managing the Point In Time Count Database where counties across the state provide an annual Point In Time (PIT) count of homeless individuals and families.

Key Indicators for Success

Indicator	07-08
# of qualified persons living in affordable housing units developed under the DHHS Targeting partnership with the NC Housing Finance Agency	-
# of mayor and/or county executive endorsed 10 Year Plans to End Homelessness as measured by endorsements passed by elected officials	-
DHHS Divisions coordinate a unified and evidence based approach to housing and homeless issues to build the capacity of the state and local human service agencies to collectively engage the housing system to meet the needs of DHHS constituents as evidenced by 80% of DHHS Divisions with a housing related activity participation DHHS Housing Work Group and department-wide participation in the Interagency Council for Coordinating Homeless Programs, Housing Policy and Coordination Council and the N.C. Consolidated Plan	-

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Division of Human Resources

Mission: The Division of Human Resources aspires to deliver superior human resource services that enhance the ability of DHHS offices and divisions to meet programmatic and operational challenges.

Vision: In the arena of human services, DHHS will be the employer of choice for those who aspire to serve in state government.

Current Environment

In support of its mission, DHR maintains staff throughout the divisions who serve as management consultants and employee advocates. DHR services over 19,000 employees and managers of the 14 divisions/offices and 18 institutions that comprise the Department of Health and Human Services through the broad functional areas of Classification and Pay, Employee and Management Development, Employee Relations, Employee Safety and Health, Recruitment Services, and Work/Life and Benefits Services.

DHR personnel are located within divisions or are shared by divisions and support offices, but formal reporting lines are centralized to individuals within the Division of Human Resources in the Secretary's Office. Department activities are controlled by the Teacher Tenure Act and the State Personnel Act and are overseen by the Office of State Personnel (OSP) for State Personnel Act matters. DHHS HR has autonomy for most day-to-day operations, but at certain times OSP approval is required before hiring, classification or pay decisions can be approved.

Human Resources exists in a world that constantly shifts emphasis from a centralized control authority to a decentralized business partner to an independent employee advocate. Balancing these roles is challenging but is essential to the success of the organization.

Key Operational Issues

The complexity of laws and regulations governing human resources makes it very difficult to implement creative solutions to the myriad of HR issues. HR operates under a bewildering array of federal and state laws, regulations, and policies that are often contradictory or duplicative. Compliance often results in a high administrative burden and confusion within the workforce. For example, most changes to the State Personnel Act (SPA) have been incremental without consideration of policy conflicts.

Demand and supply of certain occupational groups, such as nursing, and increasing licensing requirements for some professional jobs usually reduces the labor supply, increase wages and make recruitment more difficult. Other economic factors include DOL projections that health care, medical care, allied health and IT are projected to be high growth occupations, all of which have a direct effect on DHHS employment. Recruitment of key positions is further affected by the lack of policy and funding for competitive compensation programs.

DHHS HR is using career banding concepts on a limited basis to evaluate performance management, merit-based employment, delegation of authority and career development. A change in emphasis in the roles of the classification analysts to compensation/workforce planning and organizational development is planned for the central office.

Implementation of BEACON in 2008 signals a new opportunity for HR to participate more fully as a partner in strategic planning. BEACON's improved HRIS technology is a key to helping HR become more consultative and less transactional by redirecting resources to organizational planning and workforce development. Moving to a more consultative role is further enabled by HRIS providing a mechanism for employees to manage HR information. In addition, substantial numbers of DHHS employees have internet or intranet access, permitting more educational offerings to be developed as web-based classes. Human Resources has numerous technology needs that go beyond functionality provided by a robust HRIS. Examples include requirements to track and analyze over 98,000 job applicants per year; increase employee computer access through kiosks and mobile/hand held devices; and implement other technologies that will enable HR to adopt a service/consultative orientation.

BEACON Update (May 2008): Although just implemented April 1, 2008, indications by HHS HR core users is that BEACON (or SAP) has increased transactional work (entering and modifying employee and position data) due to the increased amount of employee data being entered into the system and the complexities of how position (SAP Organizational Management, or OM) and employee (SAP Personnel Administration, or PA) is configured. While functionality may increase over time with additional SAP Business Intelligence reports coupled with SAS data mining software, the system is not intuitive to users. Over time, efficiency by HHS HR core users will increase although there is clear indication that transactional time to conduct work will increase from 25% to 75%. For example, new hires required 2 to 4 screens to be completed in PMIS. SAP requires 26 to 28 screens to be completed.

A pre-BEACON implementation survey of HR benefits administration staff has been conducted to measure time spent in certain benefit areas. A follow up survey on this and other functional HR areas is planned in 9 to 12 months. Best Shared Services (BSS) is working to resolve several "ticket" items related to payroll (i.e., shift premium, extended duty, work schedule rules, immediate payout of overtime, timekeeping, etc.). BEACON's full impact on HHS HR operations is not known as this time as many HR core users are learning the nuances of the system and certain SAP functionalities are still being resolved by BSS; therefore, the ability for HR to move toward more consultative work will be hampered until all transactional, procedural and policy issues affected by BEACON are resolved.

Key Indicators for Success

Status of Past Key Indicators

1. Attract and retain high performers

A. Increase the number of qualified/highly qualified applicants by five percent per year for the next three years

Results: Qualified and highly qualified applicants increased from 12.71 applications received per job posting in 2005 to 13.12 applications received per job posting for an overall increase of 7.89% for the period. Total qualified and highly qualified applications from 2005 to 2007 increased by 2.9%, or 57,639. 96,285 total applications were received in 2007. Reduced number of qualified and highly qualified applicants in medical, allied health and direct care human services jobs continues to be a pattern in the foreseeable future based on US DOL labor projections.

B. Reduce voluntary turnover by three percent over the next three years

Results: Voluntary turnover from 2005 (10.33% for all HHS job classes) to 2007 (9.45% for all HHS job classes) decreased by 8.52%. More aggressive pay actions (i.e., class range revisions) to increase the market position for allied health, medical and other occupations coupled with significant funding of salary actions (\$21.1M from 2003-2006, not including promotional increases) may have kept

turnover stable; however, more aggressive non-compensable strategies need to be developed for future retention.

2. Maintain market competitiveness of jobs

DHHS pay levels will be at or above the median pay derived from competitive wage surveys.

Benchmark allied health, medical direct care human services job classifications used for salary surveys (reference annual DHHS HR Compensation Report) are within 5% of the market average based on industry surveys. *HR CC*

Results:

- a) Professional allied health, medical and direct care human services occupations for 2007 were (4.71%) below market.
- b) Technician and Assistant medical, allied health and human services occupations for 2007 were 8.88% above market.

3. Enhance and maintain effective employee-employer relations and quality of work life

Conduct regular employee opinion surveys and implement formal response mechanisms throughout the department

95% of formal grievances filed at Step 3 are either found in HHS' favor or are mutually settled by the grievant and department.

To address broader employment retention and satisfaction, two types of opinion surveys have been drafted and piloted, a new hire engagement survey for employees with 12 months or less of service and an engagement survey for the general employee population. BEACON training and implementation has delayed further work on the evaluation of the surveys. The surveys will be used to identify the key recruitment and retention drivers that attract potential applicants and that are most effective in retaining employees.

4. Provide for a safe and healthy work environment

Workplace accidents for schools, MR/DD/NMT centers and psychiatric hospitals do not exceed one standard deviation from their prior five-year average.

Schools

135-197	one standard deviation
198-260	two standard deviations

MR/DD/NMT

1782-2012	one standard deviation
2013-2242	two standard deviations

Psychiatric Hospitals

2909-3278	one standard deviation
3279-3647	two standard deviations

The metrics listed in 1-4 above will continue to be monitored in 2008.

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Division of Information Resource Management

Mission: To provide enterprise information technology (IT) leadership to the North Carolina Department of Health and Human Services (DHHS) and its partners so that they can leverage technology resulting ultimately in delivery of consistent, cost effective, reliable, accessible and secure services.

Vision: The Division of Information Resource Management will support the DHHS commitment to provide nationally recognized quality services to the people of North Carolina through efficient, secure and reliable IT service delivery.

The Current Environment

DIRM continues to work to meet the eight goals set by the state chief information officer (SCIO) in response to legislation enacted to improve the planning, budgeting, and management of information technology across NC state government²:

- Develop better strategic business and IT plans
- Plan and budget more effectively for future funding requirements while making the best use of available IT resources.
- Increase the cost-effective purchasing of services and assets
- Improve the performance of projects to deliver expected business results, projected benefits to the public, and value to the state within approved schedules and authorized budgets
- Ensure the efficiency, predictability, security, and reliability of IT operations through the improved management of technical services
- Increase the capabilities for inventorying and analyzing hardware, software, and applications assets to maximize benefits and minimize risks over their useful lives
- Protect critical assets from cyber and other vulnerabilities, preserve the privacy of individuals, and ensure the confidentiality of data
- Enhance the ability to recover from natural and human-induced disasters and provide continuity of operations within required timeframes

Furthermore, DIRM's staffs are actively working to meet the following goals set by the DHHS chief information officer who is also the director³ of DIRM in response to business drivers developed in the 2006 DHHS Business Plan calling for enterprise-wide approaches, continuous improvement, traceability of decisions to business needs and leveraged resources:

- Improve customer satisfaction
- In partnership with DHHS business units, ensure that the department's business needs are driving all technology decisions
- Maximize cost avoidance through automation efforts and efficient use of staffing, and provide cost effective technical solutions by eliminating redundancy and taking advantage of enterprise solutions

² *NC State Information Technology Plan: An action plan for improved citizen services through better management of information technology*, February 2007, http://www.scio.state.nc.us/Statewide_IT_Plan/Statewide_IT_Plan.pdf

³ *NC DHHS Business Plan*, Division Profile for the Division of Information Resource Management (DIRM), Department of Health and Human Services (DHHS), Office of Policy & Planning, December 1, 2006, <http://www.ncdhhs.gov/opp/businessplan/>.

- Increase the training and certification level of DIRM staff to take advantage of current knowledge and trends in information technology and the management of technology

Finally, DIRM moves ahead by addressing the ever-increasing demand from DHHS divisions and offices for information technology products and services in an environment filled with competing priorities and limited financial and personnel resources.

Key Operational Issues

DIRM observes the following challenges and risks to service delivery:

Inadequacy of Funding, IT Obsolescence, and Unfunded Mandates

The continuing use of non-recurring funds to address recurring technology needs is a key factor in DIRM's inability to address properly replacement and/or upgrades of hardware and software and creates difficulty in maintaining an underlying infrastructure that meet the needs of all departmental projects and initiatives. While DIRM complies with SCIO and OSBM requirements to forecast both one-time and recurring costs for IT initiatives, the division continues to face obstacles when trying to secure commitments to fund initiatives that span multiple years.

In addition to the adverse impact that the use of non-recurring funds has on DIRM's ability to maintain its infrastructure, DIRM has observed an increased number of unfunded state and federal mandates competing for DIRM's operational dollars, including but not limited to legislation and/or orders pertaining to race, ethnicity, HIPAA, business continuity planning, and identity theft protection. DIRM exercises careful stewardship of the state's limited resources with the goal of obtaining the most efficient, cost effective IT solutions and approaches for DHHS. The division and other offices within the department work closely with the Office of State Budget and Management (OSBM) to develop strategies for identifying adequate funding for DHHS IT initiatives and operations in an effort to address funding shortfalls.

Workforce Turnover and/or Skill Erosion

As with other businesses, DIRM experiences turnover due to workforce aging, insufficient opportunities for learning new skills or expanding existing ones, and compensation/quality of work life issues. In some cases, these issues cause DIRM to turn to contracted resources to fill gaps temporarily until permanent staff is available. This practice not only creates a higher operating cost but also fails to prepare the permanent workforce with skills and systems knowledge required for long-term stability. Inadequate funding and state compensation also affect DIRM's ability to retain and reward existing employees, to attract qualified candidates for IT positions, and to send staff for training to maintain technical certifications.

DIRM continues to work aggressively toward filling full-time state positions with permanent staff capable of filling DIRM leadership roles in the future. As a part of these efforts, DIRM will develop a training plan to provide and maintain much-needed certifications. Lastly, DIRM implemented career banding, and remains hopeful that funding to support that philosophy will be forthcoming.

Two major initiatives will improve DIRM's work performance, programs and service delivery over the next five years: (1) Centralization of IT operations and (2) Implementation of a service-oriented architecture (SOA).

Centralization of IT Operations

DHHS' past practice of decentralized IT planning has unfavorably resulted in the redundant outlay of technological, human, and financial resources.

The offices of the Secretary and the DIRM executive leadership have devised a plan to consolidate all IT operations in DHHS under a central IT organization, starting April 1, 2008. The specific objectives for centralization include the following:

- The DHHS CITO initiative will align with the statewide IT consolidation effort.
- DHHS will consolidate IT infrastructure first and then applications.
- DHHS will maintain client commitments and ensure continuity business operations during the consolidation effort.
- Divisions/offices will share common IT infrastructure, personnel, and applications in accordance with business needs and as deemed appropriate by key stakeholders.
- DHHS must have an automated tool for inventorying IT assets; the resulting information will enable managers to make informed decisions regarding the department's IT assets and personnel.
- DHHS will publish and/or modify departmental standards for common IT infrastructure, personnel, and applications.
- With increased authority, DIRM, under the leadership of the DHHS CIO, will realize a greater ability to implement and enforce IT standards and policies for IT infrastructure, personnel, and applications across the department.
- DHHS' strategic plans for IT infrastructure, personnel, and applications will be better aligned with and traceable to the department's business strategies.
- Leadership will better be able to make IT infrastructure, personnel, and application decisions at the enterprise level and hold the DHHS CIO accountable for the department's IT infrastructure, personnel, and applications.

Implementation of a Service-Oriented Architecture (SOA)⁴

Over the last five years, DHHS has relied almost entirely on the NC Statewide Technical Architecture (STA) to guide decisions surrounding IT resources. The principles and standards of the STA served DHHS well in its work to carry out corrective and perfective maintenance on existing systems. However, the department has not been able to adapt fast enough to the more recent and rapid changes in trends, policies, and regulations. A number of conditions are causative, including:

- Limitations to data sharing and manipulation
- Inability to look across enterprise business requirements to find consolidation opportunities
- Lengthy development cycles
- Separation of knowledgeable contracted development staffs
- Deficient documentation, technology, and code

Looking ahead, DHHS intends to set up its IT architecture in a manner that lowers the costs of development and integration, steps up application procurement, development and deployment processes, and reduces architecture risk.

The principles on which the DHHS IT architecture is based are:

- Business processes and operations will drive changes to information systems and the technology infrastructure
- NC DHHS will preserve and leverage information systems and technology assets for as long as those assets deliver net business value over the benefits of replacement
- Business units will control the automation of their core business activities through the use of service level agreements (SLAs) entered into with IT units

⁴ *IT Architecture*, NC Department of Health and Human Services, Division of Information Resource Management (DIRM), December 1, 2006.

- IT units will fulfill SLA requirements without distracting business units with the limitations and complexities of specific technologies
- IT units will deliver technical services to business units that are sharable and compositional with other services

Adhering to these philosophies, DHHS anticipates that the department will move away from traditional, massive systems to systems that are more componentized, easier to integrate and maintain, and have lower total cost of ownership.

Key Indicators for Success

Status of Past Indicators

During SFY 2007, DIRM completed 8 of the 16 past indicators. Those completed indicators dealt with customer service, cost avoidance, making sure business needs were driving IT action and increasing qualifications and certifications of staff. The remaining in-process indicators from SFY 2007 have been reformatted into overarching indicators and are referenced in the section below, Current Indicators. During SFY 2008, staff will continue to benchmark DIRM’s key performance indicators (KPIs). By the end of SFY 2008, DIRM’s leadership aspires to use the KPI data collected to set targets for areas needing improvement and steer the future direction of the division.

Current Indicators

During the next five years, the KPIs of most interest to DIRM’s primary customers are those that signal the critical factors necessary to ensure DIRM’s successful delivery of IT products and services. Specifically, DIRM requires know-how, strategic relationships, IT funding and project approvals, quality, customer satisfaction, and sustainability to be successful. The following three KPIs are mostly characteristic:

Key Performance Indicator	Measures
<i>Win Rate</i> focuses DIRM’s attention on meeting the standard requirements for better project management, which ultimately results in the successful delivery of the IT products and services needed to support DHHS.	Percentage of project charters approved by way of the state PPM Workflow to move forward
<i>Cycle time for warranty and repair issues</i> focuses DIRM’s attention on ensuring its IT products and services are reliable.	Average of all turnaround/resolution times (days) as reported by DIRM sections
<i>Time to develop next generation of products/process cycle time</i> , focuses DIRM’s attention on improving processes, which ultimately results in the improved cost effectiveness of IT products and services.	Average project duration for new products and services

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Office of Citizen Services

Mission: The purpose of the Office of Citizen Services is to guide citizens through the human resource delivery system by providing accurate and speedy information and referral for services to the proper department or agency and resolving customer complaints.

Vision: The North Carolina Department of Health and Human Services' (DHHS) Office of Citizen Services will have the most robust comprehensive human service database, NCcareLINK, in North Carolina and will serve as a national model among information and referral providers across the nation. In addition NCcareLINK will enable the DHHS CARE-LINE, Ombudsman Program and Disaster Coordination Services to provide state of the art services to residents across the state 24/7/365 and before, during and after a disaster or emergency occurrence.

Current Environment

A critical factor in OCS's ability to achieve its vision is collaboration and cooperation both within and outside of the department. There are three primary areas of collaboration that are important. First, as the "front door" to the department for citizens with questions or issues, OCS needs to be knowledgeable of the implications of changes to programs and services that citizens may be calling about. Second, to acquire and maintain the knowledge to provide such support, OCS staff must continually be trained about DHHS programs and services, collaborating with divisions. Third, as a call center that is viewed as a leader in the state, OCS also plays a central role in fielding calls related to a disaster or emergency. For these reasons, it is very important that the office stay in the loop with any disaster coordination efforts happening in the department.

OCS was legislatively mandated to expand service to 24/7/365 to provide services through the Returning Service Veterans Program. OCS has upgraded network hardware, obtained computers and phones and moved to larger quarters to accommodate ten additional staff.

OCS has developed a state-wide, web-based centralized data repository -- NCcareLINK -- that will be continually updated by OCS and data partners, local government entities and non-profit agencies.

OCS is developing the privacy and security infrastructure to comply with its status as a HIPAA covered entity. Work flow has been examined, privacy and security weaknesses noted and policies and procedures developed to ensure a secure environment for the personal health information of callers and customers.

Key Operational Issues

Continued growth in North Carolina's population will further increase the number of inquiries to our office and create more demand especially for information and referral services through the CARE-LINE. With more people choosing North Carolina as a place for retirement and the large Hispanic population continuing to grow, there will be an increased demand for information and referrals to government and non-profit agencies, as well as an increase in the number of inquiries to the Ombudsman Program offered by the Office of Citizen Services. It is anticipated that the volume of inquiries from Spanish-speaking residents will continue to increase.

Key Indicators for Success

Status of Past Indicators

1. Implement a statewide centralized web-based repository called NCcareLINK through collaboration with statewide government and non-profit agencies

Status: By 2008, 22 stakeholder agencies had joined with NCcareLINK and are actively contributing local program information and resources to the web-based centralized data repository, NCcareLINK and handling all inquiries using the NCcareLINK repository. These data hub partners are ensuring that the repository contains program services from all 100 North Carolina counties.

2. Enhance collaboration with DHHS Divisions in our role as the DHHS portal of entry, striving to handle more inquiries without sending to divisions/offices within DHHS thus decreasing divisions/offices workloads, i.e., “One Stop Shopping” for DHHS customers.

Status: OCS is a HIPAA covered entity of other DHHS divisions and offices. The Security Remediation Plan was developed and OCS continues to document privacy and security procedures. OCS can provide services that are more cost effective and customer driven by being a “one stop shop” for DHHS customers. OCS management developed a partnership with the Division of Services for the Deaf and Hard of Hearing (DSDHH) wherein OCS will receive voice and TTY calls generated from publicity about DHH services. OCS, with the legislatively mandated Returning Veterans Services Program (RSVP), has developed a partnership with the Veterans Administration, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, National Guard, Citizen Soldier Support Program and many other organizations that serve veterans.

3. Build on already established relationships with elected officials in assisting their constituents.

Status: The Governor’s Office and state legislators refer constituents to the Office of Citizen Services to address a variety of issues. OCS responds to the referred citizen and copies the referring official and the DHHS Office of Governmental Relations. In compliance with HIPAA regulations, no protected health information is included in e-mails. Statistical reports that outline specific constituent concerns are provided to legislators who have referred their constituents to OCS for human service assistance.

4. Foster a cohesive relationship with NC Emergency Management (EM), bringing human services to the forefront in the EM organization thus serving as more of an integral part of EM.

Status: OCS is the coordinator of DHHS human service involvement with NC Emergency Management and continues to play an active role in influencing how services are carried out before, during and after a disaster/emergency situation. Specifically, OCS is performing a key role in restructuring the statewide sheltering/mass care plan, and OCS energetically serves on Emergency Management committees that affect the delivery of human services. Emergency Management has joined with OCS as an NCcareLINK data partner further cementing our relationship. In this role, EM will supply information on emergency management services throughout the state.

5. Enhance both computer and telephone technology for OCS' CARE-LINE and Ombudsman services that will increase staff productivity and allow for better customer service.

Status: In October 2007, OCS transitioned to the Resource House Referral call tracking system, NCcareLINK, which has proven to be a streamlined, easier to use system with a more robust reporting component. Together with the telephone technology, OCS is able to define service gaps, trends and areas where staffs’ knowledge and skills need to be improved to allow for more

productivity. This new tracking system has demonstrated information given vs. referrals, time on calls, hot topics, areas of need, and information box utilization.

6. Educate and encourage DHHS Executive Management, Division Directors and staff within DHHS divisions/offices to use OCS database and phone system statistics to improve DHHS services overall and assist in making program and policy changes based on the data and identifying gaps in services.

Status: OCS management has met one on one with DHHS leadership and every DHHS division director and implemented a process for collecting and compiling data in a format that serves as a tool for all division directors.

7. Increase outreach efforts regarding services that are offered through OCS and educate DHHS employees about OCS services.

Status: By the end of 2008, a five (5) year outreach plan will be established. An overview of OCS services will be incorporated in all employee orientations as well as the Customer Service Task Force (CSTF) effort and policies relevant to customer service. DHHS HR offices will submit quarterly reports, indicating numbers of employees receiving orientation regarding OCS services and CSTF work.

8. Provide training to OCS staff to increase knowledge of human services and sharpen skills.

Status: OCS management has created a list of the trainings and orientations that are to be completed before beginning service as an Information and Referral Specialist. Monthly training is conducted on changing DHHS and community programs. By the end of June 2008, OCS management will begin sending a monthly e-mail reminder to all divisions/offices, soliciting information changes and additions to program services.

9. Encourage DHHS divisions/offices to collaborate with OCS and use OCS as a resource to decrease duplication by streamlining communication and incorporating OCS in more task force/committee work within the divisions to receive more of an internal and external customer perspective.

Status: By the end of 2008, efforts will be made to serve on at least one work group or task force or committee with every division as appropriate. In 2008, OCS will create a DHHS Programs and Services Committee. The purpose of the committee will be to meet every month to discuss program/service changes and additions to ensure OCS staff members are handling all inquiries correctly and to ensure any needed collaboration across the department is being achieved.

Current Indicators

Indicator	03-04	04-05	05-06	06-07	07-08
Maintaining and expanding a statewide centralized web-based repository called NCcareLINK through collaboration with statewide government and non-profit agencies	-	-	-	-	-
Enhancing collaboration with DHHS divisions in our role as the DHHS portal of entry, striving to handle more inquiries without sending to divisions/offices within DHHS thus decreasing divisions/offices workloads - One Stop Shopping for DHHS customers.	-	-	-	-	-
Enhancing both computer and telephone technology for OCS' CARE-LINE and Ombudsman services that will increase staff productivity and allow for better customer service.	-	-	-	-	-

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Office of Internal Auditor

Mission: To provide the management of the North Carolina Department of Health and Human Services (DHHS) with *independent* audits and analysis of various functions and programs within the department. This includes operational audits, performance audits, compliance audits, financial audits and special investigations. The office's over-all objective is to provide management with *objective* information, analysis, appraisals, recommendations and pertinent comments which facilitate management to properly discharge its responsibilities.

Vision: DHHS will have minimal exposure to audit risk as a result of effective and efficient control systems that are audited/reviewed on a regular schedule.

The Current Environment

The DHHS Office of Internal Auditor (OIA) reports directly to the DHHS Secretary. The office is comprised of nine staff: a director, a manager, six auditors and one administrative assistant. Of the six auditors, three are permanently dedicated to work with specific programs: two to the Medicaid program and one to the Women, Infant and Children (WIC) program. This leaves only three auditors to cover all the remaining agencies of DHHS. Although the audit and technical assistance services provided by the OIA are normally at the state level, OIA has performed audits and investigations at the county/subrecipient level when requested.

In an ideal world, the office would perform routine audits/reviews of control systems throughout the department to ensure that the department's exposure to risk is minimized. However, the office lacks the personnel resources to operate in this way and, consequently, primarily operates in a reactive mode. Most of the staff's time over the past four or five years has been spent reacting to federal and state audits. When there is a finding, OIA assists the divisions, facilities and schools in responding, often resulting in reductions of paybacks. Reductions that result from OIA assistance are significant—a recent finding in IVE was reduced \$60 million. OIA will also conduct a subsequent review to ensure that corrective actions have been implemented.

OIA occasionally relies on assistance from agencies outside of DHHS, most notably the NC Office of the State Auditor (OSA) and the State Bureau of Investigation (SBI). When the scope of an audit exceeds the OIA's resource capacity or when subpoena authority is needed, assistance is requested from OSA. When fraud or embezzlement is uncovered by OIA, those findings are turned over to the SBI for further investigation and prosecution.

When requested, OIA also provides assistance to the divisions' subrecipient monitoring sections. This is primarily in the form of training divisional staff on monitoring financial controls and assisting the divisional staff in developing financial monitoring guidelines and/or forms. When requested, OIA also reviews proposed program audits/edits for any new Information Technology (IT) systems that have financial or accounting functions.

Key Operational Issues

The primary operational issue facing OIA continues to be the need for more staff. Since three of the six auditors are permanently dedicated to specific programs, only three auditors are available to respond to requests from the rest of the department. Given this staffing challenge, OIA deals primarily with high priority issues as they arise, making it next to impossible to achieve the vision of proactively working to

minimize the department’s exposure to audit risks. No changes are anticipated in the current staffing level or the operational focus of the OIA, although the new Internal Audit Act for North Carolina may have an as yet undetermined impact its work.

Key Indicators for Success

The Office of the Internal Auditor continues to monitor the same indicators as presented in the business plan of 2006.

Indicator	Measure	2006-07	2007-08
OIA will assist DHHS divisions, facilities and schools in developing the audit response to outside (federal/state) audit report findings. OIA will also offer recommendations and perform follow-up to test to see if recommendations for corrective action have been implemented to prevent the recurrence of the audit finding in subsequent audits.			
OIA will conduct a survey of all divisions, facilities and schools requesting information about how OIA can better assist them.	The DHHS Business Support Functions Survey (BSFS)	91% of respondents rated OIA as very good or excellent; 7% rated OIA as good.	77% of respondents rated OIA as very good or excellent; 21% rated OIA as good.
OIA will provide input to strengthen policies, enhance internal controls and improve compliance.			

NOTE: The SBFS results quoted in this table were conducted in 2003 (results released in 2004) and 2006 (results released in 2007).

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Office of Minority Health and Health Disparities

Mission: The mission of the North Carolina Department of Health and Human Services (NC DHHS), Office of Minority Health and Health Disparities (OMHHD) is to promote and advocate for the elimination of health disparities among all racial and ethnic minorities and other underserved populations in North Carolina.

Vision: All North Carolinians will enjoy good health regardless of their race and ethnicity, disability or socioeconomic status.

The Current Environment

The OMHHD focus is to reduce health disparities. OMHHD believes state, local and community approaches to eliminating health disparities should be a unified effort aimed at increasing the capacity of DHHS state and local programs and communities to develop effective strategies and collaborative networks between community-based organizations and other local public and private agencies. Since its inception in 1992, the OMHHD has engaged faith-based organizations, local non-profits, tribes and other organizations to reduce healthcare access barriers and health disparities in their communities. To equip these organizations, OMHHD provides a range of capacity building services, including: training; leadership and skills development; resource development; financial assistance, infrastructure development; consultation and technical assistance. This approach has helped community-based organizations implement sound business practices, ensure fiscal accountability, write successful grants, influence local and state policies and legislation, and mobilize coalitions to address health disparities. With the creation of the Community Focused Eliminating Health Disparities Initiative (CFEHDI), the OMHHD has expanded its capacity to implement a community grants program.

The CFEHDI was created by the 2005 by the NC General Assembly to build the capacity of faith based/community based/American Indian tribal organizations and local health departments to reduce disparities and improve the health of African American, Hispanic/Latino and American Indian populations in the state. CFEHDI focus areas are based on the Racial and Ethnic Disparities Report Card and include infant mortality, HIV/AIDS and other sexually transmitted infections, cancer, diabetes, homicides and motor vehicle deaths.

At the state level, OMHHD leads the department in implementing an integrated, comprehensive and coordinated approach to identify and reduce disparities in services, access, and health. The department's plan, "From Disparity to Parity in Health: Eliminating Health Disparities Call to Action," guides the work of the Divisions and Offices. Each action plan is tailored to specific services and programs.

In addition to building capacity at the community and state levels, OMHHD has three other essential functions: (1) Conduct research and produce reports that present the data about health disparities in terms that a lay person can understand. These reports are used to educate a wide audience on the realities and specifics of health disparities. (2) Provide culture and interpreter trainings to ensure that culturally appropriate communication, outreach, services and materials are provided to our state's diverse population. (3) Promote legislation and policies to improve access to health services for racial/ethnic minorities.

Looking to the future, OMHHD plans to continue the emphasis at the community and state levels by increasing efforts and resources to support capacity building and infrastructure development. OMHHD

will continue to focus on performance and outcome measures for established programs. The Office continues to provide leadership to ensure that issues of health disparities are recognized and integrated throughout DHHS programs and services. As with other divisions and offices of DHHS, OMHHD will be impacted by two trends in the demographics of NC, an increase in the Latino and other minority/immigrant populations and an increase in the percentage of people living in poverty.

While organizationally a separate office from the Division of Public Health (DPH), all of OMHHD's human resources, budget, contractual and other administrative support are provided by DPH.

Key Operational Issues and Opportunities

As are other divisions, facilities and schools, OMHHD is eager for a paperless process for contracts, including tracking and electronic signatures. Currently, much of the process is paper driven requiring excessive manual labor, multiple reviews and delays. This is particularly important to OMHHD because, although the contracts are for small amounts, there is a large volume.

Key Indicators for Success

Status of Past Indicators

The work of the OMHHD engages state and community-based organizations, faith based organizations, tribes and local health and human service agencies to address the elimination of health disparities. Key indicators for success include, but are not limited to, the following areas listed below.

- 1. Each year, increase the overall number of linkages and partnerships by a minimum of 10%.**
 - OMHHD met its goal by increasing overall linkages and partnerships from 703 to 783 in 2007.

- 2. Each year, increase the number of consultation, technical assistance, and training services by at least 10%.**
 - OMHHD provided 10363 services in 2007. This also included trainings for interpreters, cultural diversity trainings, conferences and workshops.
 - CFEHDI grantees participated in at least 4 mandatory group training sessions covering such topics as reporting, administrative requirements, fiscal management, procurement, evaluation, documentation, social marketing etc.
 - In addition, organizations received individual site visits with necessary follow up, consultation, individually tailored trainings, etc.
 - Conducted 11 monthly meetings, in-services, 2 strategic planning retreats and ongoing consultation/technical assistance for the DHHS EHD Steering Committee.
 - Conducted quarterly meetings, a strategic planning retreat, and consultation/technical assistance for the Minority Health Advisory Council.
 - Conducted bi-weekly meetings, in-services, and an annual strategic planning retreat for the OMHHD staff.
 - Conducted 6 meetings annually and a strategic planning retreat for the Hispanic Health Task Force.

- 3. Each year, increase the number of organizations that focus on the use of preventive measures to support healthy lifestyles at a minimum of 10%.**

- OMHHD provided leadership and guidance to a minimum of 380 organizations to increase preventive measures to support healthy lifestyles. This includes 42 grantees funded through CFEHDI. OMHHD decreased the number of awards from 82 to 42 and moved from 1 year to 3 year contract periods. The CFEHDI moved from planning grants to program implementation grants to promote healthy lifestyles.
- DHHS Divisions/Offices have increased their investment, integration and accountability to eliminate health disparities and support healthy lifestyles. This reflects how the Divisions and Offices are taking ownership in the Call to Action to eliminate health disparities. The Divisions and Offices are working to improve services to racial/ethnic minorities and historically underserved populations. They have also linked health disparities to funding and services as well as tracking services better to document their own accountability. For example, with the leadership and technical guidance of OMHHD, 14 Divisions/Offices are answering the Call to Action to Eliminate Health Disparities (EHD). The percentages listed below are based on information that is reported to OMHHD by the divisions and offices in the EHD Steering Committee’s biannual reports, the Call to Action Integrated Approach Matrix and progress reports to the Department Secretary.
 - 85% integrated EHD into staff work plans
 - 85% increased documentation of minority health data
 - 78% included EHD verbiage, goals and/or objectives etc. in Request for Applications and contracts
 - 71% have established internal staff disparity teams
 - 57% Document EHD as a priority
 - 57% integrated EHD into their mission, goals and policies

4. Each year, update the health disparities report card and other resource tools.

- These specific measures were selected particularly because they are broad enough to cover all aspects of the OMHHD mission. The measures are re-evaluated during the annual OMHHD strategic planning retreats, as well as through bi annual staff work plan reviews. The following performance measures are documented, tracked and reviewed annually through the DHHS PMD.

Current Indicators

Indicator	2004-05	2005-06	2006-07
Increase the overall linkages and partnerships by 10% each year.	628	703	783
Increase the number of consultation, technical assistance and training services provided to organizations and individuals by 10%.	9720	10800	10363
Increase the number of organizations who focus on the use of preventive measures to support healthy lifestyles by 10%.	630	700	380
Update the health disparities report card and other resource tools.		Updated publications	Updated publications

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Office of Policy and Planning

Mission: The Office of Policy and Planning (OPP) will work with divisions and offices to develop effective policies, plans and procedures; analyze work processes and recommend improvements; and facilitate performance reviews of programs and services so that the NC Department of Health and Human Services can achieve continuous improvement.

Vision: A results oriented culture will thrive throughout DHHS and the OPP will be viewed as a leading factor in performance management and continuous improvement initiatives.

The Current Environment

The OPP has received positive recognition for its efforts to improve performance within DHHS. Although OPP is not chartered with implementing authority, numerous projects have been undertaken throughout the department that were originated or supported by OPP initiatives. These include the Performance Management Database (PMD) and associated program reviews; other initiatives such as performance based contracting and related information systems enhancements; the current effort to merge the contracts database and the subrecipient monitoring database into the PMD; LeadershipDHHS for identifying and developing high potential employees; and numerous process improvement efforts that have had direct and indirect impacts to cost reduction, efficiency gains and improved service delivery.

OPP also assumes responsibility for numerous studies and other projects whether initiated through the Secretary's Office or upon specific request from other DHHS agencies. These include policy coordination of issues with a multi-divisional focus, the facilitation of multi-divisional work groups on a variety of subjects and development of this business plan.

Key Operational Issues

In general, there is a very positive trend within DHHS toward performance based management and the importance of measuring outcomes. There is also a growing awareness of the criticality of data sharing so that better, department-wide decisions are made. However, these positives are frequently accompanied by a reluctance to change, a possessive attitude toward divisional information, and a tendency to resist process improvement in favor of layering more monitoring, review and compliance mandates onto existing processes.

There are four risks to OPP's ability to fulfill its mission: the cultural reluctance to change, an under utilization of process improvement efforts, the failure to continue the development of management and evaluative tools (such as the PMD) that allow performance measurement, and the pending justification review study being conducted by the General Assembly. Continued success within OPP depends on staff with wide experience, education and knowledge of best practices in the public as well as private sector; yet this is currently threatened by the elimination of funding as of June 30, 2008. To the extent that these risks can be mitigated, and that OPP delivers value added products that internal customers see as effective, and with strong DHHS leadership endorsement of performance based management, OPP can achieve its mission.

Key Indicators for Success

OPP continues to focus on the following critical few indicators.

Indicator	Measure	2006-07	2007-08
Number of DHHS divisions requesting OPP Assistance	Requests for assistance indicate recognition that OPP provides value added services & product.	DAAS DMA DPH OCS OPCS	DSS DCD DHSR DSDHH B&A
Recommendations Implemented	Percent of total recommendations put into practice	Between 40 & 50%	N/A
Customer service feedback	Verbal and written as well as the Business Support Functions Survey (BSFS)	68% of respondents to the SBFS rated OPP as very good or excellent (27% rated OPP as good)	69% of respondents to the SBFS rated OPP as very good or excellent (30% rated OPP as good)

NOTE: The SBFS results quoted in this table were conducted in 2003 (results released in 2004) and 2006 (results released in 2007).

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Office of Procurement and Contracting Services

Mission: To promote integrity in all phases of public purchases and ensure compliance with applicable procurement regulations in the department by providing training, research, compliance reviews, reporting, and operational assistance to all of the North Carolina Department of Health and Human Services divisions, offices and facilities so that they maximize financial and program capacities through effective procurement while simultaneously fostering trust and confidence to North Carolina citizens that the utmost fairness and impartiality is being used in expending public funds.

Vision: As a leader, the Office of Procurement and Contracting Services (OPCS) will operate in a high performance culture where procurement makes direct and significant contributions to financial stability and improved service delivery to the residents in North Carolina.

The Current Environment

In 2003, DHHS began a major effort to implement performance based contracting (PBC) throughout the department. By turning the focus to results, not activities to be performed, PBC defines performance expectations and measures, due dates and milestones, with payments based on outcomes achieved. In support and recognition of this initiative, OPCS was established as a separate unit within the DHHS Secretary's Office where it continues to drive PBC in all of the various divisions and offices throughout DHHS.

In its leading role, OPCS has three main functions: Compliance; Operational Support; and Training / Research (including studies of automation and electronic data transfer). Along with reorganization of large division contract offices, OPCS will evolve its structure to meet the needs of the department. This includes structural changes to align resources as well as process and policy changes with a focus on simplifying and streamlining work processes.

Key Operational Issues and Opportunities

PBC is a major component of the DHHS performance management initiative. Currently all DHHS contracts have some performance based components that contribute to better financial management and service delivery. OPCS leads the role in driving the establishment of divisional centers of excellence, working to strengthen the skills and confidence of divisional staff to manage programs and contracts for results, finding and sharing best practice models, assessing training needs, and providing technical assistance.

One key tool for streamlining work processes is to automate the contract approval process and electronically manage contract documents. By automating the approval process based on 3000 contracts, the department would save approximately \$112,000 annually. This cost is estimated by upkeep of division internal approval tracking logs, FTE time to enter separate system entries, FTEs time telephoning agencies to verify where the contract is in the approval process, FTE travel time routing contracts from one approval agency to another and office supply costs. Automation would address accountability, minimize legal and financial risk, minimize operational inefficiencies, maximize control and maximize

revenue. Automation will identify process delays, reduce costly record management and improve processing time.

Implementing an automated contract management system would improve productivity, reduce the contract approval process and provide data to document the impact of performance based contracts. PBC continues to be a challenge. Although contracts are compliant with the five elements of a PBC, a sample of 35 contracts in the third quarter of SFY 07/08 reflected 82% included demand measures, all included input measures and output measures, 78% included efficiency measures and only 68% included outcome or service quality measures. Analysis of the sample contracts suggests the need for a stronger emphasis on efficiency, outcome and service quality measures through training workshops.

It is imperative that the skill levels of the department procurement and contract staff meet the demands of the environment. OPCS' role is to provide two aspects of this need: (1) workshops in contract administration, performance based contracting, technology applications and process efficiency to replace or upgrade current skill sets, and (2) ensuring the new workforce have the skills to replace employees near retirement and involved with contracting and procurement. Currently, OPCS is not responsible for hiring procurement and contract positions in the three schools, twelve mental health facilities, state lab or the divisions. This makes OPCS' role more challenging. Additionally, position titles are not always synonymous with the duties performed. OPCS makes a concerted effort to work closely with all internal agencies for procurement and contract training needs.

Another operational issue within DHHS is the number of purchasing offices. In DHHS there are twelve purchasing offices in the mental health facilities, three offices at the schools and one at the state lab. The purchasing offices do not report directly to OPCS and do not always adhere to procurement policies with purchasing and contract issues. Service procurements in the purchasing offices are managed by the business office budget staff, often bypassing the purchasing officer at each location. It is difficult to ensure procurement practices at these locations and often there is duplication of services, lack of control and monitoring, lack of standardization and inefficient operations. The decentralized purchasing offices make it very difficult to monitor compliance, keep staff trained in federal and state procurement policies and provide operational support and training to all locations.

To ensure efficient and effective procurement practices OPCS recommends establishing a central office in Raleigh and regional purchasing and contract offices in Goldsboro, Butner, and Morganton for the mental health facilities. Consolidating regionally along with automation would streamline work processes and ensure effective and efficient procurement practices. In addition consolidating the offices into three regional offices that directly report to OPCS would strengthen accountability.

OPCS sees the increasing demand to outsource services; often this is attributed to lack of staff resources, workforce shortages in hard to fill positions and specialized expertise to provide services directly to the public. In the last five years, issuance of RFP's has increased over 200% because of the directive to decrease sole source contracts. OPCS has drafted over 30 RFP's resulting in awards exceeding \$350 million dollars. These RFP's ranged from simple services such as pest control to complex services such as the North Carolina Medicaid System. Drafting the multi dimensional complex RFP's requires OPCS staff to develop a higher skill level and evolve with emerging trends. OPCS staff must hone communication skills to understand user requests of a wide range of services in order to request proposals and bids. The multi-million dollar procurements must be written precisely or the result can be very costly to the residents of North Carolina.

Key Indicators for Success

Status of Past Indicators

OPCS continues to drive the use of competitive processes to procure goods and services such as RFAs, RFQs, and RFPs.

OPCS met North Carolina's historically underutilized business goal by procuring at least 10% of all purchases through HUB's in SFY 05/06 and SFY 06/07.

OPCS met the department's overall contract compliance rate of 90% in SFY 05/06 and 06/07.

Current Indicators

Key Performance Indicator	Measure	2007-08	2008-09
OPCS will meet the department's overall contract compliance rate of 90% in SFY 07/08.			
OPCS will meet North Carolina's historically underutilized business goal by procuring at least 10% of all purchases through HUB's in SFY 07/08.			

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Office of Property and Construction

Mission: To provide efficient facility services for all areas of responsibility, with special emphasis on those services that enhance the quality of care for clients of the North Carolina Department of Health and Human Services (NC DHHS) divisions/facilities/schools and that ensure work space conducive to the success of its employees in providing client services.

Vision: All DHHS employees, clients and visitors will work or reside in facilities that meet or exceed environmental and aesthetic standards that contribute to quality outcomes for all.

The Current Environment

The DHHS Office of Property and Construction (OPC) is responsible for budgeting, planning, designing and constructing of capital projects (currently authorized projects are in excess of \$600 million) for DHHS facilities. In addition, OPC manages centralized facility maintenance, repair, and renovation; approves and manages leases for facilities where employees and/or equipment are housed; and, through delegation from the DHHS Secretary, is the designated operating authority for the Butner reservation.

OPC is managing four of the largest ever DHHS capital projects—the new Central Regional Hospital being constructed in Butner, the planning, design and construction of new Eastern Region and Western Region Psychiatric Hospitals, and a new State Laboratory of Public Health/Office of Chief Medical Examiner.

Capital projects for DHHS divisions/facilities/schools are significantly impacted by economic trends, particularly inflation in labor and material costs. Today’s economic environment is unstable. Even slight changes in the economics of the construction market can create significant capital dollar impacts when the available funding is fixed, which is typical for most state capital construction projects. Re-bidding, redesigning or requesting funds transfers in an attempt to award construction contracts in a volatile market can create significant delays in projects resulting in the potential for projects to be compromised or canceled.

OPC manages the maintenance and repair and renovation of over 900 buildings throughout the state, most of which were constructed in the late 1800s thru mid 1950s. Because current funding makes it impossible to keep pace with the maintenance of deteriorating infrastructure, OPC frequently finds itself relying on “critical needs” requests to pay for materials, fuel, labor, utility and vehicular costs that are not accounted for in approved budgets. Additionally, OPC is responsible for managing in excess of 200 leases statewide to enable staff to be housed and clients to be served.

Key Operational Issues and Opportunities

OPC is modernizing maintenance functions, with the intent of having computerized maintenance management systems at DHHS facilities statewide. This will allow tracking on a comparative basis of the efficiency of maintenance groups within DHHS, including use of labor and materials. OPC is increasing the installation of building monitoring systems (BAS) to free manpower for more wrench time. This follows up with previous upgrades to database system for tracking construction projects. In the area of design and construction, OPC is moving to a paperless environment that will allow for freeing time for its primary mission, the design and construction of renovation and capital projects for DHHS.

A major risk to the department is the continuing lack of adequate personnel resources and capital and operating funding needed to accomplish implementing delivery changes. In the maintenance sector, OPC

cannot compete with adequate wages and benefits for the skilled work force needed to maintain upgraded building systems. Additional professional architects and engineers are needed for the construction of three major projects involving the expenditure of over \$400 million. This requires establishing and funding positions and recruiting employees. The benefits of making these changes include lower costs and higher efficiencies, contributing to better facilities for patients and employees.

Key Indicators for Success

OPC faces challenges in the design and construction segment, due to a number of reasons. The impact of inflation has hurt OPC's ability to receive bids within the budget allowed for projects. Restraints within the state construction process also create delays and further impact the effects of inflation. Maintenance operations are going well, and in excess of 90% of work orders are being fulfilled.

Employee morale is a key to the success of any organization and effort. Employees need to have the right tools available to them to enable them to accomplish objectives without having to worry about the basics. Design and construction indicators allow for effective measures for proceeding in the process of renovation and construction of existing buildings and construction of new capital projects. Maintenance operations measures allow for better monitoring and improving the maintenance for all DHHS facilities.

Current Indicators

Indicator	2007-08	2008-09
Employees:		
• Employees have good morale and are actively pursuing assignments	-	-
• Employees have the tools they need to complete their responsibilities effectively and efficiently	-	-
Capital Budgeting:		
• Project cost centers are established within a reasonable period after receipt of funding from the repair and renovation reserve – goal is 30 days	-	-
• Funds are allotted and available within the project code so that all contractors can be paid within 30 days of receipt of pay applications	-	-
• Capital funding requests are prepared and delivered, along with all required documentation within time frames established by the NC State Budget Office	-	-
Design and Construction:		
• Design contracts are negotiated and executed in a timely manner after approval of selection by NC State Building Commission – goal is 30 days	-	-
• Repair and renovation reserve projects are designed within the funding available from the reserve, pending a warranted change in scope	-	-
• Projects are constructed within the project budget established by the construction contract award letter	-	-
• Projects are constructed within the schedule established by contract documents	-	-
• A minimum of 10% of construction project costs are awarded to HUB contractors	-	-
Maintenance Operations:		
• Facilities are maintained so that CMS, JCAHO, etc. requirements for certification are met	-	-
• Preventative maintenance programs are in place and executed. A minimum of 90 percent of work orders are completed each fiscal year	-	-
• Customers are satisfied with the service they receive	-	-
• Wrench time is at the 70 percent level as a minimum	-	-
Property Office:		
• Lease extensions are negotiated prior to expiration of current leases	-	-
• New leases are established within the time frame required by internal customers	-	-
• Leases are consolidated where feasible and economically reasonable	-	-

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Office of Public Affairs

Mission: The DHHS Office of Public Affairs will provide communications know-how through a variety of media, such as outreach materials, news releases, fact sheets, web pages, and media guidance and advice, such as preparation for interviews, speeches and other events, to help all DHHS divisions, offices and programs communicate effectively.

Vision: By acting as the central communications arm of DHHS, OPA helps the department present a clearer understanding of services and information that will enable NC residents to live healthier, safer and more secure lives.

The Current Environment

The OPA continues to provide the department a wide range of services related to communications to the public. These include being a centralized point of contact for media, distributing communications through various media outlets, supporting divisions in the development of public relations materials, providing a professional graphics shop, and maintaining a user-friendly and informative web site for the department. While these are ongoing responsibilities, the news business has changed significantly in recent years, and will continue to change at a fast pace as communications technology changes, and the OPA needs to change accordingly.

The news business today is a 24 hour a day, seven days a week cycle, which is no longer aimed at evening newscasts and morning newspapers. This demand limits OPA's time for other non-immediate responsibilities such as writing brochures. Additionally, bloggers are not following traditional journalism ethics, in that basically anything can be placed on line without checking all the facts; this necessitates monitoring so that inaccuracies can be corrected before they are spread world wide on the Internet. Finally, OPA is impacted by substantial requests for public records, again taking staff time away from other responsibilities.

The OPA has prepared for responding to public health events by taking FEMA classes for Emergency Operations, and the office is now certified to lead a Joint Information Center (JIC) should such an emergency occur.

Key Operational Issues

OPA staff need training on the use of the today's communications methods—podcasts, more web-based information usage, YouTube, blogs, etc.—and the tools to use them. Also in the near term, is completion of the redesign of the DHHS web site, along with on-going efforts to make sure that all communications methods remain secure.

Key Indicators for Success

Status of Past Indicators

Indicator--By 2008, the web site will be operative so that citizens can use it to find out information by subject area rather than by division.

Status—Nearing completion

Indicator--DHHS OPA staff will have taken the FEMA class work required for emergency operations by the end of 2006.

Status--Completed

Indicator--By 2008, DHHS OPA will be able to run the JIC in an event of pandemic flu or other notable public health event.

Status—Completed

Indicator--By spring of 2006, NC media will have received special outreach/education on pandemic flu via web cast and teleconference.

Status—Completed

Indicator--By 2007, tool kits will have been developed to help small businesses, churches, schools and the general public prepare for a pandemic.

Status—Completed

Indicator--Public information officers working with division leadership, will develop comprehensive communication plans that focus on divisions' key objectives and use division spokespeople as key communicators.

Status—Completed

Current Indicators

Indicator	Measure	2007-08	2008-09
More emphasis on nontraditional media like podcasts, webcasts, other web-based efforts and bloggers.			
Completion of the department's web redesign.			

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Office of the Controller

Mission: The mission of the Office of the Controller is to support the North Carolina Department of Health and Human Services (DHHS) and all its divisions, facilities and schools in all fiscal operations so that they are accomplished according to state and federal requirements to the benefit of citizens, clients and employees.

Vision: As a result of the strong fiscal controls of the Office of the Controller, DHHS will experience fewer fiscal errors, maximize resources and maintain a sound and effective internal control framework.

The Current Environment

The DHHS OOC sets and interprets all accounting and financial reporting policies and procedures for the department as authorized by the rules and regulations of the NC Office of the State Controller and state statute and federal guidelines and executes all accounting transactions for the DHHS. As a centralized service, OOC is charged with establishing common policies and procedures that will yield consistent results for all divisions, facilities and schools.

Although there is a centralized reporting structure, the OOC is physically located in three separate sites in Raleigh (Oberlin Road, Albemarle Building and Dix Campus) and four other regional offices around the state. The challenge of operating in numerous locations is compounded by an inability to recruit the human resource expertise needed to support fiscal responsibilities and by reliance on old information technology that requires hand processing and paper files.

Currently the Office of the Controller is facing major staff turnover through retirement and attrition of staff that leave to pursue opportunities elsewhere. When these staffing issues are combined with increases in state and federal programmatic requirements, greater staff frustration is experienced, which further exacerbates morale and the turnover rate. The DHHS OOC will continue to focus on accountability, integrity, maintaining a service orientation and professionalism as it strives to achieve its vision. To do this, however, OOC needs to be able to attract and retain talented staff and aggressively pursue updating antiquated sub-accounting systems.

Key Operational Issues

OOC's biggest challenge is staffing. To meet its mission of ensuring accurate adherence to state and federal policies and fiscal regulations, the OOC must maintain a staff that possesses extensive financial expertise. The inability to pay competitive market rates is a main factor in both the high attrition rate and the difficulty in recruitment of qualified personnel.

The second significant challenge is that OOC conducts business through a patchwork of legacy systems where data are not integrated, systems are hard to maintain and enhance, and where many manual processes are required to pull data and reconcile systems. Current staff knowledgeable about these systems is becoming retirement eligible, creating an urgency to establish workforce plans and provide for technology transfer to newer, updated systems when funding becomes available.

In addition, there is extensive manual processing of paperwork, resulting in a vast quantity of hard copy data requiring valuable storage space. These manual processes require numerous handoffs from one person to another, sometimes through the mail service or local couriers, and they are unnecessarily burdensome and time consuming.

OOC would benefit tremendously from upgrades to its legacy systems and implementation of document management technology. Unfortunately, OOC has not received funding priority even though efficiencies could be gained that would impact virtually all DHHS operations.

Key Indicators for Success

In 2008 the Office of Controller revised their previous indicators to develop the following four major indicators.

Indicator	Measure	Results 2006	Results 2008
Minimal to no financial audit findings and positive performance appraisals and accurate NCAS reports.	Number of audit findings by Office of State Auditor and accurate NCAS reports.	SFY 05-06, there were 2 total audit findings	SFY 06-07, there were 6 total audit findings
Reduce manual efforts to more efficient automated processes and enhance existing automated systems that require modifications.	Conduct annual internal control reviews to reduce risk associated with processes and controls.		<p>The following nine initiatives have been completed:</p> <ol style="list-style-type: none"> 1. OOC Rate Setting Branch has automated registration training process for MH and foster care cost reports 2. Working with the OSA, over 1400 DHHS financial assistance grantees can now submit reports online. 3. Working with DHSR, OOC A/R section developed automated process for properly classifying and collecting outstanding receivables. 4. Working with DIRM and DOR TANF and Food Stamp overpayments collections are automatically recorded into NCAS. 5. Working with DIRM, OOC is now able to intercept NC Lottery winnings from DHHS debtors 6. Working with DIRM, OOC updated the EBT processes so that payments or drafting county agencies is more accurate.

			<p>7. OOC converted CARS to microfiche reports to dispose of paper reports and maintain documentation for audit purposes.</p> <p>8. OOC made improvements around adoption HIV funds to allow direct deposit and provide more security.</p> <p>9. Working with DPH and DIRM, OOC automated claims payment systems using a web based approach that also uploads directly into NCAS, thus eliminating errors.</p>
Low turnover and high performance	Provide job training as appropriate and pay a salary commensurate with experience and education	85 positions were vacated and filled	In SFY 06-07, 79 positions were vacated and filled. So far for SFY 07-08, 50 positions were vacated and 45 filled
Positive feedback from service divisions and public being served as a result of quality work being performed.	Current using the DHHS Business Support Functions Survey (BSFS) for internal feedback	79% of respondents to the BSFS rated OOC as very good or excellent (18% rated OOC as good)	63% of respondents to the BSFS rated OOC as very good or excellent (32% rated OOC as good)

NOTE: The SBFS results quoted in this table were conducted in 2003 (results released in 2004) and 2006 (results released in 2007).

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Part III: Appendices

Appendix 1

Business Plan Questionnaire – 2008 Version Update



Business Plan Update Questionnaire

Division/Office:

Mission:

Vision:

Last reviewed:

Last reviewed:

Section I: Current Environment

2. Provide an update of the current environment in which you operate, with emphasis on the following:
 - a. Major initiatives designed to improve programs and services, productivity, operations and related measurable progress.
 - b. Demographic/customer trends, economic trends, environmental trends, workload or other factors that affect your programs and services.
3. What are your performance measures or key indicators of recent progress and results?
4. Please comment on the status of key indicators identified last year.
5. Which are the three most critical measures/indicators of your success for your primary customers over the next five years?

6. How will your mission be furthered by emphasis on each of these indicators?

Section II: Future Direction

7. How will your work performance, programs and service delivery change over the next five years?
8. What are the challenges and risks to your service delivery and how are you addressing them?
9. What are the specific strategies or actions needed to achieve your mission and outcome goals?
10. What are the operational and public benefits to making these changes?
11. Are the performance indicators and measures you cited captured in the Program Management Database (PMD)?
12. Please add any other comments that will add to an understanding of your current operations, your plans for the future, and the challenges that you face.

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Appendix 2

Summary of Operational Issues

(2006 Data Remains Unchanged)

Summary of Operational Issues by Number of Responses

Business Functional Area	Issue Title	Issue Description	Responses
Workforce	Inability to Attract & Retain Qualified Workforce	DHHS unable to attract and retain qualified workforce due to noncompetitive salaries and lack of training opportunity to learn new skills.	12
Information Technology	Insufficient Automation of Manual Processes	Lack of automation around very manual processes, including electronic documents, electronic signatures, electronic invoicing, automatic data exchange/report generation, doing business online, EBT, JIT, contracts process, invoicing, renewing licenses etc.	11
Workforce	Not Enough Staff	Workload increased but workforce size simply not large enough to do work in key areas.	8
Management	Need Emphasis on Operational/Process Mgmt	To enhance efficiency and effectiveness of programs and services, there is a need to improve operational processes and standardize functions.	7
Workforce	Lack of Qualified Candidates	There is a shortage of qualified candidates in specialized skill areas (such as RNs, psychiatrists, drug abuse counselors).	7
Information Technology	Need More Data Collaboration	Technical crosswalks not made (ex., DSS case across counties) - Data owners prohibit cross walk of data/information	7
Program-Service Delivery	Seamless Access for Customers	Programmatic applications serving citizens should be built around the recipient of services, not the programs delivering service.	6
Workforce	Insufficient Workforce Planning	Insufficient planning for the retirement of leaders/managers.	6
Workforce	Need Increased Skills	Changes in program/service delivery and business environment have created a need for staff with more skills than current staff.	6
Information Technology	Access for Disabled	Information resources and tools need to be accessible to persons with disabilities (visual, hearing, intellectual, physical)	5
Information Technology	Legacy Systems	Existence of legacy systems creates a high risk of loss of support and difficulty enhancing and maintaining systems - the potential to fail to deliver services to the public.	5
Program-Service Delivery	Insufficient Funds to Meet Demands	Growth in demand for services surpasses available funding.	5
Management	Delays Due to State Processes	Initiatives are micro-managed, which results in significant delays or inability to carry out initiatives	5
Information Technology	Field Staff Tools and Access	Need better utilization of automation tools for gathering, analyzing and accessing data and information at the point of need/use.	4

Business Functional Area	Issue Title	Issue Description	Responses
Information Technology	Document Management	Document management to reduce storage space and secure critical vital records, improve processes, improve access to important documents, retention of records and tracking.	4
Information Technology	Lack Systems that Support Core Business	Systems required to support certain core business processes are lacking, sometimes resulting in substantial costs to the department.	4
Buildings and Facilities	Deteriorating Infrastructure	Many of the 900 buildings that DHHS occupies are old and outdated.	4
Information Technology	Need Enterprise Approach to IT Delivery	When applications are being developed whose functionality may benefit other divisions, need to assess as enterprise solution and involve all potential stakeholders.	4
Management	Contracts Process	Departmental contracts process not optimized for quick turn-around which inhibits effective enforcement of performance, creates long turnaround on IT contracts and is time consuming while adding little value.	4
Management	Lack of Cross-Organization Coordination	All impacted divisions not at table when initiatives/changes/issues being discussed.	4
Finance	Insufficient Operating Budget	Funds are not allocated on a recurring basis to cover basic operating expenses - that increase annually due to inflation and growth.	4
Workforce	Need for Employees with Multiple Languages	Staff are needed that can speak languages other than English - cultural competencies.	4
Program-Service Delivery	Real-Time Access to Patient Information	Need single electronic medical record for patients.	4
Program-Service Delivery	Use of Geographic Information System	Desire to further utilize GIS to more effectively deliver programs and services.	4
Information Technology	Video Conferencing	Desire to utilize video conferencing to communicate with staff and stakeholders across state for meetings and training.	3
Finance	Real Funding Inflexibility	Restrictions in funding inhibit department/divisions from delivering programs and services in the best way.	3
Program-Service Delivery	Need Controlled Substance Database	Need a database for tracking patient usage of controlled substances.	3
Workforce	Lack of Flexibility in Job Classifications	Managers are not able to create job classifications that they feel best suit their workforce needs, either because of funding limitations or OSP restrictions.	3
Information Technology	Not All Employees Have Access to Electronic Info	Not all staff have access to a computer. This poses difficulties in using IT to deliver information and enabling employees to manage their information.	2
Buildings and Facilities	Spread Out Workforce	Personnel performing similar functions or needing regular access to others in the department are not optimally co-located.	2
Finance	Inflexible Use of Funding Sources	Reluctance to blend funding to accomplish goals or modify program/service delivery because of actual or perceived limitations in funding stream that does not actually prohibit such usage.	2
Finance	Lack of Sustainability of Funding	Divisions often pursue or are encouraged to pursue grants that require the state to fund the effort after the initial pilot.	2
Information Technology	Ad Hoc Management Analysis of Data	Management needs the ability to access existing data for ad hoc analysis.	2
Information Technology	Desktop Mgmt	Unified approach to desktop/LAN management	2

Business Functional Area	Issue Title	Issue Description	Responses
Workforce	State Cannot Compete with County Compensation	Counties offer better compensation for similar positions which makes it difficult for the state to recruit and retain.	2
Workforce	Insufficient Training	Training available for state workforce is insufficient, either resulting in reliance on contractors, under-qualified staff, or loss of staff.	2
Information Technology	Need Business Partnering with IT	Approach of customer service is to give specific customer exactly what they want rather than a consultant model of business partner and an enterprise approach.	2
Program-Service Delivery	Legacy Systems Prevent Service Changes	Managers of programs are frequently unable to make modifications to existing legacy systems necessary to enable improvements.	2
Information Technology	EA Concern	Concerned that specific needs will be lost in enterprise approach to IT solutions	2
Buildings and Facilities	Problems with Leases	Delays experienced in resolving issues with leased property.	1
Management	Proactive Management	Anticipate need to request management information to allow divisions plenty of time to respond to requests.	1
Communications	Feedback	Desire effective feedback mechanisms, formal and informal, internal and external.	1
Communications	Need to Effectively Market Prog/Services	In some instances, the intended beneficiaries of programs and services do not know they exist.	1
Communications	Use Data Better in Communications	Need to be able to present data in formats that can more clearly communicate to constituents.	1
Program-Service Delivery	High Fuel Costs	High cost of fuel affecting program/service delivery	1
Workforce	OSP Value Operational/Mgmt Skill	The current job classification system does not value business, finance, quality and process improvement skills.	1
Information Technology	All Offices for Div not on same Network	The offices for a division are not all on the same network.	1
Program-Service Delivery	Improve Prog/Serv Delivery Through use of Tech	Many opportunities exist for improving program and service delivery with effective utilization of technology i.e., tele-medicine; electronic health records, etc.	1
Finance	Shift of Funding Burden to State	Changes in federal programs are resulting in shifts of funding burden to states.	1
Information Technology	Access to Information for External Partners	Need the ability to provide restricted access to documents and information to defined external partners.	1
Information Technology	Security	Concern that digitized information is vulnerable to hackers accessing it or modifying it.	1
Workforce	Inflexible Employment Rules	Inflexibility in the state's employment laws makes it difficult to implement creative solutions to HR problems	1
Management	Need Just In Time	The department could save space and money by using just in time inventory processes.	1
Finance	Insufficient Reimbursement Rates	The reimbursement rates for Medicaid eligible services are significantly below the cost of providing those services.	1

Most Frequently Mentioned Operational Issues for Programmatic Agencies

Business Functional Area	Issue Title
Workforce	Inability to Attract & Retain Qualified Workforce
Information Technology	Insufficient Automation of Manual Processes
Program-Service Delivery	Seamless Access for Customers
Workforce	Insufficient Workforce Planning
Workforce	Lack of Qualified Candidates
Information Technology	Need More Data Collaboration
Information Technology	Access for Disabled
Management	Need Emphasis on Operational/Process Mgmt
Program-Service Delivery	Insufficient Funds to Meet Demands

Most Frequently Mentioned Operational Issues for Support Agencies

Business Functional Area	Issue Title
Workforce	Inability to Attract & Retain Qualified Workforce
Information Technology	Insufficient Automation of Manual Processes
Workforce	Not Enough Staff
Workforce	Need Increased Skills
Finance	Insufficient Operating Budget
Management	Delays Due to State Processes
Buildings and Facilities	Spread Out Workforce
Workforce	Insufficient Training
Management	Need Emphasis on Operational/Process Mgmt

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Appendix 3

Demographic Influences from Business Plan Questionnaire

(2006 Data Remains Unchanged)

Summary by Programmatic Agencies

(CDD, DAAS, DCD, DHSR, DMA, DMH/DD/SAS, DPH, DSB, DSDHH, DSS, DVR, OEO, OES, OMHDD, ORHCC)

SUMMARY			
Group	Trend	# Hits	Rank
A	Aging Population	14	1
C	Immigration issues, especially Hispanics who don't speak English	13	2
B	Growth of eligible populations (Aged, Children, Disabled, Poor, etc)	10	3
F	Budget shortfalls / issues	10	3
L	Unemployment / layoffs / plant closings	7	5
E	Cost of care / services increasing	6	6
D	Individuals / families in poverty or minimum wage	5	7
Q	Decrease in providers / unavailability of providers or services	5	7
U	Decrease in rural industries / movement from rural to urban	4	9
G	Natural disasters	3	10
H	Technology advances, including medical technologies	3	10
K	Increase / transition to community services	3	10
M	Multiple disabilities / conditions	3	10
P	Aging Workforce	3	10
S	Aging Facilities / Equipment	3	10
T	Recruitment issues / shortages of nurses and other professions	3	10
I	Rise / Fall in Economy	2	17
R	Federal teaching requirements	2	17
V	Job market skills changing	2	17
W	Growth in uninsured	2	17
X	Increasing HS drop out rates	2	17
J	Increase in single parent families	1	22
N	Unfunded mandates	1	22
O	Obesity and associated health risks	1	22

Division	Demographic Issue	Group
CDD		
	None Enunciated	
DAAS		
	Aging population	A
DCD		
	An increase in the number and/or proportion of children and/or overall population of NC	B
	A probable increase in NC's Hispanic population	C
	The overall aging of NC's population	A
	Changes in parents' wages/employment status	D
	A possible increase in the state minimum wage will make a difference to low-income parents	D
	The cost of care is expected to increase	E
	Changes in state/federal budgets	F
	Increasing numbers of serious natural disasters/events	G
	Advances in medical technology as well as social/environmental changes	H
DHSR		
	Changes in reimbursement policies by payors that affect access to care	E
	Shifts in population over 65 (>in Assisted living and Home care)	A
	Market conditions up or down	I
	Flat lined or decreased Medicare and/or Medicaid funding to Agency.	F
	Natural or man made disasters affecting health care delivery	G
	Increases in jail population	J
	Deinstitutionalization of mental health services into community settings	K
DMA		
	Downward or upward change in the national, state or local economy	I
	Rising cost of health care and malpractice insurance	E
	Major industry closings & layoffs	L
	Natural disasters	G
	The natural aging of our existing population	A
	In-migration of retirees to our state	A
	Growing number of non-citizens and seasonal/migrant workers	C
	Federal trends threaten to increase the financial burden of each state	F

DMH/DD/SAS

A strong consumer voice that continues to grow and drive state policy.	K
Increased diversity among consumers indicates need for more linguistic and culturally competent staff.	C
Potential decreases in domestic funding at the federal level from such programs as Medicaid, block grants, housing and employment.	F
Limitations in funding of community services for MHDDSAS creating increasing demand for inpatient and institution based services.	F
Downsizing of state facilities and budget reductions.	F
Adjusting to how LMEs use the new formula for allocating bed days for individual patients.	E
Increase in unfunded regulatory mandates. Examples - HIPAA Privacy, HIPAA Security, OSHA, CMS, Federal Inpatient Prospective Payment System (IPPS), etc.	N
Absence of planned budgetary increases based on population growth and inflationary increases, especially at the community level.	F
Rise in the North Carolina population, including growing elderly and Hispanic populations.	A B C
Psychiatric hospitals' admission rate and census are affected by population increases, unemployment levels, community capacity, and prevalence of substance abuse.	BL
Need to develop programming, linguistic and cultural competencies to address the growing Latino, Asian, aging, and homeless populations.	C
Increased influx of children with autism and other developmental disabilities at state facilities.	B
Trend for state facilities to serve individuals with most extreme needs (medical and/or behavioral) and an aging population within facilities.	P
Increasingly large numbers of individuals with severe and profound developmental disabilities and cognitive impairment who are living longer and more normalized lives.	B
Poly-substance dependence is now the norm, rather than the exception, among a larger cross-section of the population who often end up with financial, mental and physical complications.	M
Increased numbers of people affected by Alzheimer's Disease (doubled since 1980), aging with developmental disabilities and the increased risk for Alzheimer's Disease among people with Down Syndrome. A percentage of those affected in North Carolina will have significant medical and behavioral support needs that can only be met in a specialized setting and nursing care facilities.	A M
Limited resources in community for placement of psychiatric rehabilitation of patients.	Q
Un-served and underserved populations and the lack of services being provided in the community setting.	Q
LMEs have had difficulty developing community capacity in rural areas.	Q
The state of and availability of the workforce in NC that is shifting from traditional manufacturing and possibly to human services.	U

DMH		
	An aging workforce at state facilities that impacts the staff's ability to perform physical requirements for their positions (i.e., NCI restraint and seclusion).	P
	Major loss of jobs in the furniture/manufacturing industry that potentially provides a larger pool of mature and stable applicants for support services (such as dietary and housekeeping) and direct care.	L
	Demand for staff with interpreting skills (Hispanic and Asian).	C
	Significant increase in retirees and elderly that increases the demand for health care services (including PT, OT, and speech) at state facilities.	A
	Inability of state to offer competitive salaries in relation to the local labor market.	T
	A nursing shortage continues to exist along with a highly competitive job market, which impacts ability to recruit/retain quality nursing staff.	T
	The aging of and need to replace state facilities.	S
	Aging equipment, lack of funding for preventative maintenance, and the need for improvements related to technology hampers productivity and patient care.	S
	Rapid advancement in information technology and information systems;	H
DPH		
	Population growth	B
	Increasing cultural diversity and language issues (Latino, Hmong and Russian growth)	C
	Aging population.	A
	Economic factors include downward trends in the economy, increases in poverty (NC has 5th fastest growth rate), and increasing numbers of uninsured citizens (17.5% in 2004).	D
	North Carolina has a high drop out rate, particularly for African American males.	X
	Increasingly, efforts addressing the prevention and control of many chronic disease conditions will focus around alarming increases in obesity and the associated health risks.	O
	Core public health funding at the federal level is being reduced. Budget cuts will result in loss of service capacity.	F
	Public health's work force is beginning to reach retirement eligibility, which will result in a significant loss of institutional knowledge and experience.	P
DSB		
	Increase in aging population and retirees in NC	A
	Growth of NC population, people moving here from other states, as well as foreign immigrants	B C
	Advances in medical treatment	H
	NC moving from a primarily agricultural state to service and technology	U
	Increase in rural planning and population	B
	A broader awareness of people with disabilities working in a wide array of career fields	V
DSDHH		
	Aging population. NC residents with hearing loss will more than double by 2030.	A
	Hearing loss is compounded by depression and anxiety and needs are growing in this area.	M

DSS		
	Increased poverty	D
	An increase in children who have difficulty speaking English / Immigration issues	C
	Unemployment	L
	High School Dropouts	X
	An increase in single parent families	J
	Lack of / losing community based MH services, SA programs, and other supportive services	Q
	Population growth, especially children	B
DVR		
	People with disabilities are an increasingly larger % of the population	A
	Significant increases in the Latino and Asian populations in NC	C
	Persons with significant disabilities are substantially under-represented in the workforce and unemployment for persons with disabilities remains disproportionately high.	L
	Forty-one million Americans are without health insurance. Those still insured are faced with demands for increased cost sharing and limits on health care coverage.	W
	Workers are staying in the job market longer.	A
	As the baby boomers continue to age, the prevalence of disability in the workplace will continue to rise.	AB
	Skills needed to remain competitive in the job market continue to change.	V
OEO		
	Population trends such as the movement of low-income families from rural to urban communities	U
	Employment trends such as the increase in dislocated workers due to the loss of manufacturing jobs	L
	Economic trends such as the rising costs of fuel	E
	National downward budget trends in funding for the programs and services overseen	F
OES		
	Growth in the Spanish speaking population across NC	C
	Federal and state requirements for Highly Qualified Teachers (No Child Left Behind, IDEIA)	R
	Recruitment: the increasing need for teachers as more retire and fewer are trained	T
	Medical advances, particularly those related to the survival rates of premature babies and new advances in medical treatment of hearing and vision loss	H
	Rising cost of transporting students, especially at the residential schools	E
	IHE programs for training teachers for low incidence population are experiencing stress in their systems	R
	Operating in old, outdated building in need of many repairs	S

OMHHD		
	Increase in Latino and other minority/immigrant populations	C
	Increase in percentage of people living in poverty	D
	Increase in number of Community Based Organizations and Faith based Organizations	K
ORHCC		
	Immigration, multilingual issues	C
	Aging population	A
	Population growth	B
	Growth in uninsured	W
	Decrease in industry in rural areas	U
	Unemployment	L
	Decrease in primary medical care providers	Q
	Federal budget deficit	F

Demographic Influences from Business Plan Questionnaire

Summary by Support Agencies (B&A, DIRM, HR, OCS, OIA, OOC, OPA, OPC, OPCS, OPP)

SUMMARY			
Group	Trend	# Hits	Rank
C	Budget cuts, budget deficits, not enough money being spent	7	1
D	Unemployment, growth in uninsured, increase in poverty, plant shutdowns, job loss	5	2
E	Aging of the workforce, increased retirements from workforce	5	2
F	Impact of federal and state regulations on technology, programs and service delivery	5	2
G	Technology advances impacting program and service delivery, need for technology	5	2
B	Immigration	4	6
A	Population Growth	2	7
H	Recruitment difficulties due to increased need for certain occupations and shortages	2	7
L	Rising cost of transporting students, rising fuel costs	2	7
I	Shortage of resources (people, tools) to effect culture change in service delivery	1	10
J	High growth occupations in DHHS will create shortages	1	10
K	Trend toward performance based management	1	10
L	Uncertainty of office status	1	10
M	Demand for healthcare services is increasing	1	10
N	Public Health Issues	1	10
O	Outsourcing	1	10
Q	Other economic factors ... high growth occupations impact to HHS employment	1	10

OFFICE	DEMOGRAPHIC TRENDS	Group
B&A		
	The effect of economic trends that influence the ability of the state to collect tax revenues has a considerable impact upon division operations. A recessional or static economy reduces the ability of the state to collect additional tax receipts. Inflationary pressure and an expansion in demands for services (often prompted by a recessional economy) creates demand for additional revenue. The net effect is the need to constrain program growth in some areas and reduce program size and scope in other areas. The budgetary impact of these influences creates a substantial burden on work load and a commensurate change in working relations with divisional budget and program offices.	C
	Changes in the availability of state appropriations or federal receipts. (e.g., block grant legislation, reduction or expansion items in appropriations bills, etc.) that will require modifications in the operating budget.	C
	Changes in federal regulations, APA rules, or special provisions contained in appropriations bills that impact program operations.	F
	Population increases as they impact department services.	A
	Public Health issues (Avian flu, mad cow disease, HIV/AIDS, etc.).	N
	Redirection of federal services to the state without sufficient funding or support.	C
	The introduction of new programs without adequate funding.	C
DIRM		
	Based on recent and anticipated state and federal legislation that affect technology (ex.: HIPAA, Identity Theft), DIRM will be required to alter its service delivery approach.	F
	Recent legislation at the state level (ex.: Senate Bill 991, IT Consolidation) will affect how DIRM delivers and manages technology solutions. The department will need to focus on the delivery of services at the enterprise level, maintaining a holistic view to improve our services to our customers and to reduce duplication of service delivery.	F
	DIRM will channel efforts toward single entry and access to our services for our customers by providing automation where appropriate and eliminating stovepipe solutions.	G
	Recent population trends in North Carolina indicate that DIRM will need to increase its focus in the delivery of multilingual services to meet the needs of our citizens.	B
	DIRM will continue to face the complexities of an aging workforce and its effect on delivery of technology solutions to the divisions and offices within DHHS.	E G
	Increasing focus on information security will continue to affect our service delivery approach in all areas of information technology.	G

OFFICE

DEMOGRAPHIC TRENDS

Group

HR		
	Aging of the workforce	E
	Demand and supply of certain occupational groups, such as nursing, and increasing licensing requirements for some professional jobs usually reduces the labor supply, increases wages and makes recruitment more difficult.	H
	Other economic factors include DOL projections that health care, medical care, allied health and IT are projected to be high growth occupations which has a direct effect on HHS employment.	J
	The absence of competitive funding for compensation programs (salary and benefits) by the legislature will see a continued erosion of state salaries and benefits compared to competitors.	C
	HR lacks resources to achieve its goal to shift to provide consultation on organizational development, enhance education offerings, and develop other initiatives.	I
OCS		
	Population growth, especially retirements and Hispanic / Latino	A B E
	Many programmatic changes such as Medicare-D, Mental Health Reform, Medicaid cuts, refugee services	F
	Plant shut downs and layoffs	D
OIA		
	None	
OOC		
	Non-Competitive pay of state workers compared to other sectors of the economy	C
OPA		
	More reliance on the Internet, email and web for information delivery.	G
OPC		
	Economic trends, particularly inflation in labor and material costs.	C
OPCS		
	High percentage of workforce near or at retirement eligibility	E
	Demand for healthcare services is increasing	M
	Outsourcing reduces internal competencies	O
	Technology - process automation	G
OPP		
	Trend toward performance based management and the importance of measuring outcomes	K
	Uncertainty of office status	L
	State wages not competitive with other sectors of the economy	C

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Appendix 4

SWOT Analysis

Management Vision and Control

Strengths	Weaknesses
<ul style="list-style-type: none"> • Recognized strong leadership from the secretary • Very strong programmatic leadership in agencies • Adoption of performance based management concepts, expectations and practices • Good regulatory and financial compliance infrastructure 	<ul style="list-style-type: none"> • Leadership is vulnerable due to lack of workforce planning and potential “brain drain” • Lack of focus on operations • Reactive vs. proactive management focus • Manual process inefficiencies • Much responsibility with little authority • Layered internal and external oversight and review • Too much emphasis on activity instead of value added and outcomes • Federal dollars are pursued even when state matching funds cannot be sustained over time • Inefficient disbursement of staff in multiple locations
Opportunities	Threats
<ul style="list-style-type: none"> • Establish culture of continuous improvement • Increase programmatic coordination • Development and utilization of better management tools <ul style="list-style-type: none"> ○ Program Management Database (PMD) ○ Integration of PMD, Contracts and Monitoring systems ○ Integration of PMD with budget processes ○ Grants coordination • Increase emphasis on management operational skills as a means to enhance program effectiveness and operational efficiencies • Establish routine workforce planning • Expand LeadershipDHHS to identify and train future leadership • Becoming more proactive (i.e., focusing on prevention, disaster planning, cost containment, etc.) 	<ul style="list-style-type: none"> • Limited resources to compensate management talent • Restricted management authority due to internal and external review • Cyclical changes in upper management can lead to: <ul style="list-style-type: none"> ○ Loss of continued support for positive/effective initiatives ○ Re-education and delays (exec staff) ○ Management void (at beginning and end of administration) • Limits on ability to easily use various data sources for management decisions making

Departmental Information Technology

Strengths	Weaknesses
<ul style="list-style-type: none"> • Department has a wealth of data available • IT has been deemed critical to business processes and program success • Systems that support federal reporting requirements are available • IT supports accessibility requirements for persons with disabilities • Renewed commitment to customer service 	<ul style="list-style-type: none"> • Inconsistent data standards complicates information sharing • Inability to optimally use electronic data to support executive decisions • Obstructions to taking an enterprise approach to IT, such as redundant and/or duplicative processes and data repositories • Inability to respond quickly to changes due to outmoded equipment and systems
Opportunities	Threats
<ul style="list-style-type: none"> • Shifting focus to IT consolidation and common shared technical infrastructure and technical services • Innovations toward remote computing • Renewed state interest in electronic document management • Federal and local partnerships and support to consolidate common systems (ex. HIS and NC FAST) 	<ul style="list-style-type: none"> • Unforeseen federal and state mandates that may impact IT • Turnover of knowledgeable IT workforce before transition to new modern environment takes place • Volatile funding support for IT salaries, training, and infrastructure needs

Workforce

Strengths	Weaknesses
<ul style="list-style-type: none"> • Experienced workforce • Strong program expertise • Commitment to serve public 	<ul style="list-style-type: none"> • Weak operational leadership <ul style="list-style-type: none"> ○ Process analysis ○ Lack of operational skills and particular expertise ○ Don't have analytical skills to best use data • Inability to recruit, retain, and reward highly qualified personnel • Reluctance to dismiss non-performers due to outdated and cumbersome HR/OSP processes • Aging workforce retiring • Lack of enterprise approach to HR – management by exceptions instead • Tendency toward acceptance of status quo rather than pushing for change • Emphasis on equity results in inequity
Opportunities	Threats
<ul style="list-style-type: none"> • Redefine workforce needs through a department wide workforce plan • Implement prompt human capital changes <ul style="list-style-type: none"> ○ Hiring ○ Transfers ○ Increases ○ Reclassifications • Implementation of HRIS • Leadership DHHS • Workforce planning for the department 	<ul style="list-style-type: none"> • Lack of availability in market of certain skill sets • Inability to do personal services contracts for particular expertise/skills • Imposed qualifications from fund sources (fund restrictions) NOT CLEAR • External review and control over workforce decisions • Classification system doesn't value operational/management skills • Accelerating retirements due to aging workforce creating management voids

Program & Service Delivery

Strengths	Weaknesses
<ul style="list-style-type: none"> • Scope of services available to populations served • New emphasis on prevention • Adoption of evidence based practices, cost containment and avoidance, emphasis on prevention, consumer choice and other initiatives • Implementation of performance management practices • Better management of service delivery via performance based contracting initiatives • Wider sharing of program and service information via the Program Management Database (PMD) 	<ul style="list-style-type: none"> • Available services do not always reach all possible intended beneficiaries • Cost containment efforts offset by program growth • Services for same intended beneficiaries reside in multiple divisions • Difficult to collect accurate race information
Opportunities	Threats
<ul style="list-style-type: none"> • Electronic delivery of programs and services. Examples: <ul style="list-style-type: none"> ○ Tele-medicine ○ Case management ○ Document management ○ E-health records ○ Better utilization of Geographic Information System (GIS) technology ○ Improvements in assistive technologies • Better Outreach/Marketing of programs and services • Data sharing on clients may lead to better coordination and efficiency on programs/services (NC Fast) • Program Review process may lead to improved program and service design and delivery and better outcomes 	<ul style="list-style-type: none"> • Regulatory requirements limit flexibility in program design • Projected program growth not accompanied by increased revenues or human resources

Budget and Finance

Strengths	Weaknesses
<ul style="list-style-type: none"> • Track funds accurately according to codes, standards, and accounts • Good financial controls • Ensure compliance with funding requirements 	<ul style="list-style-type: none"> • Perceived inflexibility of how funding can be used • Lack of financial analytical skills makes cost containment and financial analysis difficult • Lack of transparency in financial information (due to outdated state budget structure and system) makes it very difficult to determine where money is going and for what purpose • Lack of sufficient staff—particularly in the Office of the Internal Auditor—to operate in proactive mode
Opportunities	Threats
<ul style="list-style-type: none"> • Results based budgeting • Clarify restrictions of funding flexibility • Linking financial/budgeting reporting requirements to the PMD 	<ul style="list-style-type: none"> • External agencies make decisions on limited information because of lack of transparency in financial information • State does not utilize an inflationary factor to cover standard operating costs (such as for utilities, IT maintenance, growth in facility populations, etc.)

Communications

Strengths	Weaknesses
<ul style="list-style-type: none"> • Strong community networks, for example: <ul style="list-style-type: none"> ○ CCNC ○ County partners (health depts., social services, etc.) ○ LMEs ○ Other regional offices • CARE-line • Emergency response network and emergency operations center • Availability of enterprise calendar and e-mail is nearly universal 	<ul style="list-style-type: none"> • Inability or unwillingness to share information <ul style="list-style-type: none"> ○ Lack of standards of usage of information tools (i.e., calendar and e-mail) ○ Often ineffective internal communications • Good works often go unnoticed • Some staff within DHHS do not have access to electronic communications • Websites not user friendly • Failure to utilize complaint information to improve problem areas • Don't use all communications channels available (pod casting, infomercials, videoconferencing)
Opportunities	Threats
<ul style="list-style-type: none"> • Clarify roles and responsibilities around types of communications, i.e.: <ul style="list-style-type: none"> ○ Marketing/Outreach ○ Public Relations ○ Internal Communications • Be more proactive in shaping our public image • Use CARE-LINE data and other complaint desk information for early detection analysis, complaint resolution and process improvement • Website redesign • Kiosks for DHHS staff who do not have access to computers 	<ul style="list-style-type: none"> • Perceived image—in the public, General Assembly and other stakeholders and partners • Failure to identify ways to improve internal communications

Buildings & Facilities

Strengths	Weaknesses
<ul style="list-style-type: none"> • Recognized strong facilities management expertise • Statewide locations which facilitate consumers' access 	<ul style="list-style-type: none"> • Scope of renovations and repairs required to support existing infrastructure exceeds state's funding • Crowded locations • Inefficient disbursement of staff • Old buildings: <ul style="list-style-type: none"> ○ Out of date designs do not support today's operations ○ Environmental quality issues ○ Aesthetically challenged
Opportunities	Threats
<ul style="list-style-type: none"> • Construct new, state-of-the-art hospital(s) • Opportunity for new, more centralized DHHS office building depending on disposition of Dix campus • New state lab and medical examiner facility 	<ul style="list-style-type: none"> • Vital records and other records inappropriately stored and security/safety jeopardized • Layered oversight and review <ul style="list-style-type: none"> ○ Funding dictated to project level ○ Minor changes in spending plan for COPs requires review by numerous state agencies ○ State process for leases not optimal

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