



# Community Needs Assessment and Gaps Analysis

May 31, 2017

# Table of Contents

Section One: Executive Summary and Overview .....	3
I. Executive Summary .....	3
II. Progress and Achievements in Addressing Gaps (Update on FY 2016-17 Network Development Plan).....	6
III. Description of Service Region and Demographics .....	11
IV. Methodology for Consumer and Family Input .....	14
V. Methodology for Stakeholder Input.....	15
Section Two: Access and Choice Standards and Data.....	17
I. Outpatient Services .....	18
II. Location-Based Services.....	19
III. Community and Mobile Services.....	20
IV. Crisis Services.....	22
V. Inpatient Services .....	23
VI. Specialized Services.....	24
VII. C-Waiver Services .....	26
VIII. Service-Related Items .....	27
Section Three: Service Needs and Gaps Identified by Consumers, Family Members and Stakeholders.....	32
Section Four: Strategies for Addressing Service Gaps (due 6/30/17) .....	35
Section Five: Geo Maps.....	35
Section Six: Departmental (DHHS) Priorities .....	36
Appendices.....	44
A. Geographic Access Maps.....	45
B. Stakeholder and Staff Survey Questions.....	76
C. Community Feedback .....	77

*Prepared by:*  
*Carlyle Johnson, Ph.D.*  
*Director, Provider Network Strategic Initiatives*  
*Alliance Behavioral Healthcare*  
[cjohnson@alliancebhc.org](mailto:cjohnson@alliancebhc.org)

# Section One

## Executive Summary and Overview

### I. Executive Summary

On an annual basis Alliance conducts a review of its provider capacity, community needs and service gaps to inform our strategic plan for improving accessibility and effectiveness of care and supports. The report period covers Fiscal Year 2015-16 and is submitted to the North Carolina Department of Health and Human Services by June 1, 2017 as required by DHHS-MCO contracts.

The 2017 Alliance Community Needs Assessment and Gaps Analysis includes a summary of the previous year's actions, review of provider capacity, assessment of service accessibility and choice, and incorporation of community feedback about needs and gaps. The resulting analysis and conclusions are the basis for network development priorities and the Alliance Network Development Plan for FY17-18.

Alliance Behavioral Healthcare manages behavioral health services for Cumberland, Durham, Johnston and Wake counties in a catchment area that includes a mix of urban and rural areas. Our region is experiencing higher than average population growth and is challenged to meet the needs of a diverse population with important needs such as those who do not speak English, homeless individuals with mental illness and substance use disorders, and members of the military, veterans and their families.

The Community Needs Assessment process has provided an opportunity to review the status of the FY17 Network Development Plan, obtain additional community input and identify strategic goals for network development for FY18. The following analysis provides a summary of information obtained through this process and the themes and objectives that have emerged as highest priority actions for FY18. Priorities were determined based on multiple factors and sources, including demographic information, utilization data, emerging trends and input from consumers, stakeholders, providers and staff. Recommendations for priority items also considered the importance of alignment with Alliance's mission, vision and values.

**Accomplishments and Updates.** Alliance has made progress on a number of significant needs and gaps that were identified as priorities for the FY17 Network Development Plan. Over the past year, we have:

- Developed and implemented alternative service definitions to resolve gaps identified last year and to improve continuity and effectiveness of care
- Improved quality and consistency of Mobile Crisis services
- Improved crisis capacity and access through expansion of Behavioral Health Urgent Care Tier II Same Day Access in Durham and purchasing a building and selecting a provider for a new crisis facility in Wake County. We have also selected a provider and are in the process of purchasing a building for a child Facility-Based Crisis center in Wake County.
- Implemented contracts with EMS in each county to support diversion to local crisis

facilities instead of hospital emergency departments.

- Implemented Enhanced TFC service, which provides extra support and staffing for children with high needs who are living in therapeutic foster homes.
- Expanded access to evidence-based services for autism by adding Applied Behavior Analysis/Adaptive Behavior Treatment (ABA/ABT) to service array.
- Developed short-term comprehensive functional assessment program for Autism Spectrum Disorders and contracted with New Hope for this service.
- Identified funding to support development of individualized behavior guidelines for the adult IDD population.
- Evaluated continuum of care for substance use disorders in collaboration with DHHS and a nationally recognized SUD expert, and developed recommendations for improving the SUD service continuum.
- Increased access to evidence-based Medication Assisted Treatment by developing an alternative service definition and opening the provider network for this service.
- Promoted evidence-based services for Intensive In-Home, Psychosocial Rehabilitation, Therapeutic Foster Care, Peer Support through collaborative efforts with providers, provider training, technical assistance and revision of contract expectations.

### **Shift to Population Health Strategies**

Consistent with our strategic goal to improve health outcomes for the people we serve, Alliance continues to embrace the move toward population health management to address health and well-being across our entire covered population. Population health management moves beyond reactive interventions towards population monitoring and proactive approaches for promoting prevention, wellness, early identification and tailored intervention programs continuously evaluated for effectiveness.

To improve the overall health of the diverse populations we serve we must address the social determinants that drive health outcomes. This requires a level of engagement, cost-effective interventions delivered locally within multiple community systems, and the development of an array of specialty services beyond the standard clinical services covered by typical health plans. Alliance has begun to apply population health approaches to youth with high-intensity needs, individuals with long-term service and support needs, and those abusing opioid drugs.

**Service Needs and Gaps.** Alliance conducted an extensive review of service needs that included review of data and input from consumers and families, stakeholders, providers and staff. Analysis of survey results identified consistent issues and themes both across and within age/disability areas. Consistent with the findings of past network gaps analysis, service access for the uninsured and underinsured, residential treatment, housing, and transportation remain areas of concern and ongoing barriers for promoting treatment engagement and positive outcomes. Other consistently endorsed priorities are the development of an effective and accessible continuum for substance use disorders, access to services and supports for individuals with intellectual and developmental disabilities services for individuals with co-occurring conditions, service access for non-English speaking, and the adequacy of crisis, respite and hospital diversion service capacity.

Several noteworthy priorities include:

- Development of a comprehensive, evidence-based continuum of care for individuals with substance use disorders and concerns about the increased prevalence of opioid abuse and overdoses in our communities
- Plans to address disparities between uninsured and insured, and geographic disparities in service availability for the uninsured
- Increased information about services and system navigation

Several areas identified in the FY16-17 Network Development Plan remain areas of focus for the upcoming year and will be included in the FY17-18 Network Development Plan. These areas include development of a more uniform State benefit package, addressing gaps for individuals with co-occurring IDD/MI, and continued development of a comprehensive SUD service continuum. Further information regarding FY18 network development priorities will be included in the FY18 Network Development Plan that will be submitted by June 30, 2017.

## II. Update on FY2016-17 Network Development Plan

In response to needs and gaps identified in the 2016 Community Needs Assessment and Gaps Analysis, Alliance developed a FY16-17 Network Development Plan to address ten identified priorities. Many of these priorities also aligned with Alliance plans for reinvestment of Medicaid savings.

The following tables summarize progress from July 1, 2016 through April 1, 2017 for the FY2016-17 Network Development Plan. A more detailed summary of the FY17 Network Development Plan is also available in **Appendix D**.

### Expand services to meet geographic access and choice standards

Initiative	Status
Develop and implement plans to address identified access and choice gaps	<ul style="list-style-type: none"> <li>Developed alternative service definition for Medication Assisted Treatment and opened network to new providers. This service provides enhanced reimbursement rates to eligible psychiatrists who prescribe Buprenorphine, and is now available in all Alliance counties.</li> <li>Added contract for Non-Medicaid funded Psychosocial Rehabilitation in Cumberland County</li> </ul>

### Develop a more uniform State benefit package across the four-county Alliance area

Initiative	Status
Review State benefit package across the four-county Alliance area and address disparities within available funding	Developed proposal for realignment of State funding to enable a more consistent basic benefit plan, and discussed with Alliance Board at FY18 budget retreat.

### Expand capacity for crisis, hospital diversion and respite services for all ages/disabilities

Initiative	Status
Assure the availability of high quality, accessible and effective Mobile Crisis services in all counties	<ul style="list-style-type: none"> <li>Selected two agencies through an RFP to provide Mobile Crisis services for Alliance catchment area.</li> <li>FY18 Contract modifications and a new centralized dispatch function have been developed to improve quality and accessibility of Mobile Crisis services.</li> <li>New SOW has emphasized clinical quality indicators and incorporates the use of Peer Support Specialists on Mobile Crisis teams.</li> </ul>

Initiative	Status
Expand access to Behavioral Health Urgent Care Centers (Tier II Same Day Access)	<ul style="list-style-type: none"> <li>Alliance has selected a vendor to provide Tier II Same Day Access care in Durham County. The facility will have a soft opening in May, 2017 while the provider completes renovations.</li> <li>Alliance developed, submitted and received approval for a Medicaid “in lieu of” service definition to support this service. This service requires same day access to prescribers and includes added functions to address social determinants of health and connection to community resources.</li> </ul>
Expand capacity for facility based crisis services in Wake County	Alliance has purchased a building in Wake County for a new crisis facility and has selected a vendor to provide Facility-Based Crisis care. Facility renovation is expected to be completed by June 2018.
Develop Peer Respite capacity as alternative to higher levels of care	We are conducting research into Peer Respite models. This project will continue in FY18 and will be incorporated into the FY18 Network Development Plan.
Develop Facility Based Crisis Capacity for Children	Alliance has purchased a building in Wake County for a new crisis facility for children and has selected a vendor to provide Facility-Based Crisis care for children and adolescents. We project closing on building in June, 2017 and will procure an architect to begin planning for building renovation.
Expand access to rapid response crisis diversion services for children and adolescents.	<ul style="list-style-type: none"> <li>Developed Medicaid “in lieu of” service definition and obtained DMA approval for this service.</li> <li>Issued RFP and selected two additional providers</li> <li>Adding Rapid Response to Client Care Web database in order to see real time bed availability across catchment area.</li> </ul>
Develop Peer Transition Teams	Conducting research into models for this service.
Develop Short Term Stabilization PRTF	<ul style="list-style-type: none"> <li>Developed specialized 30-day intensive evaluation service in PRTF facility to serve youth with challenging behaviors</li> <li>Contract is in place with Alexander Youth Network to provide this service in addition to New Hope</li> </ul>
Reimburse first responders for crisis diversion in all counties	Implemented contracts with EMS in each county to support diversion to local crisis facilities instead of hospital emergency departments.

**Increase breadth, access and quality of residential treatment and housing options**

Initiative	Status
Enhanced Therapeutic Foster Care	<ul style="list-style-type: none"> <li>• Implemented Enhanced TFC service, which provides extra support and staffing for children with high needs who are living in therapeutic foster homes.</li> <li>• Selected two providers for this service through RFP, and contracts are in place with two providers.</li> </ul>
Intensive Wrap-Around for children and transition age youth	<ul style="list-style-type: none"> <li>• Developing plans for implementation of Intensive Wrap-Around model, which provides service coordination for high-risk, multiple system involved youth to divert from inpatient and residential treatment.</li> <li>• Developed RFI to select providers, and submitted response to NC DHHS Request for Applications.</li> <li>• We were awarded the DHHS grant to begin implementation of this service, and services are scheduled to begin in June, 2017 in Durham.</li> </ul>
Support technology assisted homes	<ul style="list-style-type: none"> <li>• Developed plans to outfit a group home for adults with IDD with an array of independence enabling technology and safety monitoring devices. The home is intended to help consumers and families learn to use technology in the supported home, followed by installation in community residences.</li> <li>• This project will be implemented as a pilot in FY18, and next steps will include identification of a provider and technology vendor, as well as planning for ongoing funding. Projections are to have planning completed by the end of FY17 with pilot implementation in FY18.</li> </ul>

**Increase capacity to serve consumers with IDD or co-occurring IDD/MI**

Initiative	Status
Implement intensive autism treatment and assure service availability	<ul style="list-style-type: none"> <li>• Expanded access to evidence-based services for autism by adding Applied Behavior Analysis / Adaptive Behavior Treatment (ABA/ABT) to service array. Implementation tasks included identification of providers and development of contracts, funding mechanisms, and public awareness plans.</li> <li>• Contracts are in place with six providers in all ABH catchment counties, and services have begun.</li> </ul>
IDD Crisis Respite Facility (PRTF)	Developed short term comprehensive functional assessment program for Autism Spectrum Disorders and contracted with New Hope for this service.

Initiative	Status
Development and implementation of behavior plans	Identified funding to support development of individualized behavior guidelines for the adult IDD population.

**Develop and enhance the continuum of care for individuals with Substance Use Disorders with specific focus on increasing access to Medication Assisted Treatment**

Initiative	Status
Define a service continuum for substance use disorders	<ul style="list-style-type: none"> <li>• In collaboration with DHHS, obtained consultation from Dr. David Mee-Lee to assist with evaluation of the Alliance continuum of care for substance use disorders. Conducted provider survey, focus groups and other activities to evaluate the current continuum of care, service needs and gaps.</li> <li>• Prepared recommendation for enhancement of Alliance SUD continuum that will be incorporated into FY18 Network Development Plan.</li> </ul>
Expand Opioid Treatment availability for Medicaid (Cumberland) and State-funded consumers (Cumberland, and Johnston).	Developed service definition modifier and enhanced rate to support provision of Medication Assisted Treatment using Buprenorphine. Alliance has opened its network for this service and expanded access to MAT by adding provider contracts in each Alliance county.

**Improve Access to Services for Underserved Populations**

Initiative	Status
Services for non-English speaking consumers	<ul style="list-style-type: none"> <li>• Developing improved mechanism for tracking and publicizing provider specialties and non-English language capacity, in coordination with redesign of web-based provider search function</li> <li>• Evaluating options for funding language interpretation services through FY18 reinvestment plan.</li> </ul>
Improve referral resources for underserved	Redesigning web-based provider search function to improve public awareness of referral resources, including provider specialties and languages spoken.

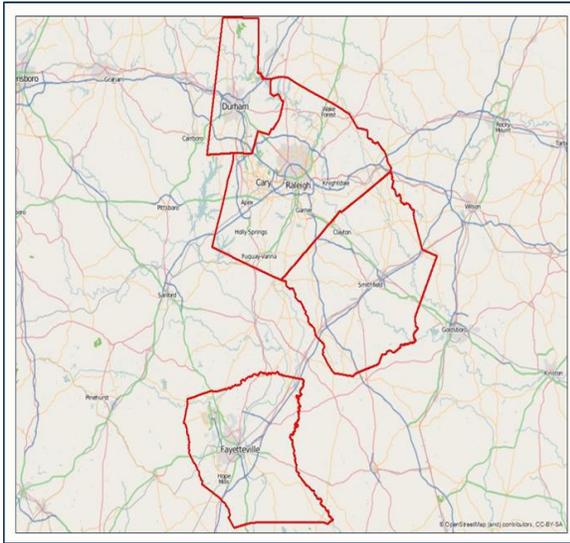
**Increase availability, tracking and oversight of specialty services and evidence-based practices**

Initiative	Status
Promote Evidence-Based Practices (EBPs) for Psychosocial Rehabilitation (PSR) programs	<ul style="list-style-type: none"> <li>• Contracted with consultant to facilitate provider collaborative and consult on implementation of evidence-based, recovery-oriented practices within PSR programs</li> <li>• Meeting monthly with PSR providers to develop and coordinate plans for implementation of psychiatric rehabilitation practices and recovery principles</li> <li>• Developing contract Scope of Work for FY18 PSR contracts.</li> </ul>
Implement EBP in Therapeutic Foster Care programs	<ul style="list-style-type: none"> <li>• Contracted with consultant for facilitation of provider collaborative and consultation on implementation of EBPs within TFC.</li> <li>• Identified five promising or evidence-based models for implementation within TFC and required each agency to select a model for implementation</li> <li>• Working with providers to incorporate EBPs into FY18 contract requirements.</li> </ul>
Implement Family Oriented EBPs within IIH	<ul style="list-style-type: none"> <li>• FY17 IIH Provider contracts require use of identified family-oriented, externally validated EBPs within IIH services, and all providers have received training on at least one of the identified models</li> <li>• Working with providers on implementation tasks through monthly provider collaborative</li> </ul>
Expand Trauma Informed Therapeutic Foster Care	<ul style="list-style-type: none"> <li>• We supported providers sending potential trainers to be rostered through learning collaborative at CCFH.</li> <li>• The rostered Alliance trainers will begin training our network in the Resource Parent Curriculum developed by the National Traumatic Stress Network.</li> <li>• Trainings will start in June 2017 and will continue through FY18.</li> </ul>

**Increase availability of resources for transportation and employment**

Initiative	Status
Mobility on Demand	We are exploring models and expanding original scope to include multiple methods of mobility. This initiative will continue in FY18.
Peer Run Business	Exploring models through research.

### III. Description of Service Region and Demographics



Alliance Behavioral Healthcare comprises Cumberland, Durham, Johnston and Wake Counties and covers roughly 2,565 square miles with a total population of 1,871,580. By far the largest county by population is Wake, exceeding the population of the other three counties combined. Wake and Durham are the most densely populated counties, reflecting their more urbanized settings. Johnston is the least densely populated county, which may create a challenge to recruit and engage providers to offer services in this area, particularly when there are more populous and urban areas nearby.

The service area includes both urban and rural areas but the majority of the population lives in urban areas. Because of the proximity to relatively dense population areas such as Raleigh, Durham and Fayetteville, all Alliance counties are classified as ‘metropolitan/urban’ counties according to United States Office of Management and Budget criteria.

County	Population	Square Miles	Persons per Square Mile	Medicaid Enrollees
Cumberland	327,127	652	502	78,149
Durham	306,212	286	1,071	51,713
Johnston	191,450	791	242	40,438
Wake	1,046,791	835	1,254	124,868
Alliance Total	1,871,580	2565	730	295,168

*2016 U.S. Census Bureau Estimate, State and County QuickFacts*

**Growth.** All counties in the Alliance area anticipate growth over the next five years, and with the exception of Cumberland, all counties are expected to grow at a rate almost double the state growth rate. This growth will be a significant challenge for Alliance as population increases lead to increased demand for services and competition for available resources such as transportation, housing and public assistance.

**Race and Ethnicity.** Across the Alliance area the primary racial group is White followed by Black and Hispanic/Latino. There is some variability across region, however. Johnston has a higher percentage of white population, with Black and Hispanic/Latino populations roughly the same percentage. Compared to the state average, Alliance has a higher percentage of Hispanic/Latino population with Durham and Johnston having the highest percentage of Alliance counties.

County	White	Black	Asian	American Indian	Hispanic/Latino
Cumberland	52.7%	37.9%	2.7%	1.8%	11.3%
Durham	53.1%	38.4%	5.1%	0.9%	13.4%
Johnston	80.2%	16.1%	0.8%	0.9%	13.4%
Wake	68.7%	21.3%	6.7%	0.8%	10.1%
NC	71.2%	22.1%	2.8%	1.6%	9.1%

*Will not equal 100% due to more than one race being reported. Source: US Census Bureau, 2016 QuickFacts*

**Languages spoken.** The primary language spoken across the Alliance area is English, followed by Spanish most notably in Durham and Johnston Counties where the rate exceeds 10% of the population. All Alliance counties exceed the state average with respect to non-English languages spoken in the home, with Durham and Wake showing the highest proportion of non-English speakers. Although the primary non-English language spoken is Spanish, it is noteworthy that other languages account for over 6% of the population and that there are 20 languages or language groups for which there are over 1,000 or more speakers in the Alliance catchment area.

County	Language other than English spoken at home
Cumberland	11.4%
Durham	19.4%
Johnston	12.0%
Wake	16.5%
NC	11.2

**Military/Veterans.** The Alliance catchment area includes several important resources for active military, veterans and their families, including the Fort Bragg military installations, VA Hospitals in Fayetteville and Durham, Reserve Command and local units, and NC National Guard units. An estimated 138,149 veterans live in the Alliance catchment area, according to the 2015 NC Veterans Annual Report, with the following distributions by county:

- Wake 59,109
- Cumberland 49,239
- Durham 15,700
- Johnston 14,101

The largest concentration per capita is in Cumberland County, with approximately 15% of its

residents having served in the military, compared to the NC state average of 7.6%. Alliance works closely with community stakeholders, providers, military and veterans' organizations and all levels of government to promote effective and accessible care for military, veterans and family members. Alliance has developed a FY 2016/17 Veterans Plan that provides additional information about current and planned initiatives to improve services for the military/veterans population. <https://www.alliancebhc.org/consumers-families/veterans-resources/>

**Homeless population.** Three of the four Alliance counties have higher rates of homelessness than the surrounding region and rates of homelessness for Cumberland and Durham exceed the state average, while Wake County's rate is approximately equal to the state average, based on the 2016 North Carolina Point-in-Time Count of People Experiencing Homelessness. Rates are highest per capita for Durham and Cumberland, but the number of homeless individuals is highest in Wake County. The highest rate of homeless veterans was observed in Durham. The homeless populations in Cumberland was found to have higher rates of serious mental illness and substance use among the homeless than were observed in other counties.

**Health outcomes and disparities.** Alliance counties vary significantly with respect to health outcomes, and population health data reveals higher needs for health care improvements, particularly in Cumberland county. Although all counties were found to be below state and national averages on specific health outcomes domains, Cumberland demonstrated the most significant health disparities, followed by Johnston and Durham. Wake was rated the highest overall in the state for health outcomes. Several areas of consistently below average performance are rates of excessive drinking, severe housing problems and air pollution, with each county demonstrating results below the state average.

Research has demonstrated significant health disparities for individuals with mental illness, substance use and intellectual and developmental disabilities, and growing evidence indicates that shortened lifespans are primarily associated with chronic health conditions, health behaviors, substance use and limited access to appropriate medical care. Both the demographic data and research evidence support an increased emphasis on integrated behavioral health/medical care and strategies to address social determinants of health.

### **Description of Provider Network**

Alliance has a large network of credentialed providers and most organization types are available in each county, as are prescribers and licensed practitioners. Providers by categories for FY16 are as follows:

- 1,613 licensed professionals
- 285 agencies
- 249 outpatient practices
- 36 Hospitals/Residential Treatment Facilities

Services available in the network include a broad array of Medicaid and State-funded care, and providers served 45,500 Medicaid consumers and 18,767 with State funds in FY16.

## IV. Methodology for Consumer and Family Input

The process for soliciting consumer and family feedback included the following approaches:

- 1. Consumer and Family Advisory Committee (CFAC) feedback.** Feedback approaches included presentation and discussion at CFAC meetings, and submission of a CFAC summary of identified needs and gaps. CFAC members also helped inform others about the electronic survey and distributed hard copy version of the survey to those without internet access and those who preferred to submit a handwritten response.
- 2. Community Survey.** Feedback was solicited through an internet-based survey using SurveyMonkey®. The survey included separate sections for Intellectual and Developmental Disabilities (IDD), Child Mental Health/Substance Abuse (Child MH/SA), Adult Mental Health and Substance Abuse (Adult MH/SA) and Traumatic Brain Injuries (TBI), with the option for respondents to skip those sections with which they were unfamiliar. Additional sections were included regarding needs and gaps in areas of housing, employment and transportation. The same questions were used for all respondents, which included consumers and family members, stakeholders, providers and Alliance staff. Surveys were administered anonymously and no identifying information was required. Survey links were posted on the Alliance website and were distributed to multiple consumer, provider and stakeholder e-mail lists. A request was sent to all Alliance staff requesting that links be forwarded to community contacts, and Alliance staff were surveyed regarding community needs and gaps.

### Community Needs Assessment Survey Questions

Introductory questions collected limited background information about respondent category, county of respondent, and respondent's organization type if applicable.

Each section of the survey included a similar format and consisted of the following sections/questions:

1. Listing of service types and Likert rating scale for availability of each service.
2. Follow-up questions (text box) for entry of additional feedback about service availability, including:
  - a. Services not covered on survey questions
  - b. Barriers to receiving services
  - c. Identification of underserved groups or populations
3. Questions for all respondents soliciting input (text boxes) regarding the most significant needs for housing, employment and transportation, as well as an opportunity to provide other comments regarding service needs and gaps

Hard copy versions of the survey were posted on the Alliance website in formats that included a full version and separate versions for IDD, Child MH/SA, Adult MH/SA and TBI. The full hard copy version is available at: <https://alliancebhc.org/wp-content/uploads/ABH-CNA-Survey-Full-Version.pdf>

## V. Methodology for Stakeholder Input

The process for soliciting stakeholder feedback included the following approaches:

- 1. Alliance Provider Advisory Committee (APAC) feedback.** Provider feedback included discussion at APAC meetings as well as follow-up discussion and feedback from local PAC meetings in each county.
- 2. Community Survey.** As described above, the online survey solicited responses from consumers, family members, providers, stakeholders and staff.
- 3. Collective feedback from community workgroups, collaboratives and committees.** Alliance staff contacted existing groups such as crisis collaboratives, System of Care collaboratives, provider collaboratives, and Alliance staff meetings to request collective responses regarding highest priority needs and gaps. A survey form was provided to each group with suggested questions for group discussion, and groups submitted summaries of group recommendations. The Alliance Stakeholder and Staff Group Feedback Form is provided in **Appendix B**.

### Community Input Sources:

Numerous community groups were invited to provide input through collective responses, completion of on-line surveys, or both. Alliance staff attended meetings of many of these groups to solicit and summarize feedback. The following groups provided feedback through focus groups or written summaries of group discussions:

- Consumer and Family Advisory Committee (CFAC)
- Alliance Provider Advisory Committee (APAC), including local PAC meetings in each county
- Durham and Wake Juvenile Justice SA/MH Partnership (Durham and Wake JJSAMHP)
- Provider Collaboratives for Community Support Team (CST), Substance Use Disorders, Intensive In-Home (IIH), Therapeutic Foster Care (TFC), Peer Support and Psychosocial Rehabilitation
- Crisis Collaboratives in Cumberland, Durham and Wake
- Alliance Hospital Partners Collaborative
- Child and Family Community Collaboratives in each county
- Judges and judicial partners in Cumberland and Durham counties
- Partnership for a Healthy Durham
- Alliance Clinical Operations Staff
- Alliance Call Center Staff
- Alliance MH/SA Care Coordinators
- Alliance Cultural Competency Committee
- Johnston County DSS

The following groups were contacted to request completion of online surveys and distribution of survey materials to members:

- Wake County Domestic Violence Fatality Review Team
- Child Fatality Prevention / Community Child Protection Team (Wake)
- Early Childhood Collaborative (Wake)
- Youth Thrive Action Teams
- Alliance providers through e-mail and All-Provider Meeting
- NAMI chapters in Cumberland, Durham and Wake
- Durham Parks and Recreation
- CFT Trainers Group (Durham)
- Durham Public Schools CTAG
- My Brother's Keeper (Durham)
- Durham TRY
- Durham Partnership for Seniors
- Cumberland County Reclaiming Futures
- Stepping Up (Durham)
- Durham CIT Collaborative
- Durham Family Partners

## Section Two

### Access and Choice Standards and Data

**Introduction:** Although the counties comprising Alliance Behavioral Healthcare’s catchment area vary significantly in population density, all are classified as “metropolitan/urban” counties according to United States Office of Management and Budget criteria. Accordingly, the DHHS-MCO contract requires that Alliance ensure availability of providers within a 30-mile radius or 30-minute drive time for any consumer residing in the Alliance catchment area. The following section summarizes geographic access and choice data for Alliance services in several categories:

- Outpatient Services include psychiatric care, medication management, evaluations, and individual, group and family psychotherapy.
- Location-Based Services include an array of services that are facility or site-based, such as Psychosocial Rehabilitation, Child and Adolescent Day Treatment, and SA Intensive Outpatient Treatment.
- Community-Based and Mobile Services include those services that are provided in home and community settings such as Supported Employment, Peer Support and Intensive In-Home services.
- Crisis Services include Facility-Based Respite, Facility-Based Crisis and Non-Hospital Detoxification services.
- Inpatient Services include inpatient psychiatric care all ages.
- Specialized Services includes a specific list of services, most of which are residential services.
- C-Waiver Services include those that are covered through the Innovations / 1915(c) waiver.

Access and choice standards are specified for each category of service and vary depending on the service category and funding source. The following table summarizes DHHS requirements:

	<b>Medicaid</b>	<b>State</b>
Outpatient	Choice of TWO (2) providers within <b>30 miles /30 minutes</b>	Choice of TWO (2) providers within <b>30 miles or 30 minutes</b>
Location-Based	Choice of TWO (2) providers within <b>30 miles or 30 minutes</b>	Access to ONE (1) provider within <b>30 miles or 30 minutes</b>
Community / Mobile	Choice of TWO (2) providers within <b>ABH catchment area</b>	Access to ONE (1) provider within <b>ABH catchment area</b>
Crisis	Access to ONE (1) provider within <b>ABH catchment area</b>	Access to ONE (1) provider within <b>ABH catchment area</b>
Inpatient	Access to ONE (1) provider within <b>ABH catchment area</b>	Access to ONE (1) provider within <b>ABH catchment area</b>
Specialized	Access to ONE (1) provider within <b>ABH catchment area</b>	Access to ONE (1) provider within <b>ABH catchment area</b>
C-Waiver (two sections)	Section A: Choice of TWO (2) providers within <b>ABH catchment area</b> Section B: Choice of ONE (1) provider within <b>ABH catchment area</b>	N/A

For each category, service accessibility and provider choice were evaluated using a methodology and report format determined by DHHS. The tables provided below include summary results of this analysis as well as specific needs and gaps identified through the community survey, as described in Section One.

## I. Outpatient Services

**Medicaid and state-funded access and choice standard:** 100% of eligible individuals must have a **choice of two** different outpatient services provider agencies **within 30 miles or 30 minutes** of their residences. Outpatient behavioral health services can include psychiatric and biopsychosocial assessment, medication management, individual, group, and family therapies, psychotherapy for crisis, and psychological testing. Tables below were completed for outpatient services as one group, using geomapping software to calculate the number and percentages of individuals with choice:

Categories	Medicaid			Non-Medicaid Funded		
	# of enrollees with choice of two providers within 30 miles/minutes*	# of Medicaid Enrollees	%	# of consumers with choice of two providers within 30 miles/minutes*	# of Consumers	%
Reside in urban counties	237,942	237,942		17,087	17,087	
Reside in rural counties	n/a	n/a		n/a	n/a	
Total (standard = 100%)	237,942	237,942	100	17,087	17,087	100
Adults (age 18+)	93,616	93,616		15,666	15,666	
Children (age 17 and younger)	144,326	144,326		1,421	1,421	
Total (standard = 100%)	237,942	237,942	100	17,087	17,087	100

\*"30 miles/minutes" is the abbreviated term used in this document for individuals having choice and/or access within 30 miles or 30 minutes of their residences.

### *Medicaid-funded services exceptions*

- Is an exception for Medicaid-funded outpatient services in place as of the date of the 2017 gaps report submission, 5/1/2017? No
- If the access and choice data is not at 100%, is an exception request included with the 2017 gaps report? N/A

### *Non-Medicaid-funded services exceptions*

- Is an exception for non-Medicaid-funded outpatient services in place as of the date of the 2017 gaps report submission, 5/1/2017? No
- If the access and choice data is not at 100%, is an exception request included with the 2017 gaps report? N/A

## II) Location-Based Services

1. Medicaid access and choice standard: 100% of eligible individuals must have a **choice of two** different provider agencies for each location-based service **within 30 miles or 30 minutes** of their residences.
2. State-funded access and choice standard: 100% of eligible individuals have **access to at least one** provider agency for each location-based service **within 30 miles or 30 minutes** of their residences.

Service	Medicaid			Non-Medicaid Funded		
	# and % of enrollees with choice of two providers within 30 miles/minutes of their residences		Total # of Medicaid Enrollees	# and % of consumers with at least one provider within 30 miles/minutes of their residences		Total # of Consumers
	#	%		#	%	
Psychosocial Rehabilitation	93,616	100	93,616	11,734	100	11,734
Child and Adolescent Day Treatment	144,326	100	144,326	968	90.13	1,074
SA Comprehensive Outpatient Treatment Program	237,942	100	237,942	3,379	77.48	4,361
SA Intensive Outpatient Program	237,942	100	237,942	4,361	100	4,361
Opioid Treatment	64,696	69.11	93,616	2,817	65.04	4,331
Day Supports				1,296	95.58	1,356

### *Medicaid-funded services exceptions*

- Are exceptions for any Medicaid-funded location-based service in place as of the date of the 2017 gaps report submission, 5/1/2017? Yes, exceptions are in place for the following services:
  - Child and Adolescent Day Treatment
  - Opioid Treatment
- If the access and choice data is not at 100% for any Medicaid-funded location-based service, are exception requests included with the 2017 gaps report? Yes, exception requests have been submitted for the following services:
  - Opioid Treatment: exception request to continue use of Alliance Medication Assisted Treatment-Buprenorphine service codes to demonstrate access to Opioid Treatment

### *Non-Medicaid-funded services exceptions*

- Are exceptions for any non-Medicaid-funded location-based service in place as of the date of the 2017 gaps report submission, 5/1/2017? Yes, exceptions are in place for the following services:
  - Child and Adolescent Day Treatment
  - Opioid Treatment
  - Day Supports: exception in place for use of Day Activity (YP660) in lieu of Day Supports

- If the access and choice data is not at 100% for any non-Medicaid-funded location-based service, are exception requests included with the 2017 gaps report? Yes, exception requests have been submitted for the following services:
  - Child and Adolescent Day Treatment
  - SA Comprehensive Outpatient Treatment Program
  - Opioid Treatment
  - Day Supports: request to continue use of Day Activity (YP660) in lieu of Day Supports

### III) Community/Mobile Services

1. Medicaid access and choice standard: 100% of eligible individuals must have a **choice of two** provider agencies **within the LME-MCO catchment area** for each community/mobile service.
2. State-funded access and choice standard: 100% of eligible individuals have **access to at least one** provider agency **within the LME-MCO catchment area** for each community/mobile service in the chart below.

Service	Medicaid			State Funded		
	# and % of enrollees with choice of two provider agencies within the LME-MCO catchment area		Total # of Medicaid Enrollees	# and % of consumers with access to at least one provider agency within the LME-MCO catchment area		Total # of Consumers
	#	%		#	%	
Assertive Community Treatment Team	93,616	100	93,616	11,734	100	11,734
Community Support Team	93,616	100	93,616	14,736	100	14,736
Intensive In-Home	144,326	100	144,326	1,074	100	1,074
Mobile Crisis	237,942	100	237,942	17,069	100	17,069
Multi-systemic Therapy	144,326	100	144,326	1,074	100	1,074
(b)(3) MH Supported Employment Services	237,942	100	237,942			
(b)(3) I/DD Supported Employment Services	237,942	100	237,942			
(b)(3) Waiver Community Guide	237,942	100	237,942			
(b)(3) Waiver Individual Support (Personal Care)	237,942	100	237,942			
(b)(3) Waiver Peer Support	237,942	100	237,942			
(b)(3) Waiver Respite	237,942	100	237,942			
I/DD Supported Employment Services (Non-Medicaid-funded)				1,356	100	1,356
I/DD Long-Term Vocational Supports (Non-Medicaid-				990	100	990

Service	Medicaid			State Funded		Total # of Consumers
	# and % of enrollees with choice of two provider agencies within the LME-MCO catchment area		Total # of Medicaid Enrollees	# and % of consumers with access to at least one provider agency within the LME-MCO catchment area		
	#	%		#	%	
Funded)						
MH/SA Supported Employment Services (IPS-SE) (Non-Medicaid-Funded)				14,736	100	14,736
I/DD Non-Medicaid-funded Personal Care Services				1,356	100	1,356
I/DD Non-Medicaid-Funded Respite Community Services				1,356	100	1,356
I/DD Non-Medicaid-Funded Respite Hourly Services not in a licensed facility				1,356	100	1,356
Developmental Therapies (Non-Medicaid-funded)				1,356	100	1,356

*Medicaid-funded services exceptions*

- Are exceptions for any Medicaid-funded community/mobile service in place as of the date of the 2017 gaps report submission, 5/1/2017? No
- If the access and choice data is not at 100% for any Medicaid-funded community/mobile service, are exception requests included with the 2017 gaps report? N/A

*Non-Medicaid-funded services exceptions*

- Are exceptions for any non-Medicaid-funded community/mobile service in place as of the date of the 2017 gaps report submission, 5/1/2017? No
- If the access and choice data is not at 100% for any non-Medicaid-funded community/mobile service, are exception requests included with the 2017 gaps report? N/A

#### IV) Crisis Services

Medicaid and state-funded access and choice standard: 100% of eligible individuals must have access **within the LME-MCO catchment area to at least one** provider agency for each crisis service.

Crisis Service	Medicaid		Total # of Medicaid Enrollees	Non-Medicaid Funded		Total # of Consumers
	# and % of enrollees with access within the LME-MCO catchment area to at least one provider agency			# and % of consumers with access within the LME-MCO catchment area to at least one provider agency		
	#	%		#	%	
Facility-Based Crisis - adults	93,616	100	93,616	15,650	100	15,650
Facility-Based Respite	n/a	n/a	237,942	17,069	100	17,069
Detoxification (non-hospital)	237,942	100	237,942	4,361	100	4,361
FOR INFORMATION PURPOSES ONLY: Facility-Based Crisis - children	N/A	N/A	144,326	N/A	N/A	1,356

##### *Medicaid-funded services exceptions*

- Are exceptions for any Medicaid-funded crisis service in place as of the date of the 2017 gaps report submission, 5/1/2017? No
- If the access and choice data is not at 100% for any Medicaid-funded crisis service, are exception requests included with the 2017 gaps report? N/A

##### *Non-Medicaid-funded services exceptions*

- Are exceptions for any non-Medicaid-funded crisis services in place as of the date of the 2017 gaps report submission, 5/1/2017? No
- If the access and choice data is not at 100% for any non-Medicaid-funded crisis service, are exception requests included with the 2017 gaps report? N/A

## V. Inpatient Services

Medicaid and state-funded inpatient services access and choice standard: 100% of eligible individuals must have access **within the LME-MCO catchment** area to **at least one** inpatient provider agency for each inpatient service.

Service	Medicaid		Total # of Medicaid Enrollees	Non-Medicaid-Funded		Total # of Consumers
	# and % of enrollees with access within the LME-MCO catchment area to at least one provider agency			# and % of consumers with access within the LME-MCO catchment area to at least one provider agency		
	#	%		#	%	
Inpatient Hospital – Adult	93,616	100	93,616	14,736	100	14,736
Inpatient Hospital – Adolescent/Child	144,326	100	144,326	1,074	100	1,074

### *Medicaid-funded services exceptions*

- Are exceptions for any Medicaid-funded inpatient service in place as of the date of the 2017 gaps report submission, 5/1/2017? No
- If the access and choice data is not at 100% for any Medicaid-funded inpatient service, are exception requests included with the 2017 gaps report? N/A

### *Non-Medicaid-funded services exceptions*

- Are exceptions for any non-Medicaid-funded inpatient service in place as of the date of the 2017 gaps report submission, 5/1/2017? No
- If the access and choice data is not at 100% for any non-Medicaid-funded inpatient service, are exception requests included with the 2017 gaps report? N/A

## VI. Specialized Services

Medicaid and state-funded specialized services access and choice standard: 100% of eligible individuals must have access to **at least one** provider agency for each specialized service.

Service	Number Parent Agencies with Current Medicaid Contract	Number Parent Agencies with Current Contract for Non-Medicaid Funded Services
Partial Hospitalization	0*	1
MH Group Homes	N/A	35
Psychiatric Residential Treatment Facility	15	0
Residential Treatment Level 1	5	N/A
Residential Treatment Level 2: Therapeutic Foster Care	22	1
Residential Treatment Level 2: other than Therapeutic Foster Care	7	0
Residential Treatment Level 3	23	N/A
Residential Treatment Level 4	1	N/A
Child MH Out-of-home respite	N/A	3
SA Non-Medical Community Residential Treatment	0*	0*
SA Medically Monitored Community Residential Treatment	1	1
SA Halfway Houses	N/A	1
I/DD Out-of-home respite (non-Medicaid-funded)	N/A	5
I/DD Facility-based respite (non-Medicaid-funded)	N/A	3
I/DD Supported Living (non-Medicaid-funded)	N/A	0
(b)(3) I/DD Out-of-home respite	26	N/A
(b)(3) I/DD Facility-based respite	12	N/A
(b)(3) I/DD Residential supports	84	N/A
Intermediate Care Facility/IDD	87	N/A

### *Medicaid-funded services exceptions*

- Are exceptions for any Medicaid-funded specialized services in place as of the date of the 2017 gaps report submission, 5/1/2017? No
- If there is a Medicaid-funded specialized service without a current (5/1/2017) contract with the LME/MCO, is an exception request included with the 2017 gaps report? \*No, exception requests were not submitted since gaps have been addressed, as follows:
  - Partial Hospitalization: Medicaid contract added for partial hospitalization services
  - SA Non-Medical Community Residential Treatment: this level of care is available to both Medicaid-funded and State-funded consumers through three CASAWORKS providers who are funded through State Non-UCR contracts.

*Non-Medicaid-funded services exceptions*

- Are exceptions for any non-Medicaid-funded specialized services in place as of the date of the 2017 gaps report submission, 5/1/2017? No
  
- If there is a non-Medicaid-funded specialized service without a current (5/1/2017) contract with the LME/MCO, is an exception request included with the 2017 gaps report? Yes.  
exception requests have been submitted for the following services:
  - PRTF
  - Residential Treatment Level 2: other than Therapeutic Foster Care
  - I/DD Supported Living

As noted above, an exception request was not submitted for SA Non-Medical Community Residential Treatment because this level of care is available through Non-UCR contracts with three CASAWORKS providers.

## VII. C-Waiver Services

- A. C-Waiver access and choice standard: 100% of eligible individuals must have a **choice of two provider agencies within the LME/MCO catchment area** for each service.

C-Waiver Services-Choice of two providers					
Services	Adult	Child	# and % of enrollees with choice of two provider agencies within the LME/MCO catchment area		Total # of C-Waiver Enrollees
			#	%	
Community Living and Supports, In Home Intensive, In Home Skill Building, and Personal Care Services	✓	✓	1,715	100	1,715
Community Navigator	✓	✓	1,715	100	1,715
Community Navigator Training for Employer of Record	✓	✓	1,715	100	1,715
Community Networking	✓	✓	1,715	100	1,715
Crisis Behavioral Consultation / Crisis Consultation	✓	✓	1,715	100	1,715
Crisis Intervention & Stabilization Supports	✓	✓	1,715	100	1,715
Residential Supports 1, 2, 3 and 4	✓	✓	1,715	100	1,715
Respite Care - Community	✓	✓	1,715	100	1,715
Respite Care Nursing – LPN & RN	✓	✓	1,715	100	1,715
Supported Employment	16 & older		1,275	100	1,275
Supported Employment – Long Term Follow-up	16 & older		1,275	100	1,275
Supported Living	18 & older		1,274	100	1,274

- B. C-Waiver access and choice standard: 100% of eligible individuals must have access within the LME/MCO catchment area to **at least one** provider agency for each service.

C-Waiver Services – Access to at least one provider					
Services	Adult	Child	# and % of enrollees with access within the LME-MCO catchment area to at least one provider agency		Total # of C-Waiver Enrollees
			#	%	
Day Supports	✓	✓	1,715	100	1,715
Out of Home Crisis	✓	✓	1,715	100	1,715
Respite Care - Community Facility	✓	✓	1,715	100	1,715
Financial Supports	✓	✓	1,715	100	1,715
Specialized Consultative Services (at least one provider of one of multiple services)	✓	✓	1,715	100	1,715

### *Medicaid-funded C-Waiver services exceptions*

- Are exceptions for any Medicaid-funded C-Waiver service in place as of the date of the 2017 gaps report submission, 5/1/2017? No
- If the access and choice data is not at 100% for any Medicaid-funded C-Waiver service, are exception requests included with the 2017 gaps report? N/A

## VIII. Service-Related Items

- A. Medicaid-funded “In Lieu of” Services. Using the list in Appendix D of approved Medicaid “in lieu of” services or alternative service definitions for the LME/MCO (to be provided), address the following:
1. Geographic area covered by each approved “in lieu of” service or alternative service definition
  2. Service capacity of each “in lieu of” service/definition
  3. Demonstrate how each “in lieu of” service/definition filled the gap it was intended to address
  4. Barriers encountered and aha moments experienced during implementation

**Family Centered Treatment (H2022 22 Z1, H2022 22 Z2, H2022 U3 HE):** available in all ABH counties

Service capacity: limited by expansion potential of each agency, but not currently restrained by funding limitations

Gaps addressed: need for evidence-based family-focused approaches to in-home care for children and adolescents.

Barriers / aha moments: Clarification needed regarding differences between FCT, IIH, Intercept Model and MST. In response to questions from providers, UM staff and Care Coordinators, we developed guidelines to assist with referral decisions.

**Outpatient Plus (90837 22 PL, 90834 22 PL, H0036 22):** available in all ABH counties

Service capacity: Service is limited to nine eligible providers, but of these, only four are providing services at this time. Service capacity depends upon expansion potential of each agency, but is not currently constrained by funding limitations

Gaps addressed: Gap between intensive services and outpatient

Barriers / aha moments: rate of service and ratio of care coordination to outpatient sessions reduces flexibility of service to respond to varying consumer needs

**ACT Step Down (H0040 TS):** available in all ABH counties

Service capacity: all in-network ACTT teams have this service available, and capacity is constrained only by the capacity of each ACTT team

Gaps addressed: gap between ACTT and lower level services

Barriers / aha moments: resubmitted to add LPN to make service more cost effective; need to work with providers on being proactive in anticipating step-down

**Rapid Response (S5145 22 Z3):** Wake County

Service capacity: currently six beds, with plans to increase to twelve

Gaps addressed: children’s crisis needs

Barriers / aha moments: NC licensing requirements are inconsistent with treatment needs

B. Non-Medicaid-funded (State-Funded) Services. The next two items apply to services referenced in:

- State-Funded Enhanced Mental Health and Substance Abuse Services 2016 effective 10/1/16
- State-Funded ACT Policy
- State-Funded DMHDDSAS Service Definitions 2003-2016 effective 9/1/16
- Individual Supported Employment with Long-Term Vocational Supports YP630/YM645

For additional information, see

<http://www.ncdhhs.gov/divisions/mhddsas/servicedefinitions>.

1. For non-Medicaid-funded services, describe any geographic discrepancies in services included in the LME/MCO's local benefit plan. That is, are residents of some counties excluded from coverage under the LME/MCO benefit plan, or have stricter eligibility requirements? Include which services, why this occurred, and whether there is a plan in place to ensure equal access based on need across all geographic areas.

The following services in the Alliance benefit plan have varying availability based on county of residence:

Child & Adolescent MH/SUD:

- Child & Adolescent Day Treatment: Available in Cumberland and Wake only
- Adolescent SAIOP: Available in Cumberland only
- Community Respite: Not available in Cumberland
- Residential Levels II & III: Available in Cumberland only

Adult MH/SUD:

- SACOT: Available in Durham and Johnston only
- Opioid Treatment: Available in Durham only
- Halfway House: Available in Durham only
- Group Living High: Stricter limits in Johnston
- Supervised Living-Low: Available in Cumberland only
- SA Medically Monitored Community Residential Treatment
- Supervised Living-Moderate: Available in Wake only

Child and Adult IDD:

- IDD Supported Employment: Available in Cumberland only
- IDD Long Term Vocational Supports: Different authorization limits for Cumberland, Durham/Johnston, Wake
- IDD Supported Employment-Group: Available in Cumberland and Wake only, and stricter limits in Cumberland
- Developmental Therapies (professional): Available in Cumberland and Wake only, and stricter limits for Cumberland

- Developmental Therapies (paraprofessional): Available in Johnston and Wake only, but providers only in Durham and Wake
- Developmental Day: Available in Johnston and Wake only; different benefit plans for each county and stricter eligibility limits for Johnston
- ADVP: Stricter limits for Cumberland; closed to new admission in Durham
- Behavior Plan Development: Available in Cumberland and Wake only
- Community Respite: Not available in Cumberland
- Day Activity: Available in Cumberland and Durham only, and lower benefit in Cumberland
- Group Living Moderate: Not available in Wake
- Group Living Low: Available in Cumberland and Wake only
- Hourly Respite: Not available in Durham, and stricter limits for Cumberland and Johnston
- Personal Assistance: Not available in Cumberland, and stricter eligibility requirements for Johnston; closed to new admissions in Durham
- Psychological Testing: limited to adults for Durham and Wake
- Supervised Living 1-6: Not available in Wake
- Supervised Living-Low: Available in Cumberland and Wake only

Explanation for geographic discrepancies: The Alliance benefit plan reflects historic differences in State funding and LME benefit plans of the former single county LMEs that now comprise Alliance Behavioral Healthcare. Each single county LME developed its local provider network based on different community needs and resources, network capacity, state allocations and local funding, resulting in different approaches to allocation and management of state funding for each county

Plans for addressing discrepancies: Alliance is working on a new basic benefit plan realignment that will decrease geographic discrepancies. The new benefit plan has been presented to the Alliance Board of Directors and is pending approval.

2. For non-Medicaid-funded services, describe any services that were closed to new admissions or not offered during the year. Include which services, why this occurred, the period of time, and how the LME/MCO ensured priority populations continued to access appropriate levels of care.

Other than the community-specific geographic differences noted above, no services were closed to admission during the past year.

3. Using the list in Appendix D of approved non-Medicaid-funded alternative service definitions for the LME/MCO (to be provided), address the following:
  - a. Geographic area covered by each approved non-Medicaid-funded alternative service definition
  - b. Service capacity of each non-Medicaid-funded definition
  - c. Demonstrate how each non-Medicaid-funded definition filled the gap it was intended to address
  - d. Barriers encountered and aha moments experienced during implementation

### **Assertive Engagement (YA323): Cumberland, Durham and Wake**

Service capacity: limited to one provider in Cumberland, three in Durham and eight in Wake

Gaps addressed: assistance for individuals who have difficulty engaging in treatment, especially those with severe and persistent mental illnesses who are transitioning from crisis or inpatient care, jails or homelessness.

Barriers / aha moments: One significant barrier is that this service is not available through the Medicaid benefit plan, which reduces its availability to many who would benefit from it.

### **Crisis Evaluation and Observation (YA324): Cumberland and Durham**

Service capacity: limited to one Behavioral Health Urgent Care provider in Cumberland County and one in Durham County.

Gaps addressed: short-term evaluation and observation for individuals whose symptoms warrant careful evaluation to determine if inpatient care is necessary, as well as the need for specialized behavioral health evaluation in a setting that can serve as an alternative to hospital emergency departments

Barriers / aha moments: Barriers include limited State funding as well as limited reimbursement for insured and underinsured service recipients

### **Recovery Support (YA325): Durham**

Service capacity: limited to one provider in Durham

Gaps addressed: Services to link individuals with substance use disorders to basic resources and services such as housing, employment, medical care, transportation to services, recovery self-help programs and other services that promote independence and recovery

Barriers / aha moments: Limitations in State funding prevent replication and expansion of this service, and many of the needed services and supports are difficult to access for individuals without insurance

### **Peer Support Hospital Discharge & Diversion-Individual (YA343), and Hospital Discharge Transition Service (YA346): Wake**

Service capacity: provided by only one provider in Wake County

Gaps addressed: need for effective transition from inpatient hospitalization to community services

Barriers / aha moments: Limited State funds lead to reduced availability of this service, and there is no current comparable Medicaid-funded service.

**Comprehensive Screening and Community Connection (YA377): Wake**

Service capacity: Limited to one provider in Wake County

Gaps addressed: This service is generally regarded as a beneficial service for individuals needing support while on waiting list for other services, and it has been helpful in diverting individuals from escalation of crisis situations.

Barriers / aha moments: limited non-Medicaid funding; alternative service definition only approved for Wake County.

**Outpatient DBT Group and Individual (YA386 and YA387): all ABH counties**

Service capacity: limited to two providers in Cumberland, one provider in Johnston, two providers in Durham and five providers in Wake. Each provider has a team of eight clinicians who have received advanced training in DBT, which is required to receive the enhanced rate for this service.

Gaps addressed: evidence-based services for individuals with Borderline Personality Disorder

Barriers / aha moments: Need for ongoing training and supervisory infrastructure that supports high fidelity DBT services in an environment of frequent staff turnover.

## Section Three

### Service Needs and Gaps Identified by Consumers, Family Members and Other Stakeholders

- I) What mental health, developmental disabilities and substance use disorder services gaps were identified by consumers and family members?

Consumers and family members who responded to the online survey identified the following services as being the least accessible in their communities:

- Child and Adult IDD: Institutional Care (ICF/IID), crisis services, residential options, inpatient psychiatric treatment for dually diagnosed
- Adult MH/SA: respite, short-term residential treatment for substance use disorders, vocational services, long-term structured daily activity programs and partial hospitalization services
- There were too few responses for Child MH/SA and TBI surveys to yield meaningful rankings. However, based on feedback from CFAC, several priorities are crisis services for children, services for transition-age youth, and adolescent substance use disorder treatment

The Alliance CFAC and local CFAC chapters provided feedback that identified the following as service needs and gaps:

- Child and Adult IDD: lack of Innovations slots and waiting list for IDD services, shortage of qualified direct care workers, need for increased access to assistive technology, increased crisis respite and case management services, effective school inclusion, retirement services, and family education
- Child MH/SA: crisis services for children, services for transition age youth, and adolescent substance use disorder services
- Adult MH/SA: increased recovery-oriented services such as Recovery Center or Peer-Run Respite, improved access to psychiatric appointments, effective Peer Support, peer-operated warm line, Drop-In Center in Cumberland, medication education, case management, withdrawal management services, jail transition services, and services for uninsured

Additional information about consumer and family feedback is available in **Appendix C**.

II) What mental health, developmental disabilities and substance use disorder services gaps were identified by other stakeholders?

Stakeholders who responded to the online survey identified the following services as being the least accessible in their communities:

- Child MH/SA: Short-term structured programs (e.g., Day Treatment, Partial Hospitalization), respite, outpatient treatment of opiate abuse, intensive outpatient treatment of substance use disorders, and services for transition age youth
- Adult MH/SA: Services for the elderly, vocational services, Peer Support services, respite, and partial hospitalization services.
- There were too few responses for IDD and TBI surveys to yield meaningful rankings.

Stakeholder participants in focus group discussions provided extensive feedback about community needs and gaps, yielding the following priorities:

- Housing
- Access / availability of appointments
- Medication access for uninsured
- Medication Assisted Treatment
- Respite services
- Inpatient capacity and access
- Continuum for justice-involved
- Housing for individuals with SUD
- System navigation and information
- Cross-disability fluency and expertise
- Case Management
- Adolescent SUD continuum
- Innovations waiting list
- SUD Withdrawal Management continuum

Additional information about stakeholder feedback is available in **Appendix C**.

III) What specific geographic, cultural or demographic groups experience gaps in mental health, developmental disabilities and substance use disorder services that need to be addressed? Describe gaps and how the information was gathered.

Feedback about populations that are considered to be underserved was obtained through the online survey as well as stakeholder focus group discussion. Based on these sources, the following groups were identified most often as being underserved:

- Uninsured / underinsured
- Non-English speaking
- Transition Age Youth, including youth aging out of foster care
- Dually Diagnosed (IDD/MI & SUD/MI)
- Sex offenders, sexually aggressive youth and youth sex offenders
- Individuals with IDD
- LGBTQ (including transgender youth)
- Elderly
- Homeless
- Veterans (including homeless veterans)
- Individuals connected to criminal justice system

## **Section Four**

### **2017 Network Development Plan**

This is a separate document due Friday, June 30, 2017. Strategies for addressing service gaps identified by access and choice data as well as by consumers, family members and other stakeholders are to be included in the 2017 Network Development Plan, due Friday, June 30, 2017.

## **Section Five**

### **Geo Maps**

Geo maps are provided in **Appendix B** for all Medicaid-funded services listed in these requirements, except for outpatient services. Geo maps show provider agencies with Alliance contracts as of 1/1/2017 to provide Medicaid services in the following categories:

- I) Location-based services – one geo map for each Medicaid location-based service. Provider locations are shown with a **radius of 30 miles**.
- II) Community/Mobile Services – one geo map for each Medicaid crisis service that shows provider locations within the **Alliance catchment area**.
- III) Crisis Services – one geo map for each Medicaid crisis service that shows provider locations within the **Alliance catchment area**.
- IV) Inpatient Services – one geo map for each Medicaid crisis service that shows provider locations within the **Alliance catchment area**.
- V) Specialized Services – one geo map for each Medicaid specialized service that shows provider locations within **North Carolina**.
- VI) C-Waiver services – one geo map for each **C-Waiver residential** and **day supports** service.

## **Section Six**

### **Departmental (DHHS) Priorities**

The NC Department of Health and Human Services (DHHS) has established six priority initiatives for MCOs for the past year. The following section provides an update on each initiative, including goals, actions taken, accomplishments and plans for further development.

#### **1. Prevention and Education**

***Mental Health First Aid (MHFA).*** MHFA is a foundational part of Alliance’s strategic goal to advance person-directed health by educating our system and members to promote wellness and prevention. Alliance’s eight-hour MHFA course teaches a five-step action plan that guides trainees through the process of reaching out and offering appropriate support to a person in need until professional treatment is secured or the crisis resolves. Specific accomplishments for the past year include the following:

- We offer two different tracks, one designed for working with adults and the other designed primarily for adults who regularly interact with young people ages 12-18.
- As part of our collaborative effort with Wake County Human Services, Alliance has trained over 100 Human Services staff and has plans to train 400+ over the coming months. We’ve also provided training for other governmental agencies at the state and local levels, school systems and universities, police departments, hospitals and behavioral health providers, homeless shelters, the faith community, every adult probation and parole officer in our four-county region, and more.
- In addition to regular Adult Mental Health First Aid training, Community Relations staff in Johnston County have conducted a specialized Older Adult Mental Health First Aid training targeted to people who work with our older adult population and the sometimes unique mental health issues they face, including caretakers, nursing staff and other healthcare professionals.

***Wake Network of Care.*** In 2016 Alliance teamed with Wake County Government to launch Wake Network of Care, a searchable online resource directory that helps citizens locate services related to mental and behavioral health, addiction, advocacy, support, housing and more. It allows users to find the services they need on an interactive map, and it houses a Learning Center of over 30,000 articles to topics related to health and well-being. Visit Wake NOC at [wake.nc.networkofcare.org](http://wake.nc.networkofcare.org).

***Recovery University.*** Alliance’s commitment to the concepts of recovery and true self-determination, and the use of system of care principles to fundamentally shift the way services and supports are designed, funded, managed and delivered continues to extend beyond our walls with the introduction of Alliance Recovery University. We have assembled a broad curriculum of live workshops and events, online training videos, and comprehensive information and are investigating a robust web-based registration platform to allow stakeholders across our region to tap into the learning experience. We are also creating guidelines to help ensure our internal policies and procedures that shape the way Alliance does business are developed through a lens of recovery and self-determination philosophy.

## 2. Intervention and Treatment

### **Crisis Continuum:**

Alliance continues to strengthen its crisis continuum of services anchored by our Crisis and Assessment Centers, providing access to quality, community-based clinical care to ensure that people obtain the right care in the right place, and when possible avoid the unnecessary use of emergency departments and jails. Specific initiatives include:

- ***Building Crisis Response Capacity in Wake County.*** Renovation is underway on an additional Crisis and Assessment Center in Wake County to expand the capacity there for behavioral health urgent care, non-hospital detox, and crisis, evaluation and observation services, also employing a recovery-based model. The facility is expected to open in mid-2018.
- ***Facility-Based Crisis Services for Children.*** It is critical to serve children and youth in crisis in a specialized setting equipped to respond to their unique needs in a safe environment. Alliance's new Facility-Based Crisis Center, now in development, will provide a community-based, non-hospital residential setting that serves as a specialized and cost-effective alternative for children and youth.
- ***Mobile Crisis Teams.*** Our Mobile Crisis Teams support people experiencing a behavioral health crisis in their home or other community setting. The goal is to stabilize the crisis situation and link them to appropriate treatment and community services, helping them avoid trips to emergency departments and crisis facilities. Alliance is enhancing Mobile Crisis by implementing centralized dispatching and requiring more robust team staffing, including a licensed clinician and a Peer Support Specialist to provide immediate and follow-up support.
- ***Advance Practice Paramedics.*** Specially-trained paramedics in Durham, Wake and Johnston counties who redirect care for people with mental health or substance use crises at facilities other than the emergency room when no other medical emergency exists. During a six-month period, the program freed 2,400 bed-hours in local emergency departments.
- ***NC START for Child and Adolescent I/DD.*** Alliance was first in the state to expand NC-START to children and adolescents. NC-START is a crisis prevention and intervention program providing crisis response, clinical consultation, training and respite. A recent university study found an association between a connection with START and a decrease in the use of costly and restrictive psychiatric services for this population.
- ***Rapid Response Crisis Diversion Service.*** Rapid Response is a short-term treatment option in a family setting that can prevent or minimize the need for behavioral health inpatient admissions. It serves as a crisis diversion service that offers youth and families the option of a therapeutic foster care home environment as an alternative to inpatient or other intensive options. Pilot results show that 72% of youth admitted to the program were diverted from higher levels of care and that the use of crisis services was decreased. The service is now expanding to all counties.

### **Implementation of Evidence-Based Practices:**

Alliance has used education, technical assistance, and enhanced provider payment rates to encourage and support members of its provider network in their efforts to incorporate and help more people with evidence-based services that are proven to work. This year the number of people served by innovative programs like Dialectical Behavioral Therapy, Trauma-Focused Cognitive Behavioral Therapy and Parent-Child Interaction Therapy more than doubled. Additional initiatives have included implementation of externally validated family-oriented EBPs within Intensive In-Home Services and current efforts to integrate EBPs into Psychosocial Rehabilitation and Therapeutic Foster Care services.

### **Substance Use Disorder Interventions:**

Specific accomplishments for the following year include:

- When our data analytics, utilization management and peer case reviews identified a pattern of risky prescribing of benzodiazepines and opioids, we worked with our providers to design and implement a set of tiered responses that aligns closely with the State's plan to reduce prescription drug abuse.
- Alliance offers ongoing technical assistance for members of our provider network and provide education on appropriate best practice prescribing guidelines and how to assess and effectively treat opioid use disorders.
- We work with local pharmacists to understand opioid addiction as a chronic, preventable and treatable disease, and to increase awareness of the risk of opioids and possible drug interactions. We also initiate conversations with them about offering naloxone to people identified as high-risk for opioid overdose. Naloxone is a medication used to quickly block the effects of opioids and possibly save the life of a person who has overdosed.
- Invested \$100,000 to supply naloxone free of charge to community providers as well as consumers with known addictions and their families, along with education on how to use it, including \$25,000 to supply our Crisis and Assessment Center in Wake County. We also began including instruction in the use of naloxone in our Crisis Intervention Training for law enforcement officers and other first responders. We supplied naloxone to the Wake County Sheriff's Office and to TASC, a program in Cumberland County that works with people whose substance use or mental health problems have put them at risk for chronic involvement with the justice system.
- Increased reimbursement rates to providers who implement Medication-Assisted Treatment, an evidence-based program that uses buprenorphine, which has been found to be effective in treatment of opioid use disorders.
- Partnered across our region in community efforts to combat the opioid crisis at the grassroots level, including the Wake County Drug Overdose Prevention Coalition, Durham County Public Health, the Cumberland County Opioid Abuse and Awareness Task Force, and the North Carolina Harm Reduction Coalition.
- Collaborating with the Law Enforcement Assisted Diversion program in Cumberland County to divert heroin and other opioid users with low-level criminal offenses into the treatment they need as an alternative to arrest.

### 3. Housing and Employment

*Housing Initiatives* include the following actions over the past year:

- Contracted with TAC to complete a study of the Alliance residential continuum.
- Completed the Alliance Housing Plan per DHHS request
- Housing Plan includes overview of current community-based housing initiatives, identified needs relating to housing capacity and access to quality affordable permanent supportive housing, wraparound services and supports needed to promote sustainable housing, and crisis planning objectives for consumers
- Hired a Director of Housing to provide leadership for housing initiatives
- Forging diverse partnerships with providers and landlords to ensure a sufficient supply of housing for people experiencing behavioral illnesses. We offering regular workshops for providers to increase their knowledge of fair housing and tenancy supports.
- The Independent Living Initiative, or ILI, is a short-term, one-time assistance program for adult consumers and children receiving enhanced services through Alliance. It helps people facing possible eviction or loss of their utilities, and those in need of start-up funds to move into permanent housing. Restoring Hope, part of ILI, supports transitions of people with behavioral illnesses from jail or extended hospital stays into secure housing.
- For the third year, Alliance's DASH program provided supportive housing vouchers funded by the U.S. Department of Housing and Urban Development. This intensive wraparound model combines help with housing with ongoing physical and behavioral healthcare, and community support services that build life skills like communication, finding a job and managing a budget.
- Offered a special four-part Fair Housing workshop for providers, equipping them with the knowledge to be able to advocate for people in need. We also partnered with local advocacy groups to host Fair Housing training in each of our communities.
- Provided Ready to Rent training for consumers, with plans to expand implementation across the catchment area
- Provided training for providers on supportive housing
- Managed voucher and subsidized housing programs, including Section 8 Housing Choice Vouchers, Shelter Plus Care
- Exploring further partnerships with public housing authorities
- Included housing allocation in Alliance savings reinvestment plan.
- Convened an internal housing and investment strategies committee to explore financial incentives and development of supportive housing
- Continue to promote and develop a comprehensive supportive housing model
- Developing strategies to expand accessibility for individuals who have significant barriers to supportive housing

- Continuing to forge collaborative partnerships with supportive housing developers and organizations
- Continued consultation with TAC and Corporation for Supportive Housing

***Transitions to Community Living.*** The Transitions to Community Living initiative helps make sure that North Carolinians with mental illness are able to live in their communities in the least restrictive settings of their choice. Alliance is working to offer the opportunity for supportive housing to individuals being admitted to adult care homes, or those already in adult care homes or State psychiatric hospitals. This community-based housing comes with paid, competitive employment and intensive, customized, community-based mental health services. Alliance’s goal is to ensure they have the supports to successfully integrate into their community of choice – in line with our strong belief that all people deserve the freedom to make their own life decisions. Specific accomplishments over the past year include:

- Consulting with Enterprise, a firm that specializes in affordable housing, to take on subsidy administration for TCLI.
- Exploring financial incentives to developers with the help of Enterprise consultants
- Developing a Master Leasing policy and piloting in Wake for TCLI

#### **4. Children and Families**

***Therapeutic Foster Care.*** Alliance has strengthened the services provided through Therapeutic Foster Care, or TFC, a unique model of care that provides children with a combination of the best elements of traditional foster care and residential treatment centers. Specific projects have included the following:

- Developing and measuring the effectiveness of a number of the services available through TFC. Members of our provider network are employing models that target adolescent substance users, and youth with co-occurring mental health and intellectual and developmental disability challenges. There are also models proven effectiveness in focusing on family dynamics, and with youth who have experienced significant trauma.
- Requiring providers to use an evidence-based or promising practice approved by Alliance in their work with kids. We have also developed and implemented an internet-based referral tool that allows Alliance to collect and track data on the capacity of foster homes and how well they are serving our young people.
- Partnering with Duke Psychiatry to develop a model of statistical analysis of health insurance claims to generate real-time identification of youth at risk for needing treatment in therapeutic foster care, or in emergency departments at a point when psychiatric treatment in an out-of-home setting is the only option. With grant support from the Duke Institute for Health Innovations, we will collaborate with Duke to intervene earlier with mental health services and care coordination to help young people avoid the need for more intensive care.
- Since 90% of kids entering TFC have experienced trauma, Alliance supports network providers in becoming trainers of the Resource Parent Curriculum developed by the National

Traumatic Stress Network. This allows them to train other therapeutic foster parents to understand the impact of trauma on brain development and behavior and to learn interventions that support healing from traumatic events.

- Initiated Tiered Case Management Pilot including High Fidelity Wraparound in Durham County. This service is expected to support youth coming back to the community from residential and PRTF programs, so it will support community placement and treatment for some youth in Therapeutic Foster Care.

## 5. Quality Monitoring and Management

Quality Improvement Projects for the past year include the following:

**Improve Crisis Services** (Cumberland and Wake Counties) – Reduce Emergency Department admissions for youth in best practice programs in Cumberland; increase consumers using Open Access during non-business hours (crisis diversion) and reduce percentage of time WakeBrook Crisis & Assessment (CAS) is closed due to over-capacity (called “diversion”).

- *Interventions:* Evidence-based programs in Cumberland, Open Access provider open until 7 PM in Wake County.
- *Results:* Lower ED admissions post-discharge in Cumberland; increase in consumers using Open Access after business hours, but no improvement in WakeBrook CAS closures (intervention still new).

**First Responder** – Test crisis lines of providers by making calls after business hours to check if someone answers in a timely manner.

- *Interventions:* Some providers are called more frequently because of poor performance in previous tests, repeat poor performers are referred to Compliance, written feedback to all providers tested, and technical assistance.
- *Results:* 1<sup>st</sup> testing period: 65% of calls answered in satisfactory manner, 2<sup>nd</sup> testing period: 79% satisfactory.

**Access to Care (Routine/Urgent)** – improve % of consumers who show for first appointment based on need.

- *Interventions:* Routine – reminder calls and feedback letters to providers, Urgent – Feedback letters to providers, expanding assessment hours on Fridays, and interventions for criminal justice population.
- *Results:* Routine: revised baseline (FY 16, Q1)=40%, post interventions=(FY 17, Q1) 48%; Urgent: revised baseline (FY 16, Q4)=19%, post intervention=not taken yet, interventions are new.

**Access to Care (Emergent)** – improve by 10% consumers who show for care within 2:15 hours of start of call; baseline: (FY 16, Q4) 67%.

- *Intervention:* RFP and new contract for Mobile Crisis services (starting July 1, 2017).
- *Results:* Not yet available.

**Care Coordination (MHSA)** – improve % (to 80%) of Care Coordination contacts within 2 business days.

- *Intervention:* Training and coaching of staff.
- *Results:* Aug-Oct 2015 – 87%, Jan – Mar 2016 – 66%, and April – June 2016 – 72%; did not meet benchmark; team is developing new interventions.

**IDD Timeliness** (to show evolution of IDD Care Coordination, not a CMS project) - 85% of new Innovations consumers receive services within 45 days of plan approval.

- *Intervention:* To be determined. Project Advisory Team is in process of completing a comprehensive, current state process map to identify bottlenecks that are within control of Alliance.

**Improving Intensive In-Home** – improve outcomes of consumers receiving Intensive In-Home services.

- *Intervention:* Require certain evidence-based models with fidelity monitoring.
- *Results:* Not yet available; interventions implemented in early FY 17, collect post-intervention data in late 2017.

**Improving Person-Centered Plans** – Improve quality of health and safety elements within person-centered plans for individuals receiving intensive SA services.

- *Intervention:* Targeted training and technical assistance for providers of substance abuse services.
- *Results:* Baseline, using revised review tool focused on health and safety elements, is being collected.

**Transition to Community Living Initiative (TCLI) QIP** – Increase private housing options for TCLI population

- *Goals:* Increase the # of housing units available within the private sector, Increase the # of units that get rented to TCLI pop
- *Interventions:* Training to property owners on Alliance, housing program, anti-stigma and recovery oriented system of care.

## 6. Integrated Care

In 2016 we continued to expand our initiatives to integrate behavioral and physical healthcare in our communities, and we sharpened our focus on social determinants of health – the environmental factors that impact peoples’ health and quality of life. We know that people with severe mental illness die 20 to 25 years earlier than the general population. When people can get all the care they need in one location, the result is improved overall health and wellness. Integrated care initiatives for the past year include the following:

- Behavioral health professionals funded by Alliance are housed at the Duke Outpatient Clinic, and at another primary care practice in Cumberland County, to allow early identification of behavioral health and substance use disorders and provide integrated treatment. They assist clinic patients with a variety of healthy behavior activities geared at patient motivation and self-care. This way access to community psychiatric providers can be reserved for individuals with serious and persistent mental illnesses.

- In Johnston County a behavioral healthcare professional works at a pediatric practice to intervene early when kids coming to the clinic for physical healthcare also display developmental or behavioral concerns.
- In Wake County Alliance is partnering with UNC Health Care at WakeBrook, one of Alliance's Crisis and Assessment Centers, to improve health outcomes and increase preventive care. Alliance funds time for consultation and coordination between doctors and other clinicians at WakeBrook's primary care clinic and the medical staff of the UNC Assertive Community Treatment Team.

# APPENDICES

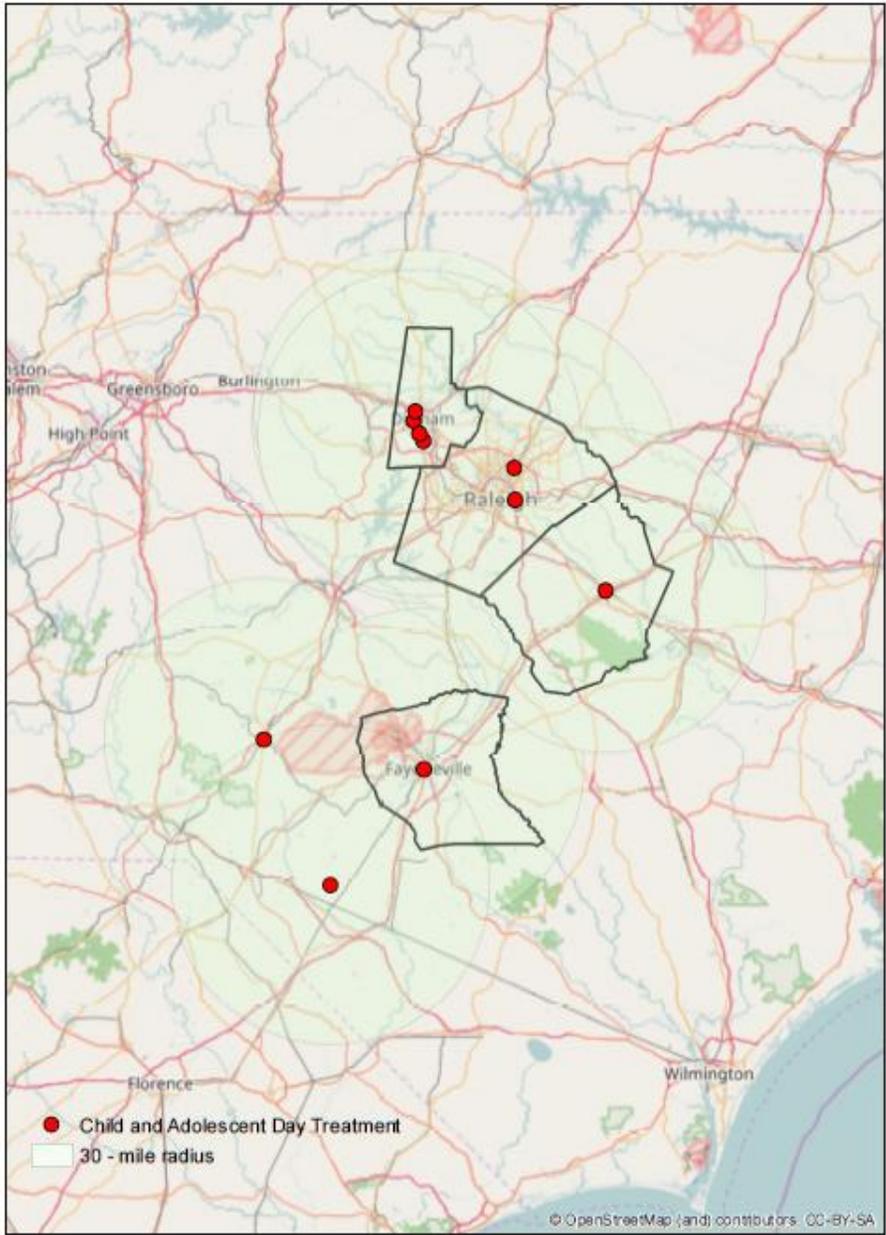
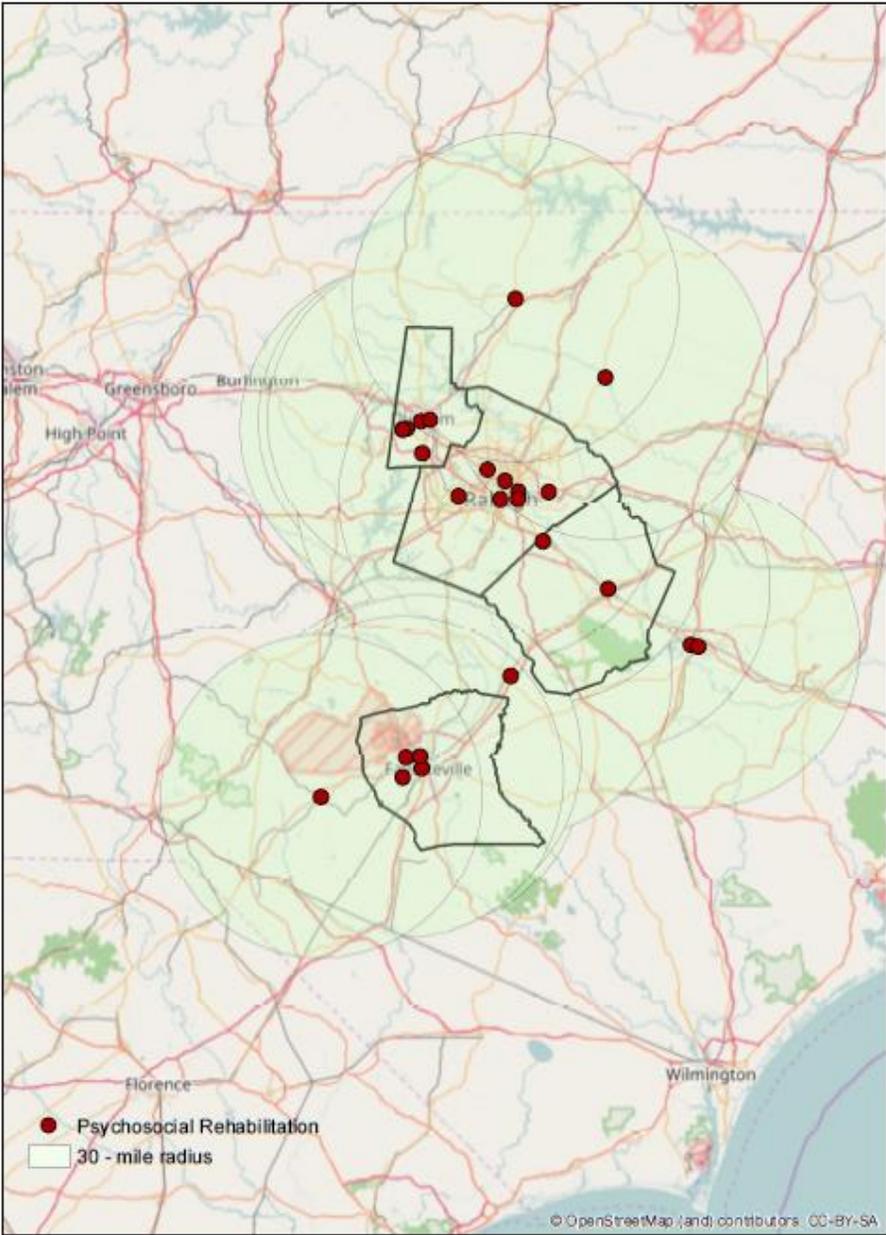
## Appendix A: Geographic Access Maps

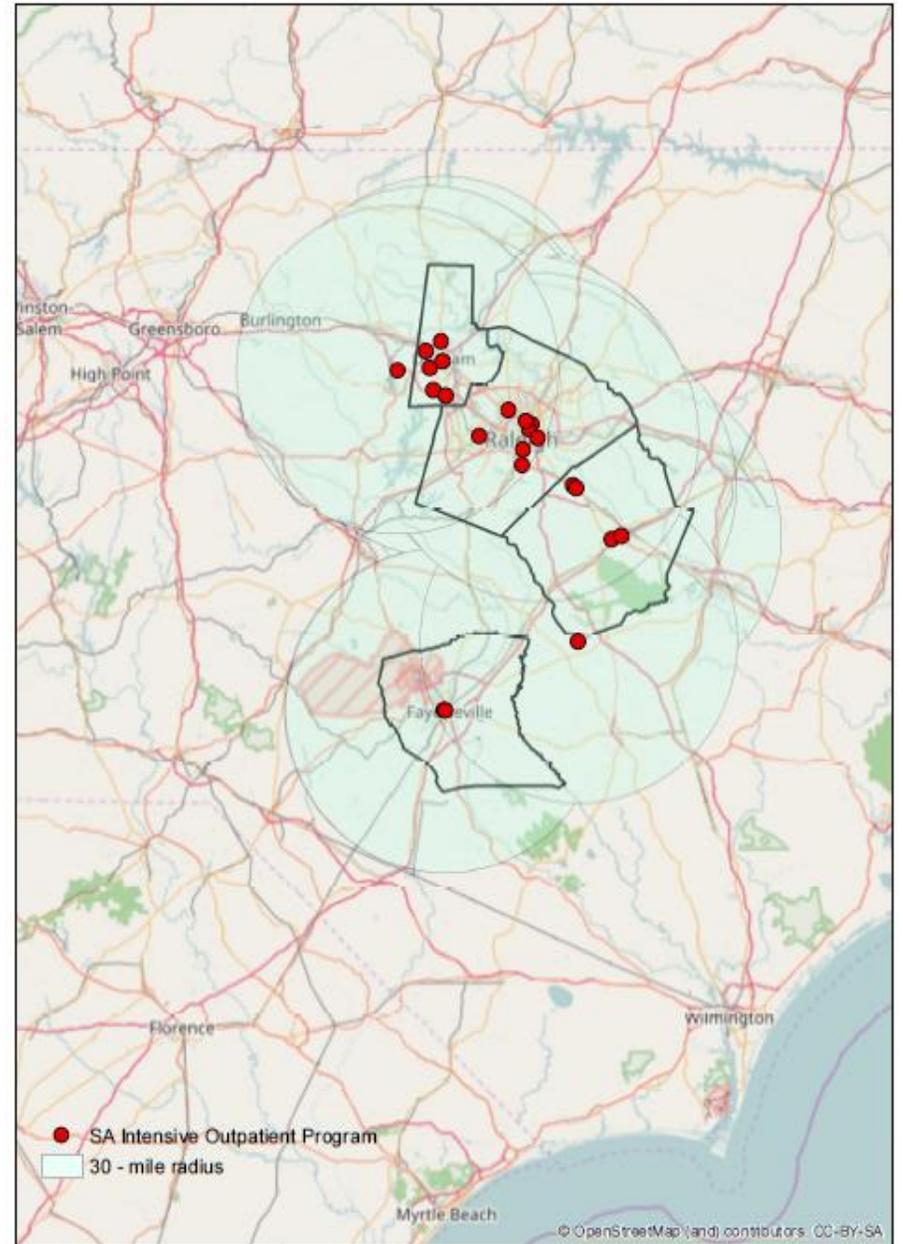
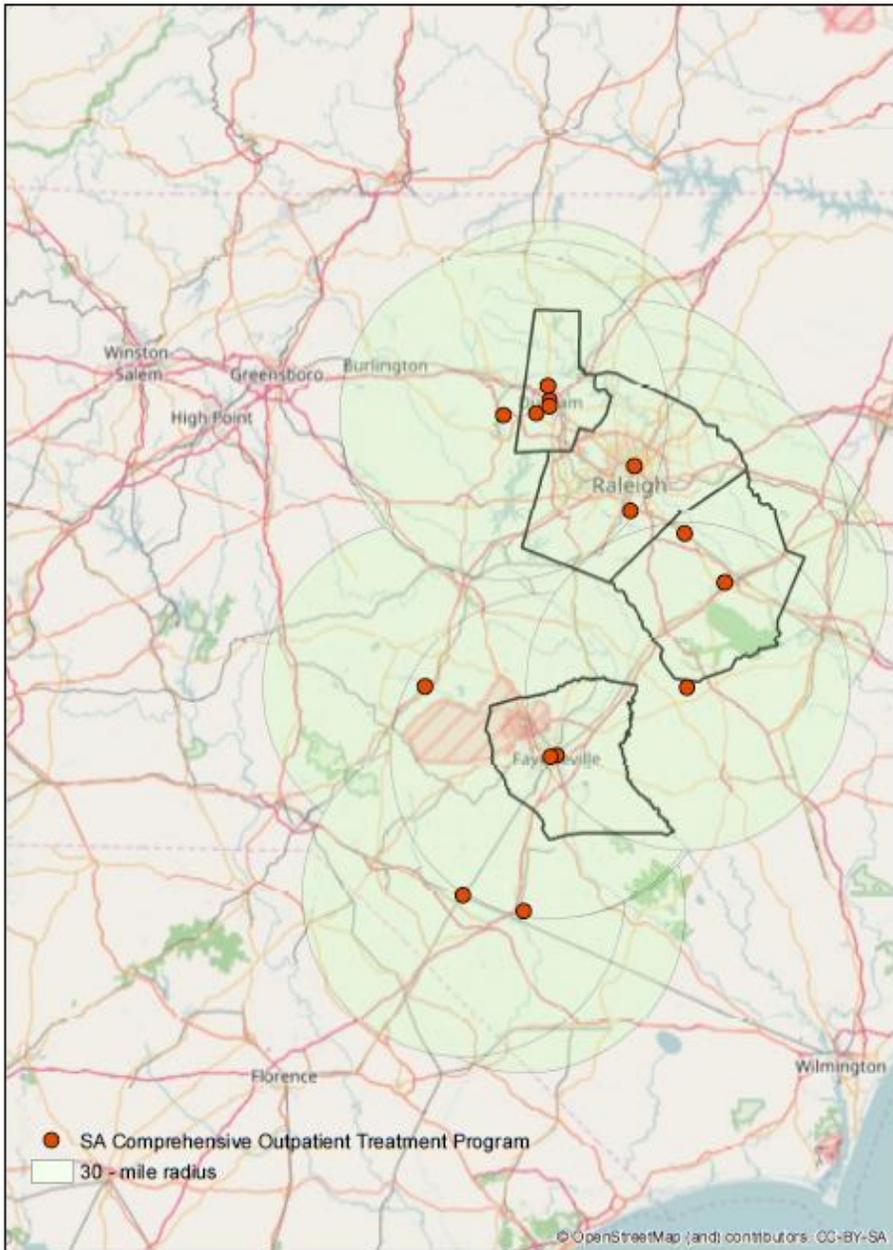
The following geo maps are provided for all Medicaid-funded services listed in Section Two, except for outpatient services, and reflect contracted provider agencies as of January 1, 2017.

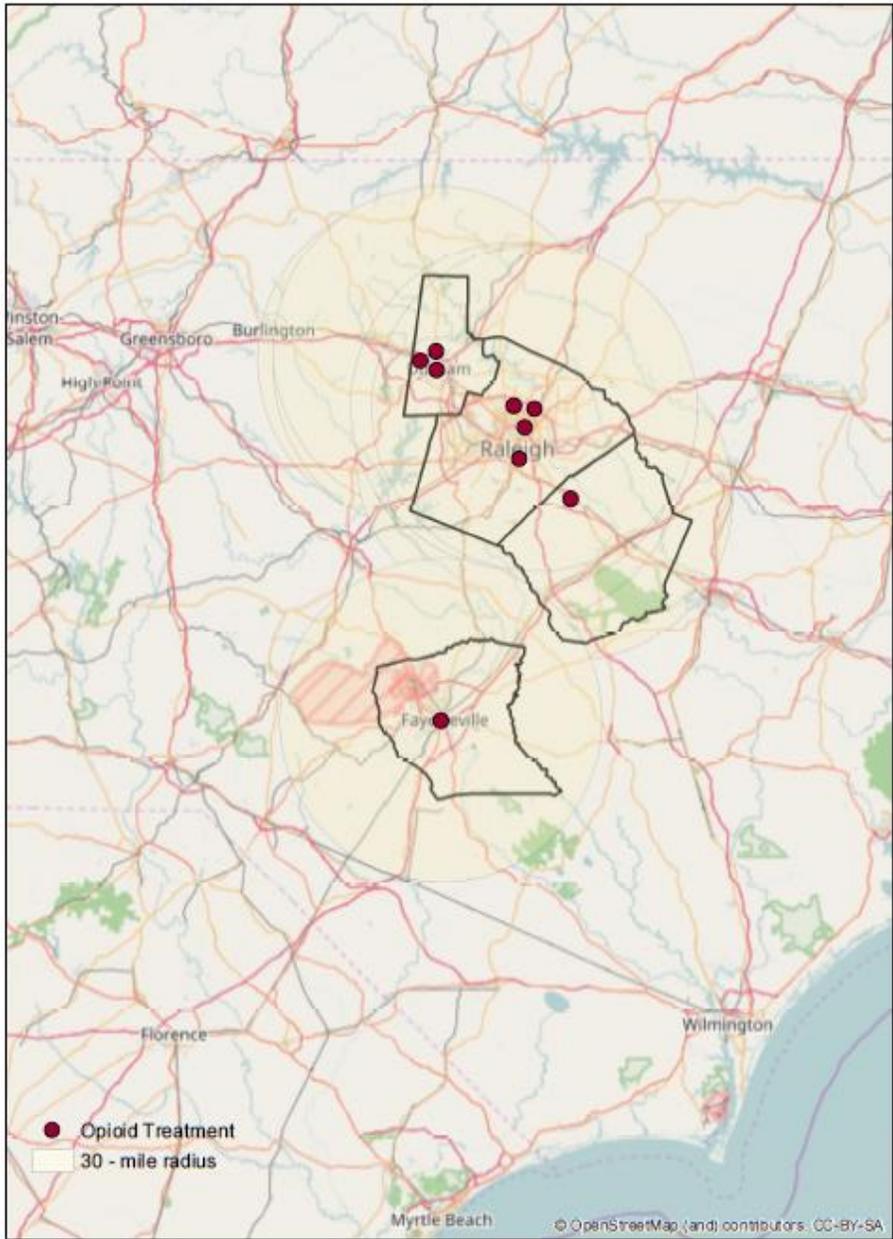
### Appendix A Table of Contents

Location-based .....	46
Community/Mobile Services .....	49
Crisis Services.....	55
Inpatient Services .....	56
Specialized Services.....	57
C-Waiver services.....	63

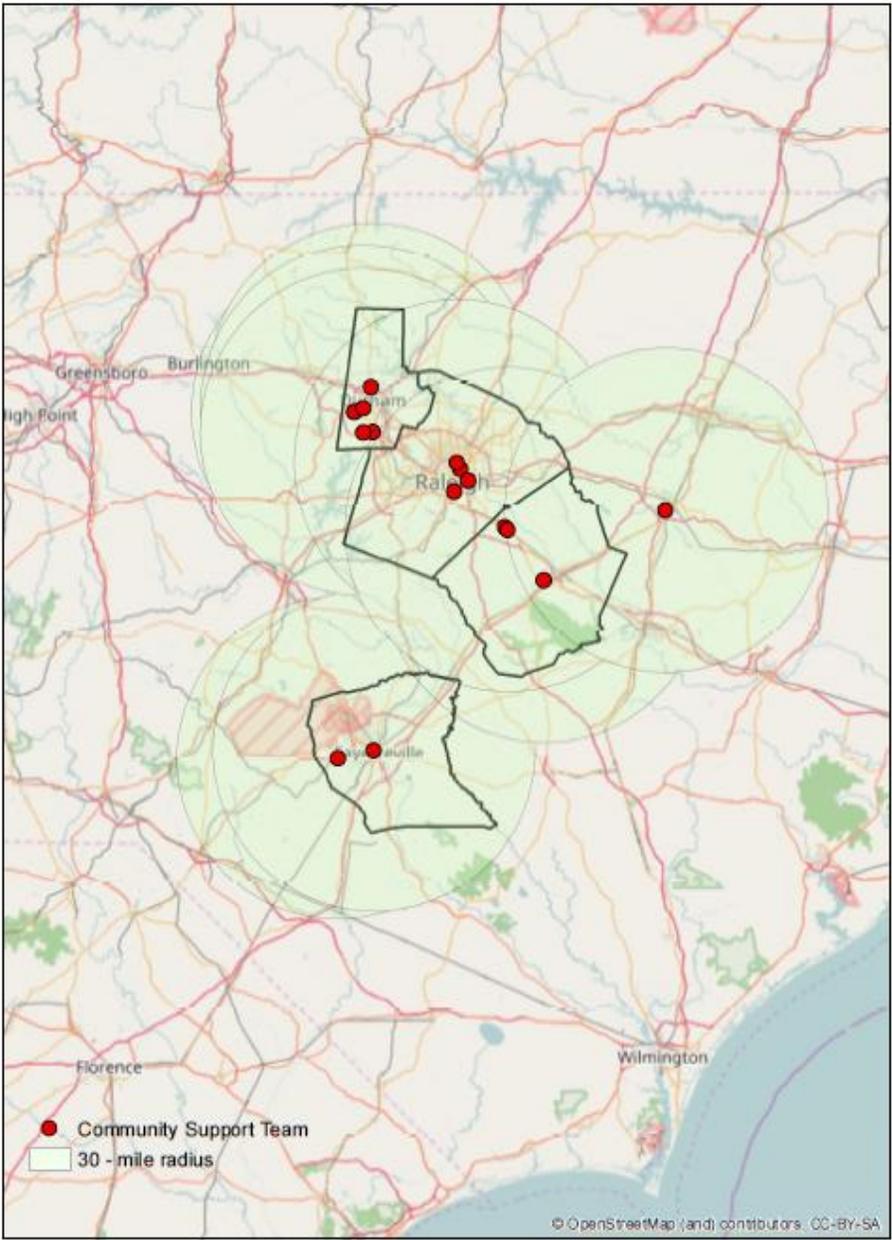
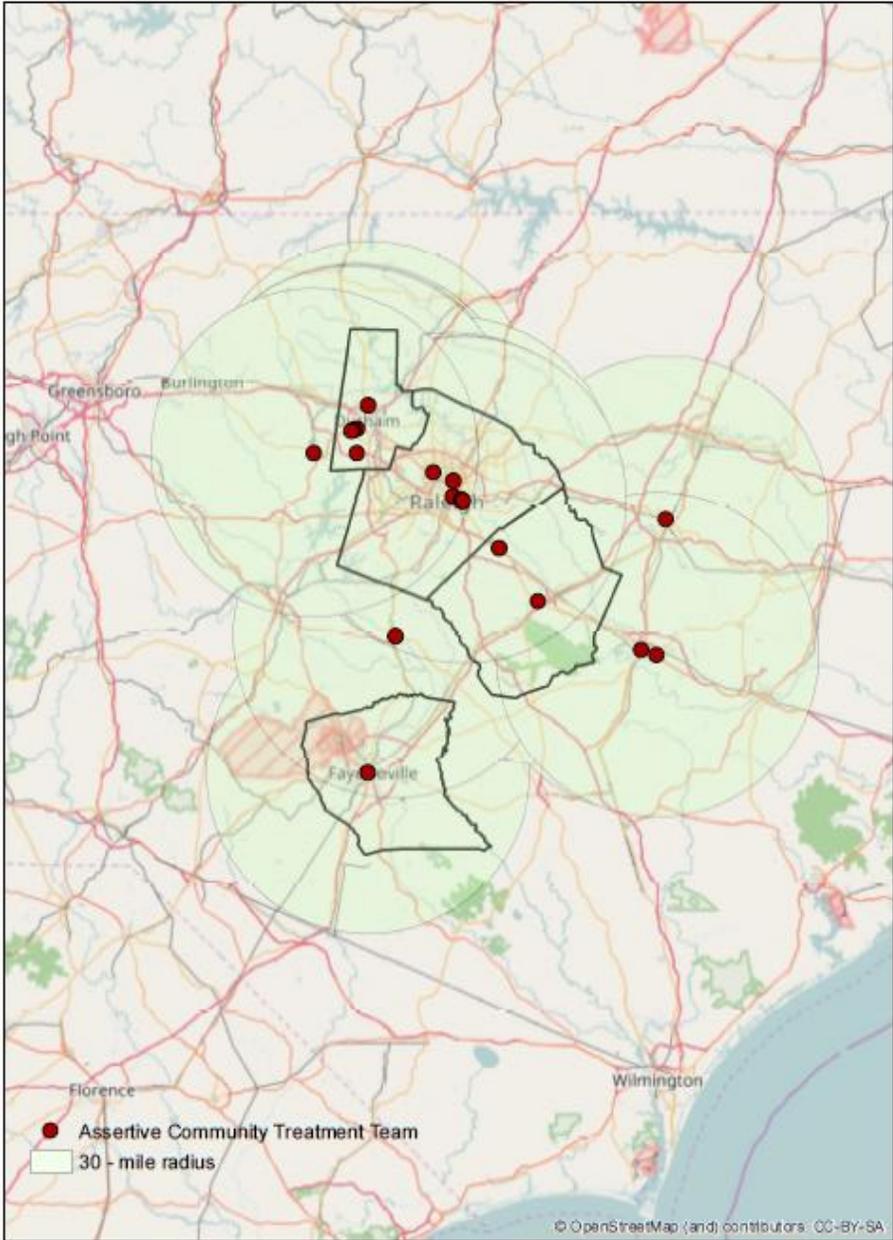
# LOCATION-BASED SERVICES

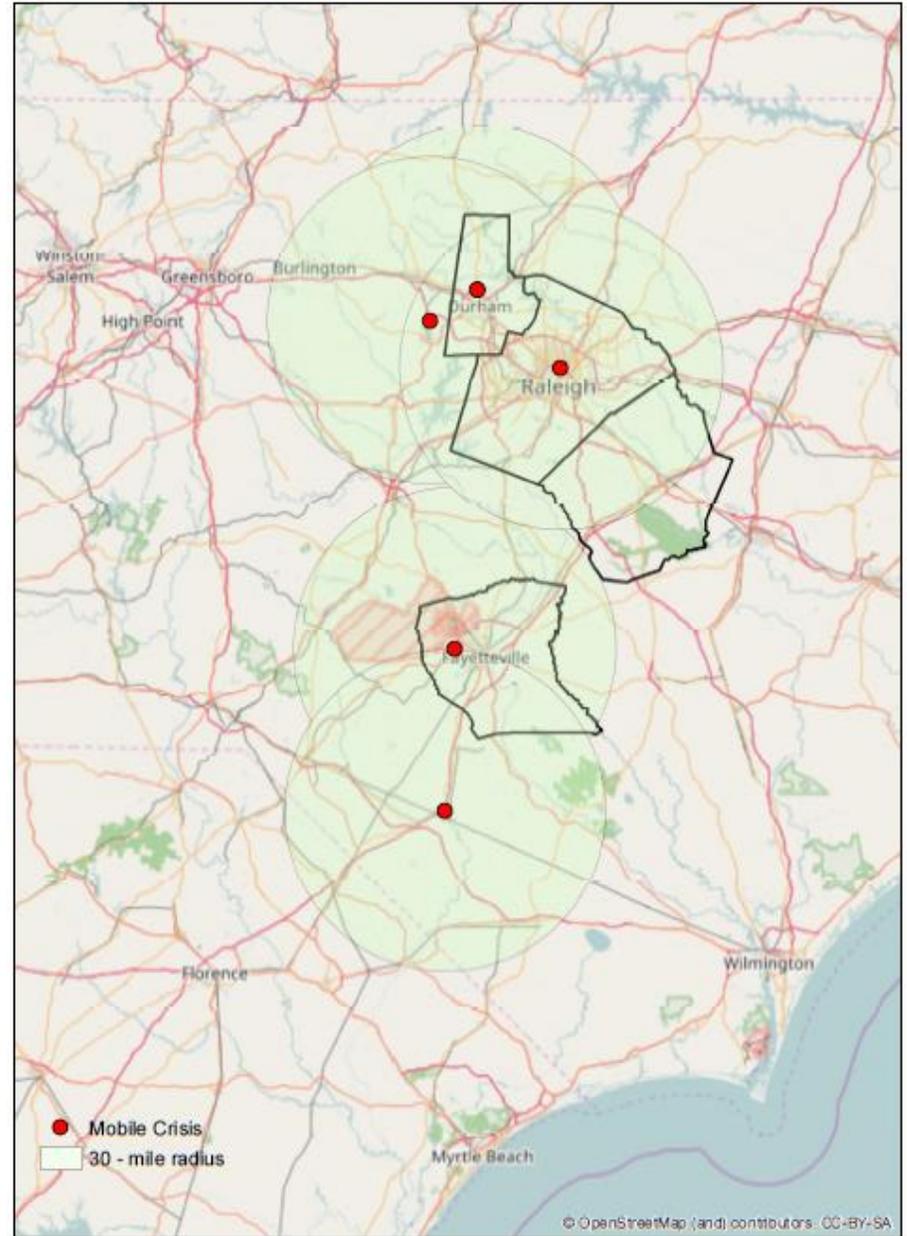
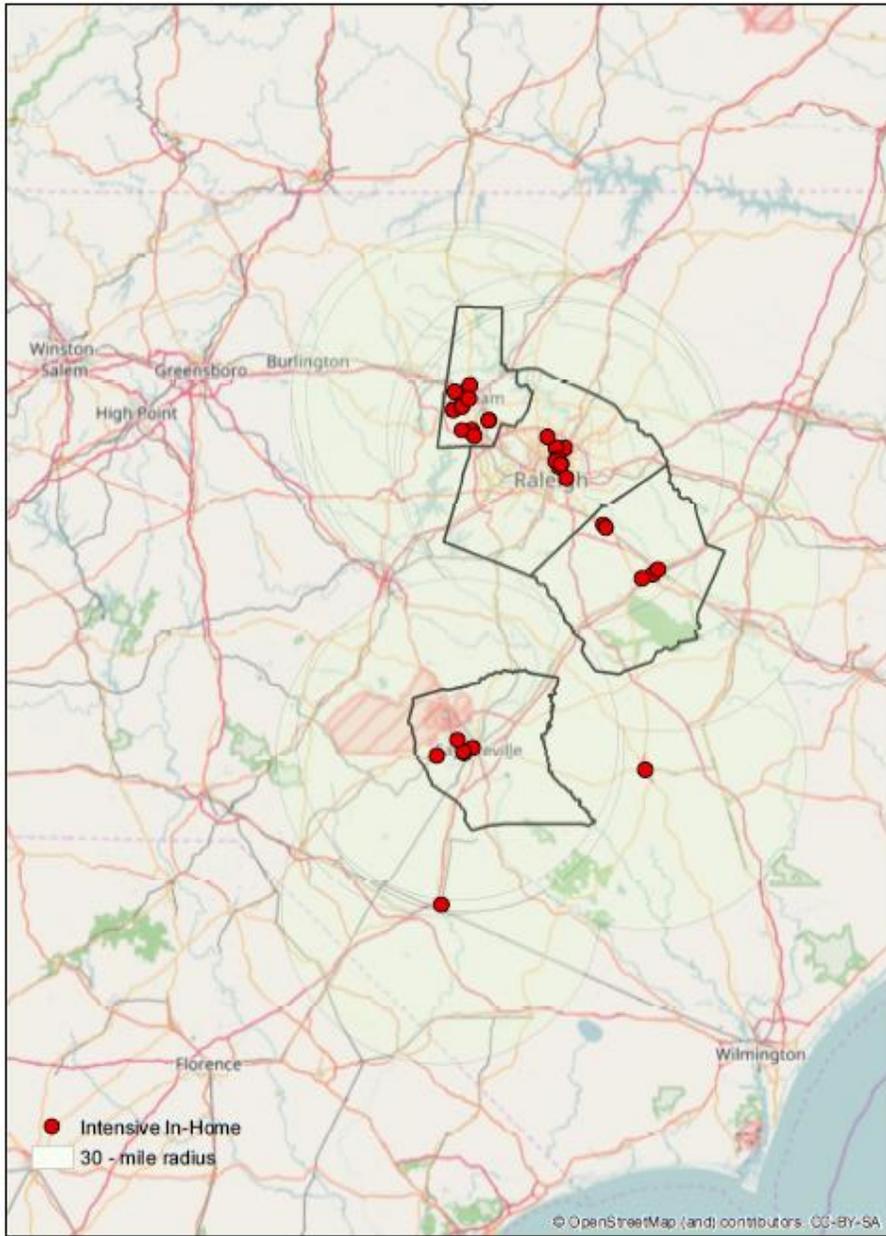


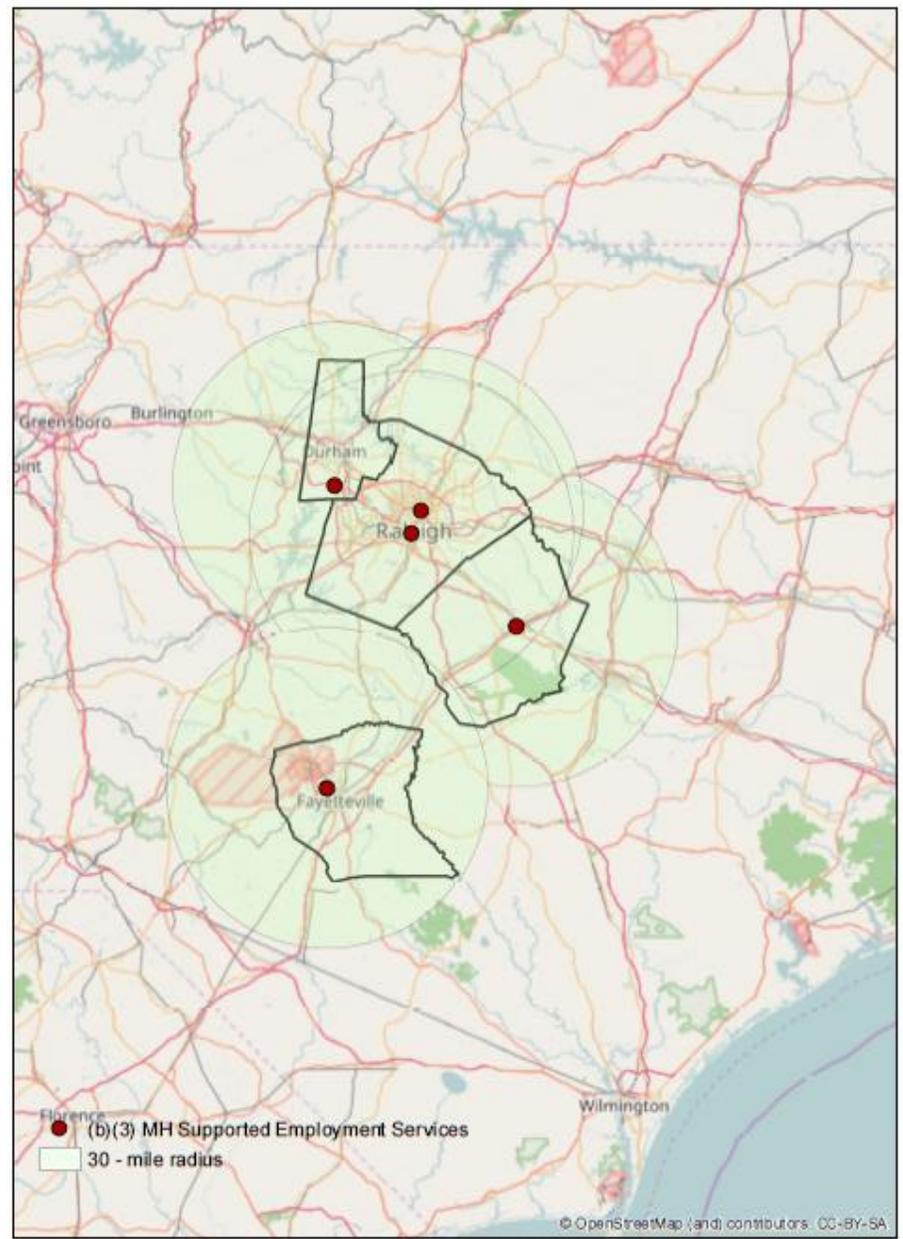
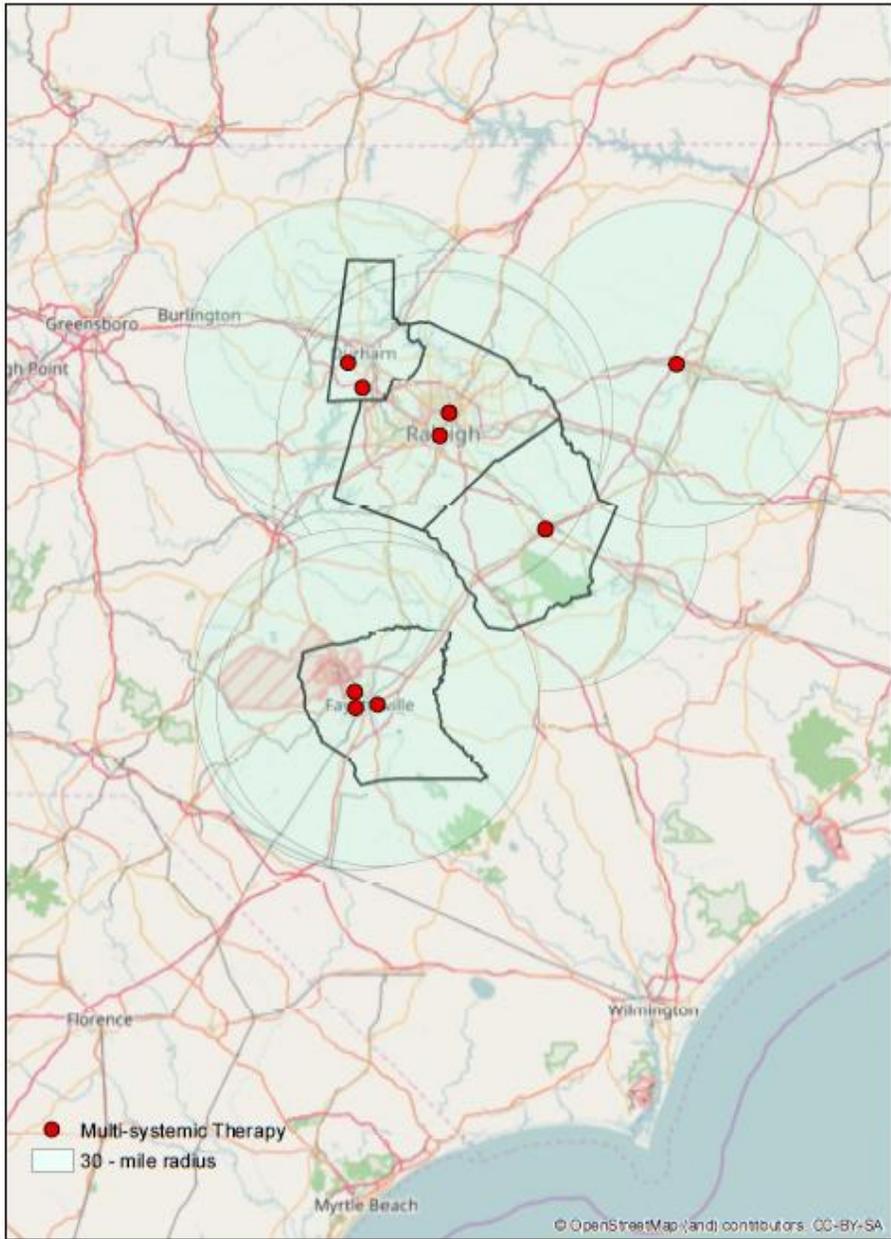


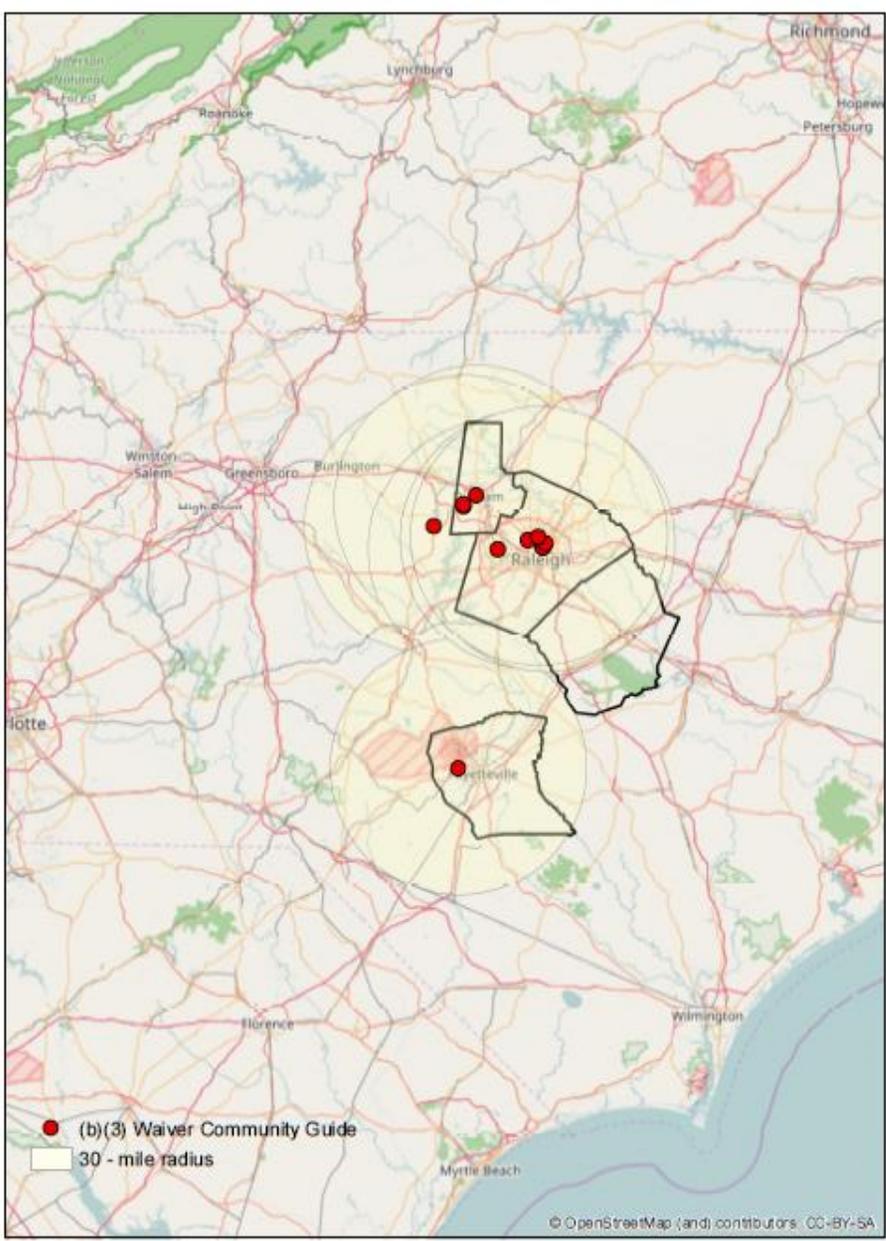
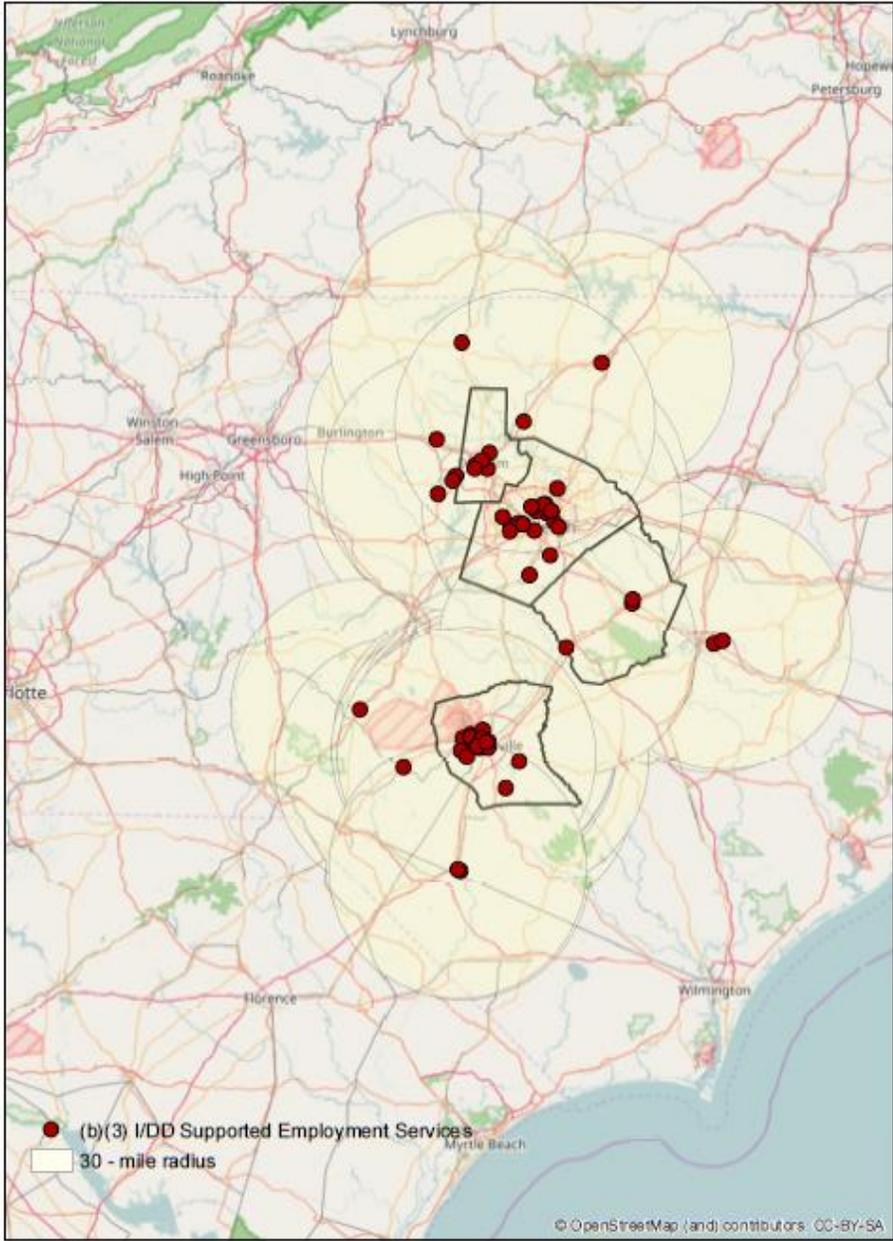


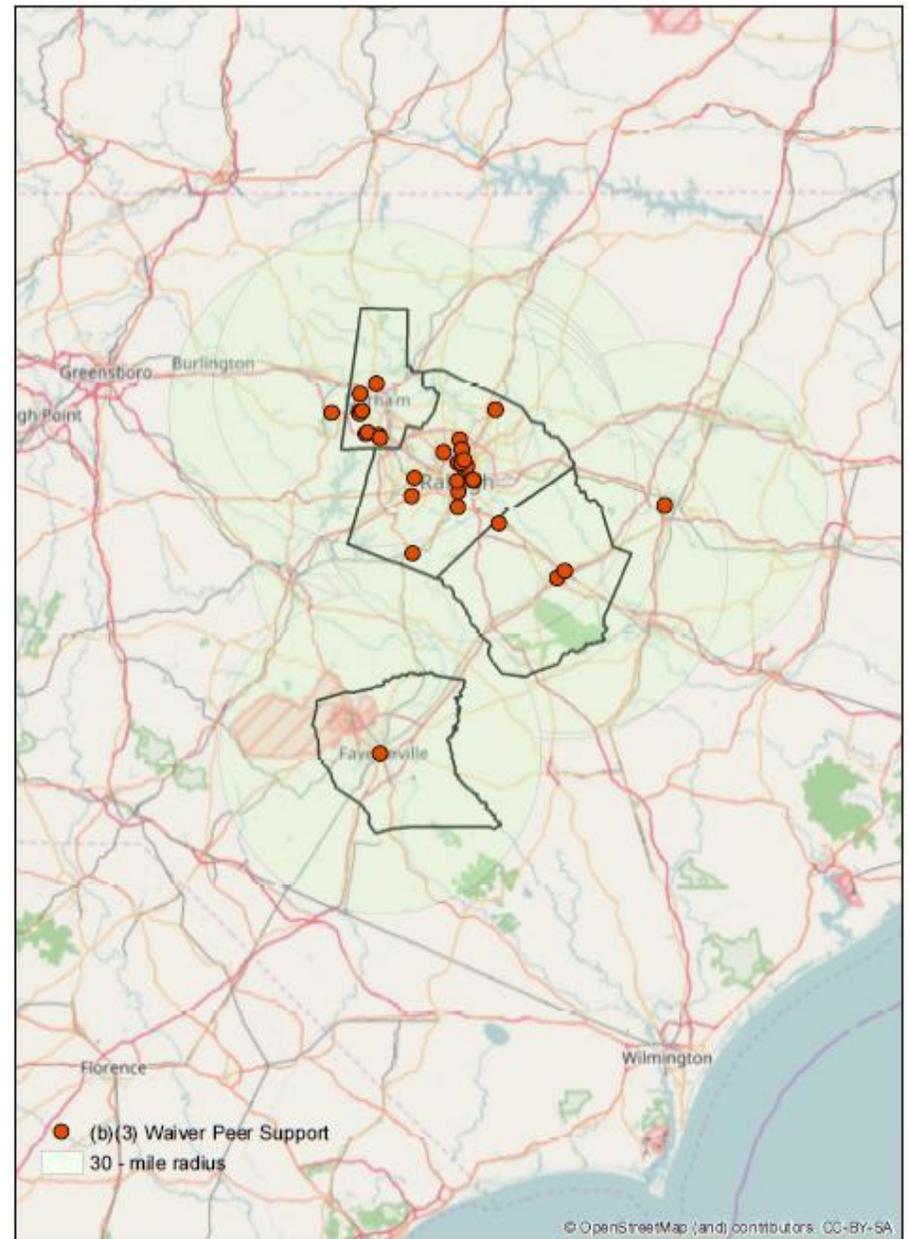
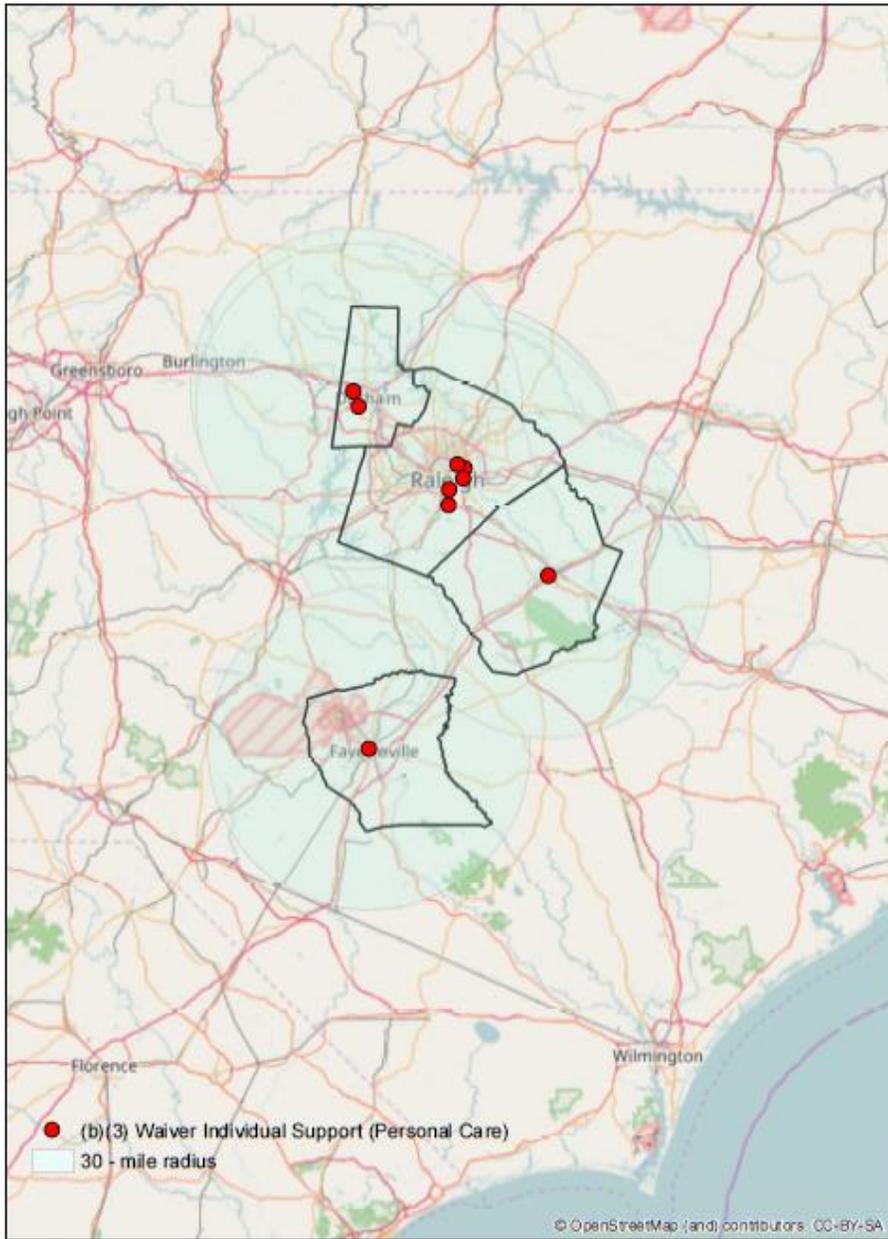
# COMMUNITY / MOBILE SERVICES

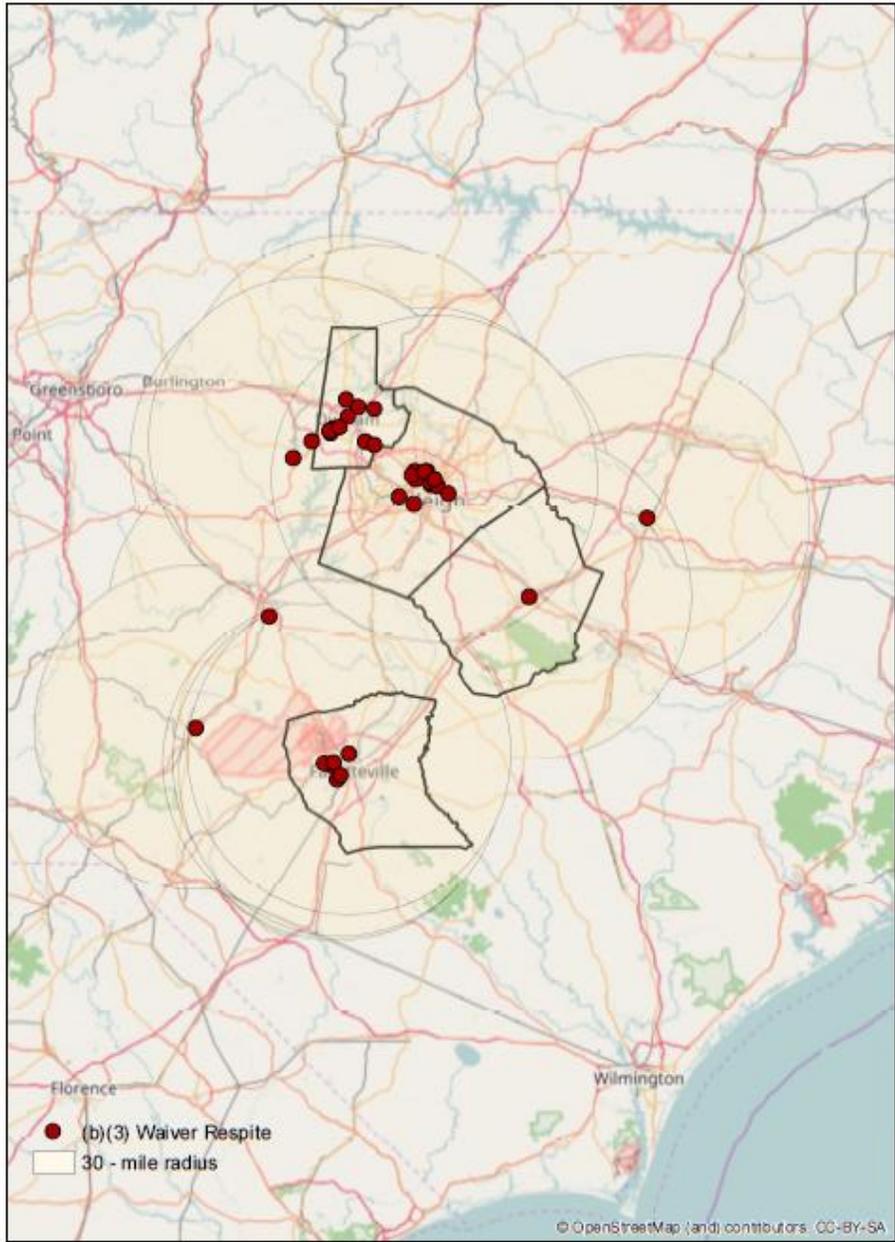




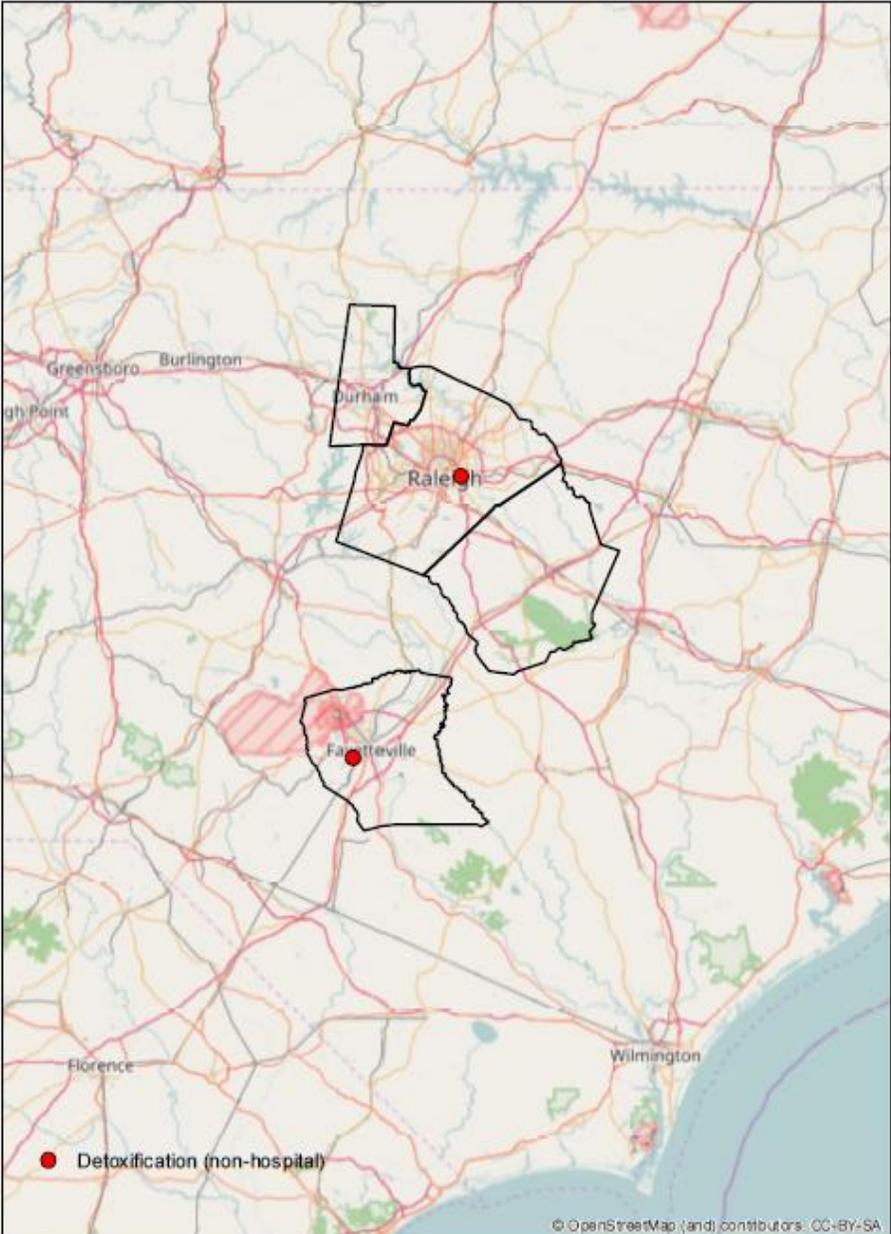
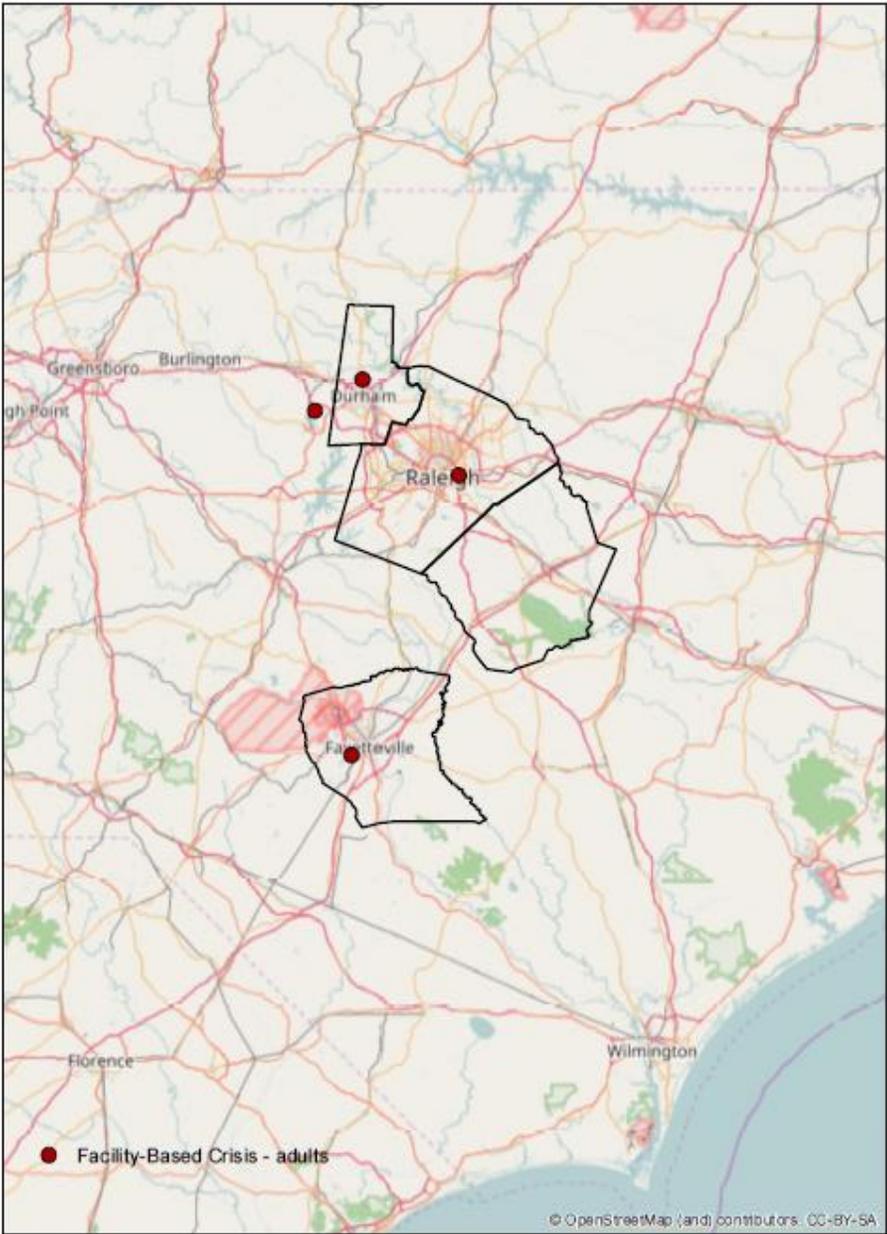




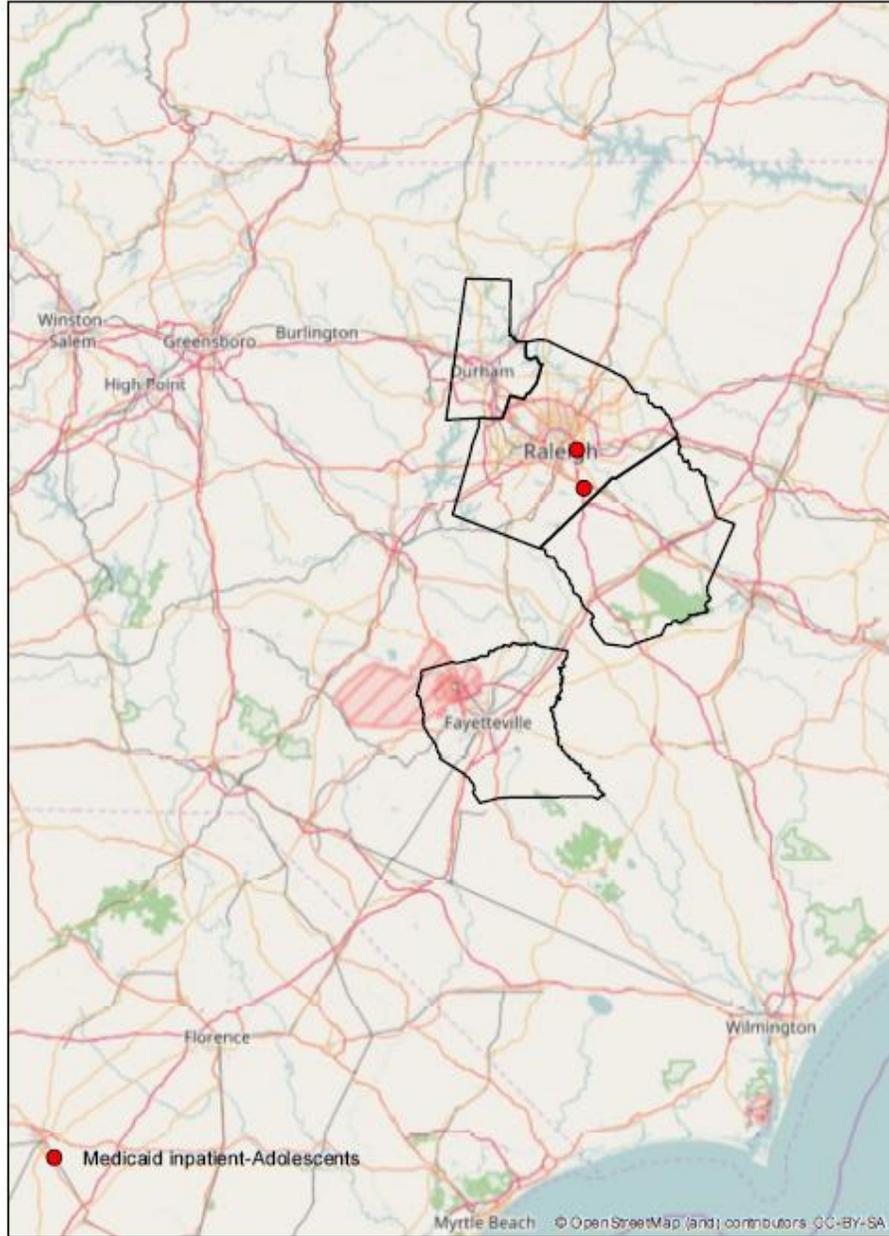
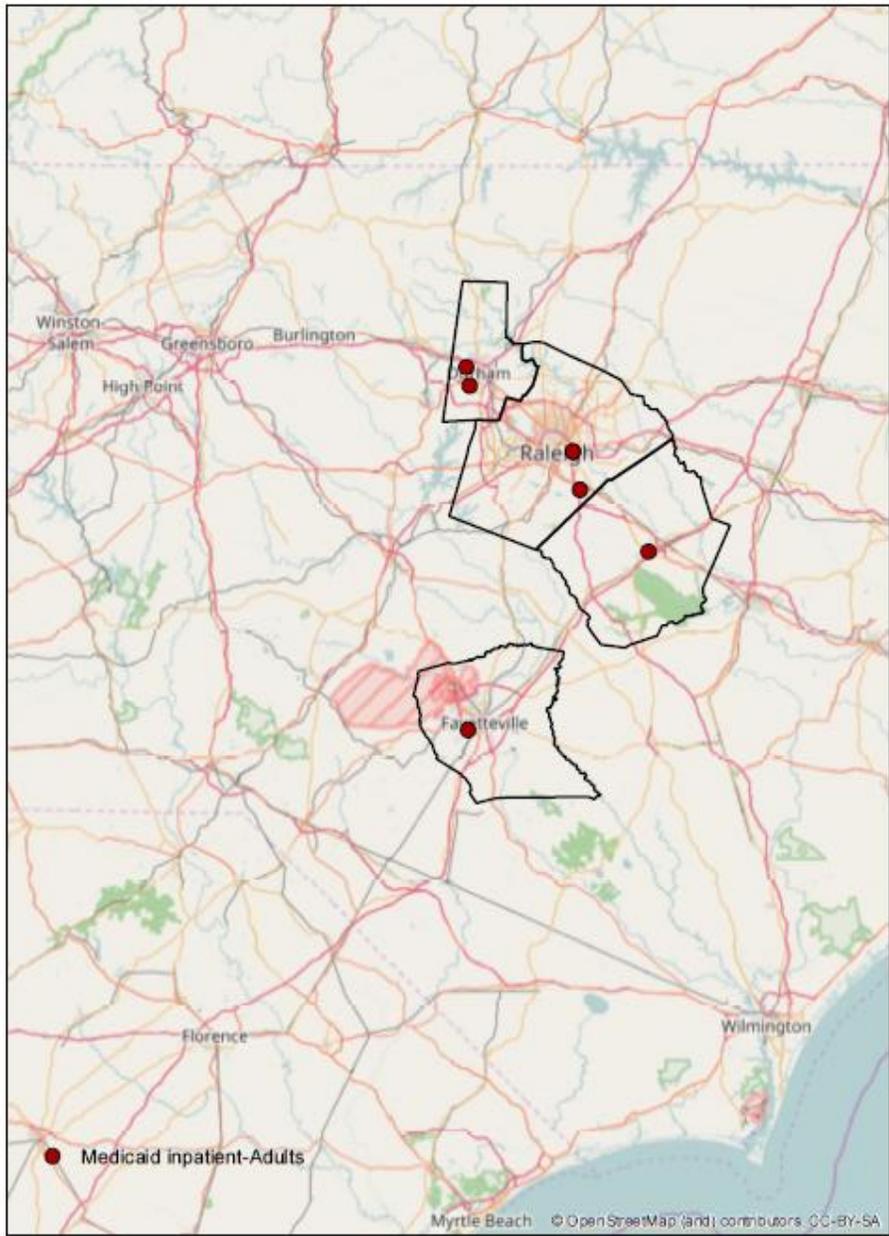




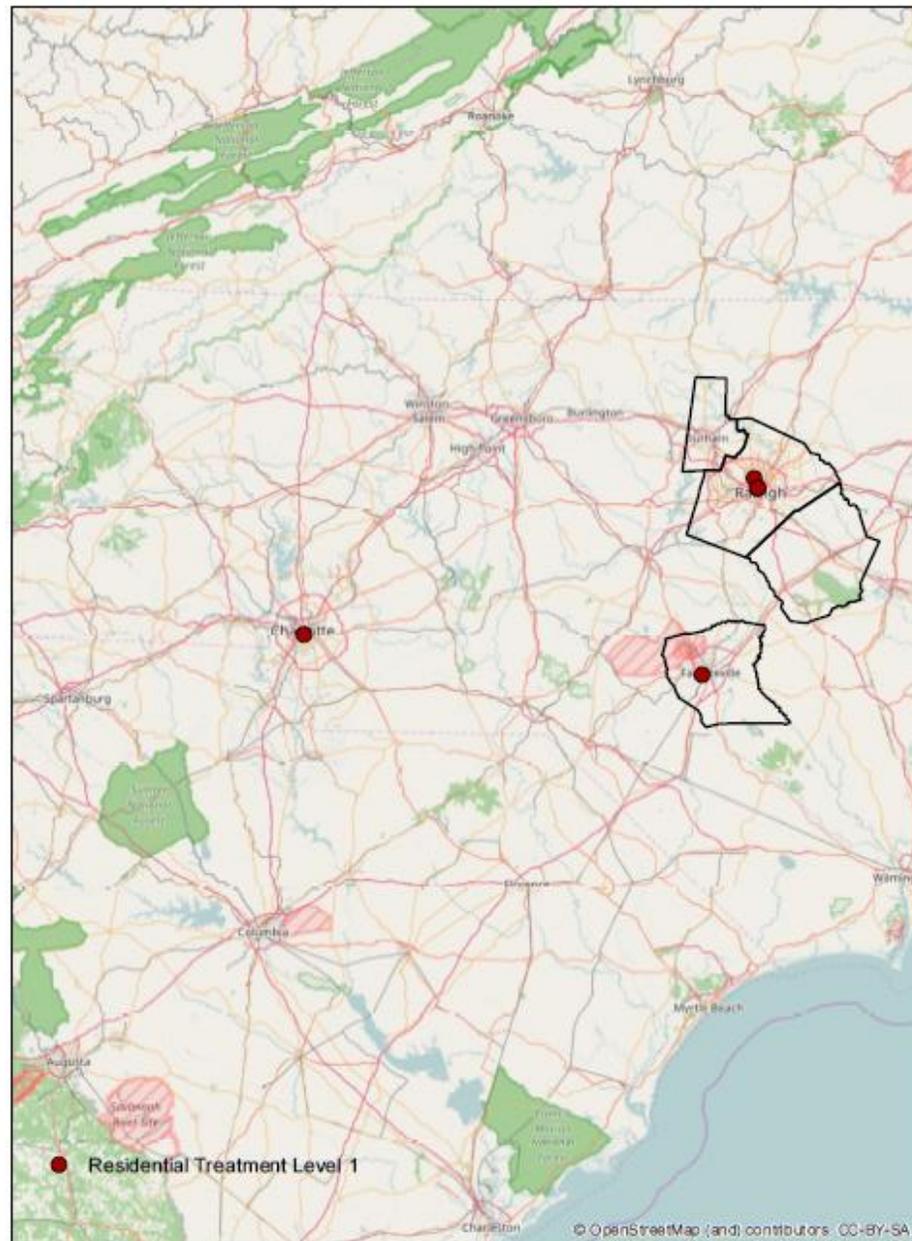
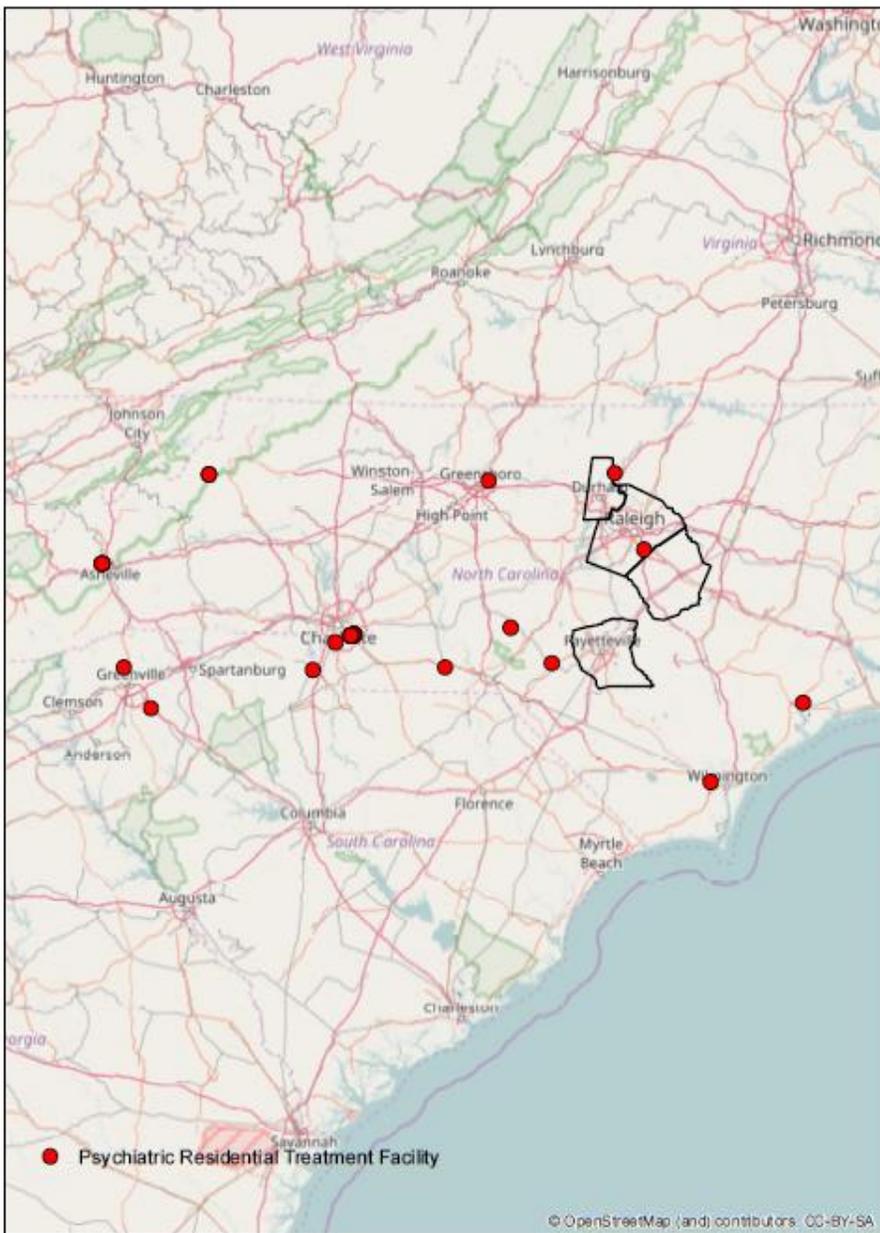
# CRISIS SERVICES

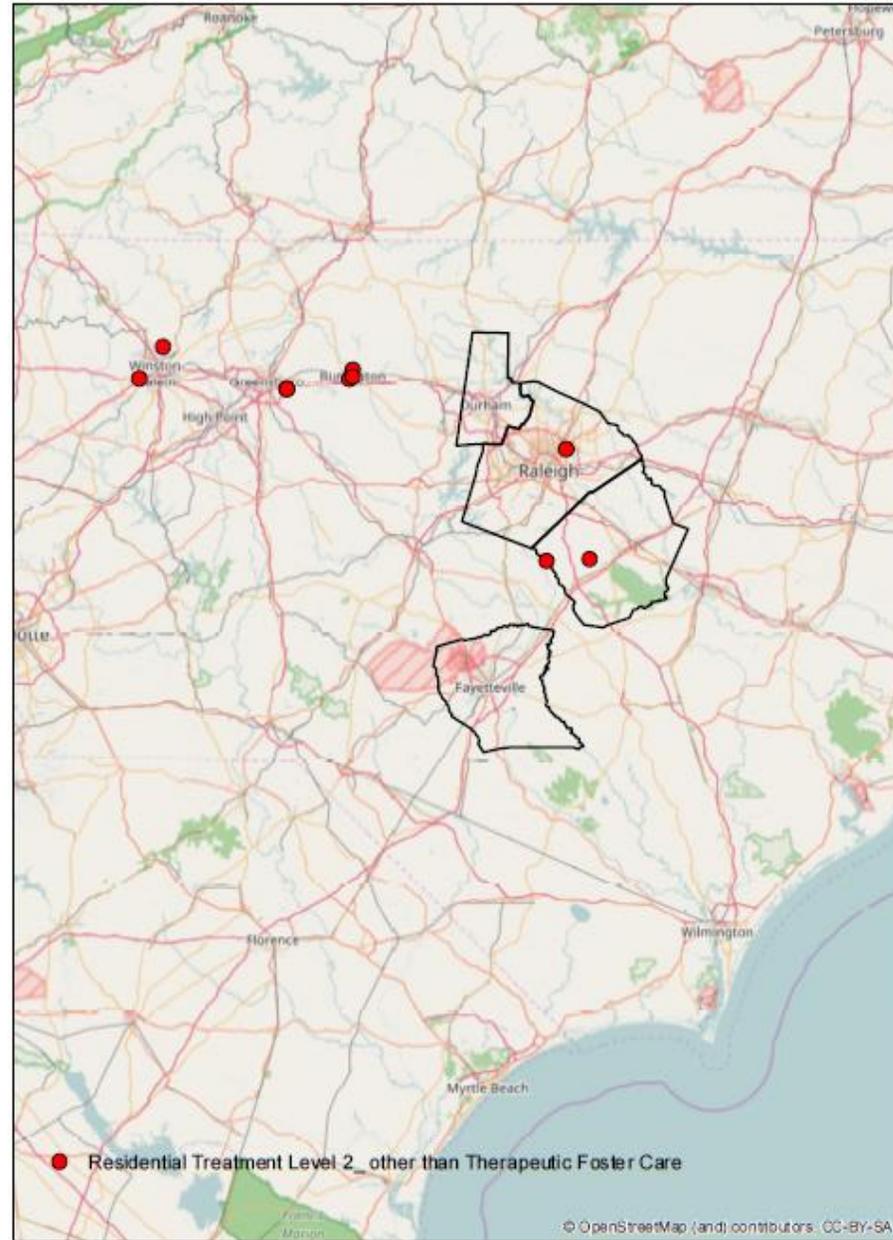
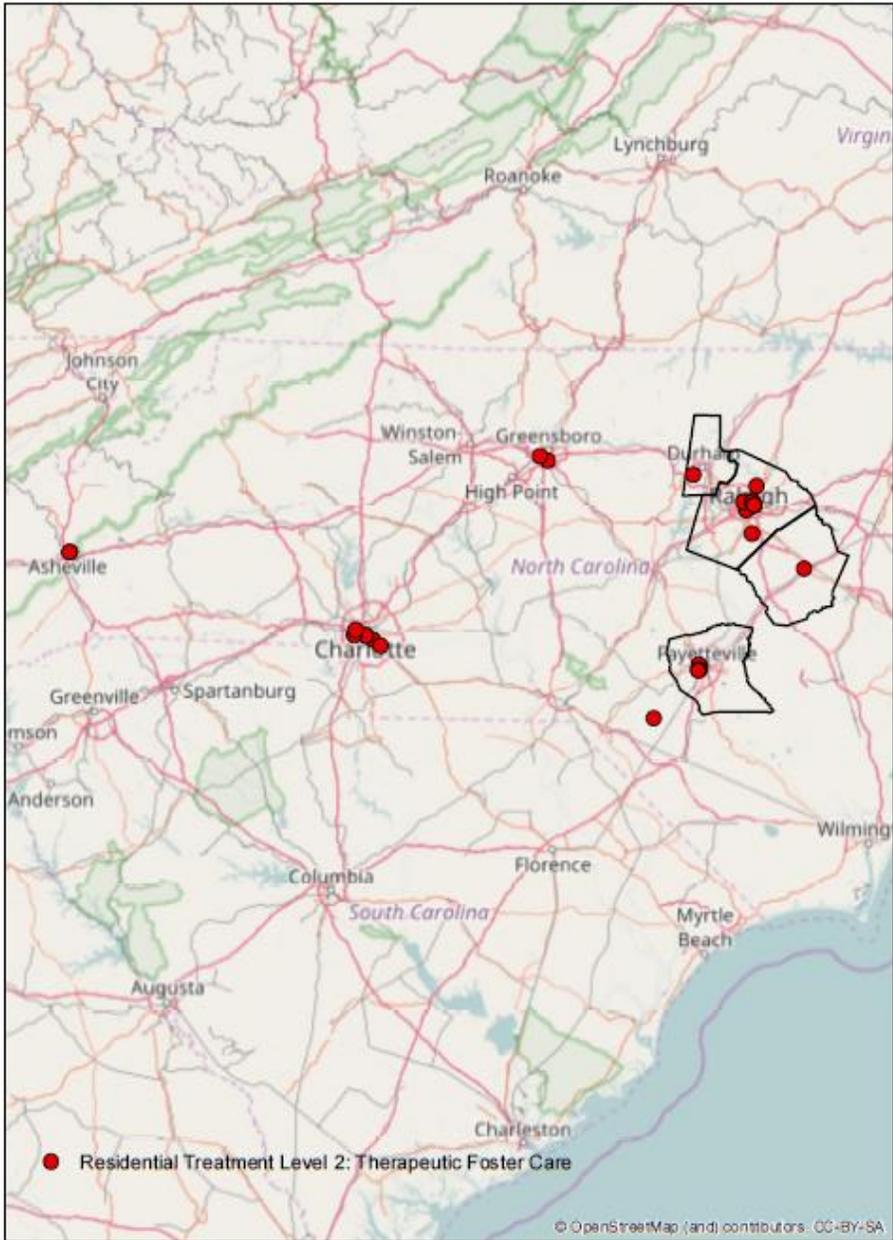


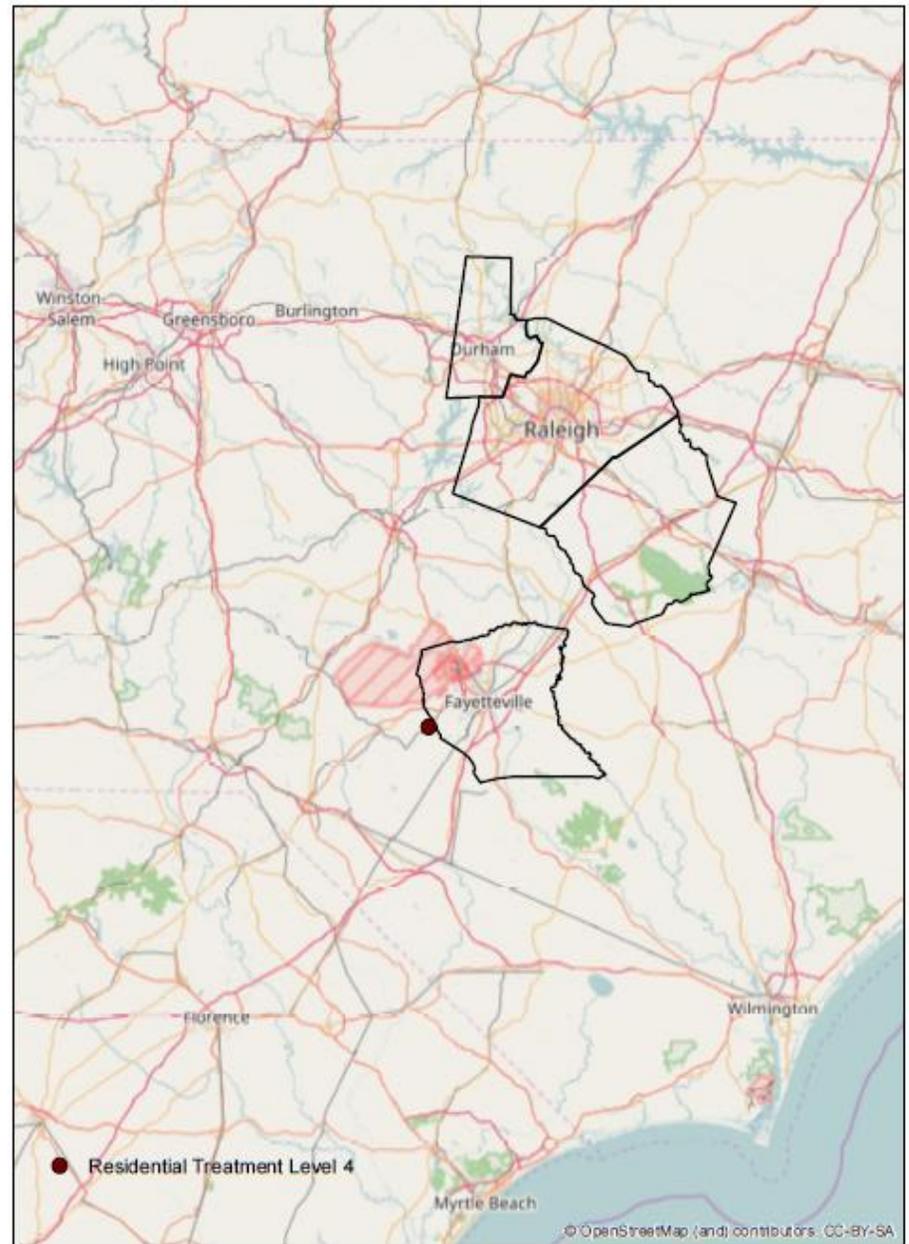
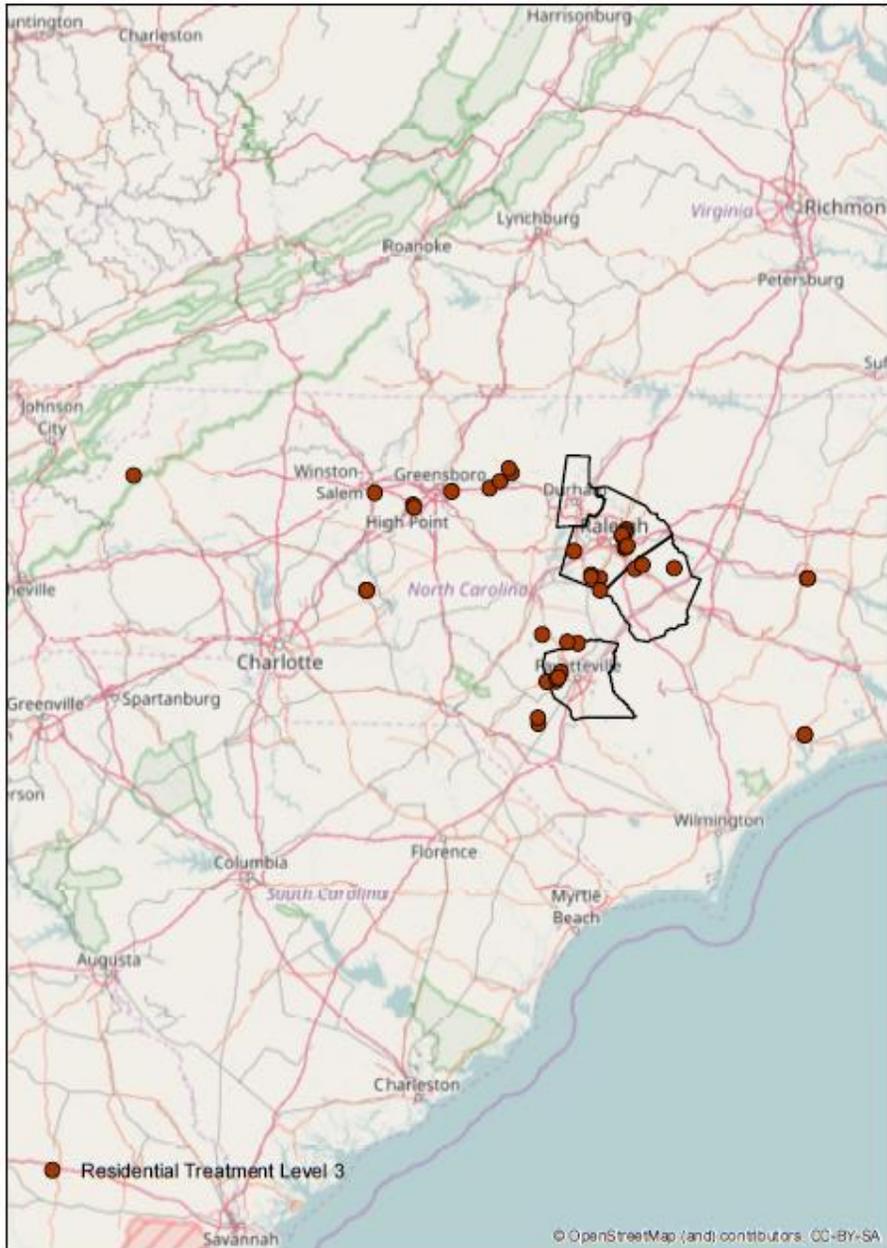
# INPATIENT SERVICES

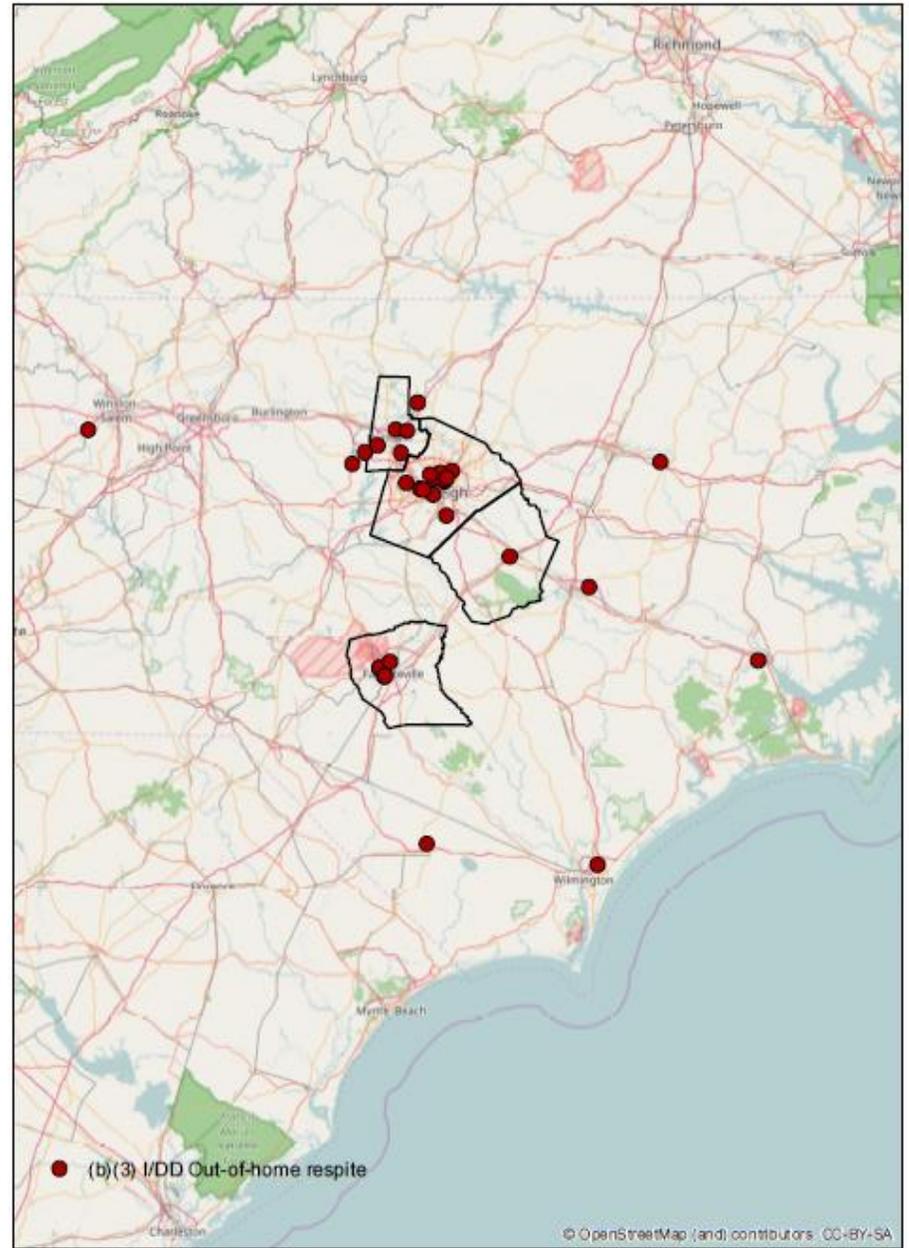
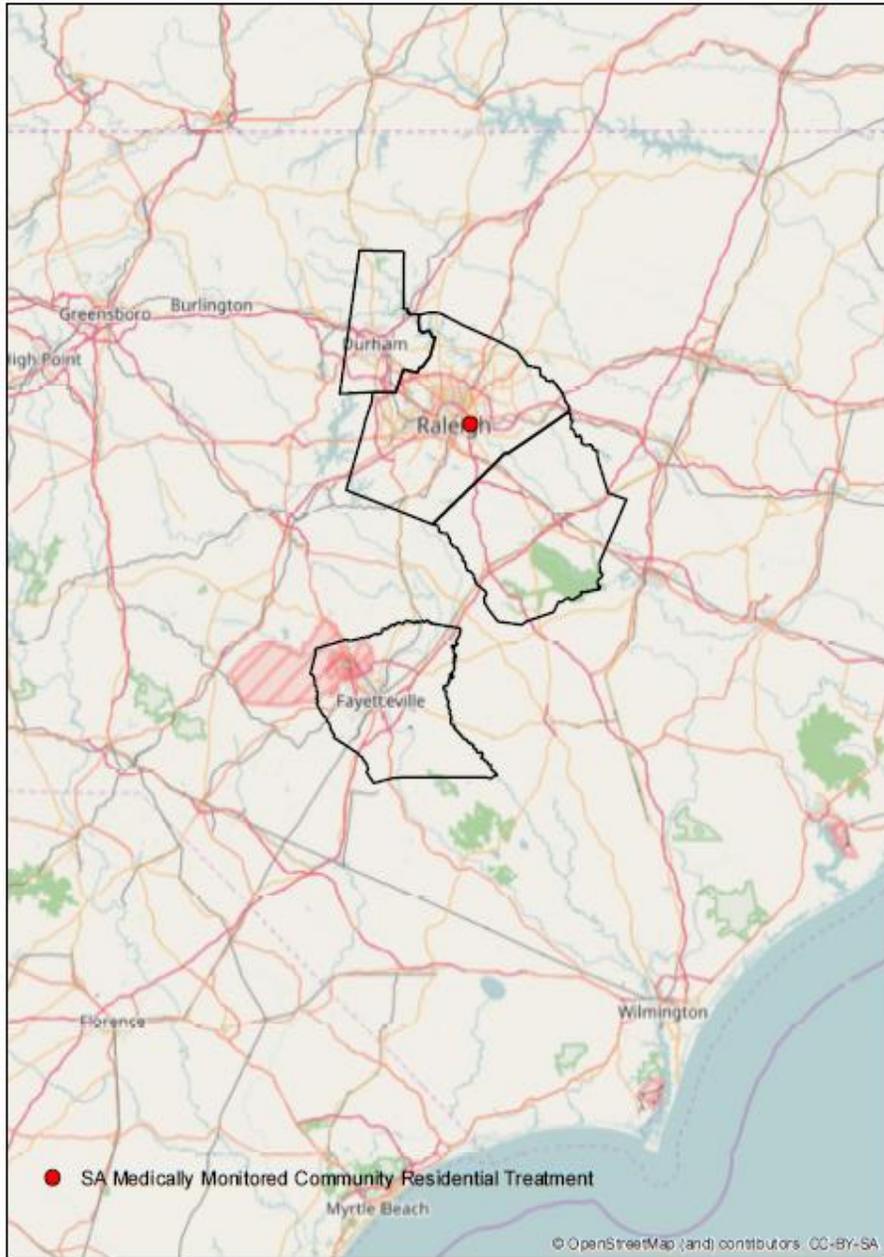


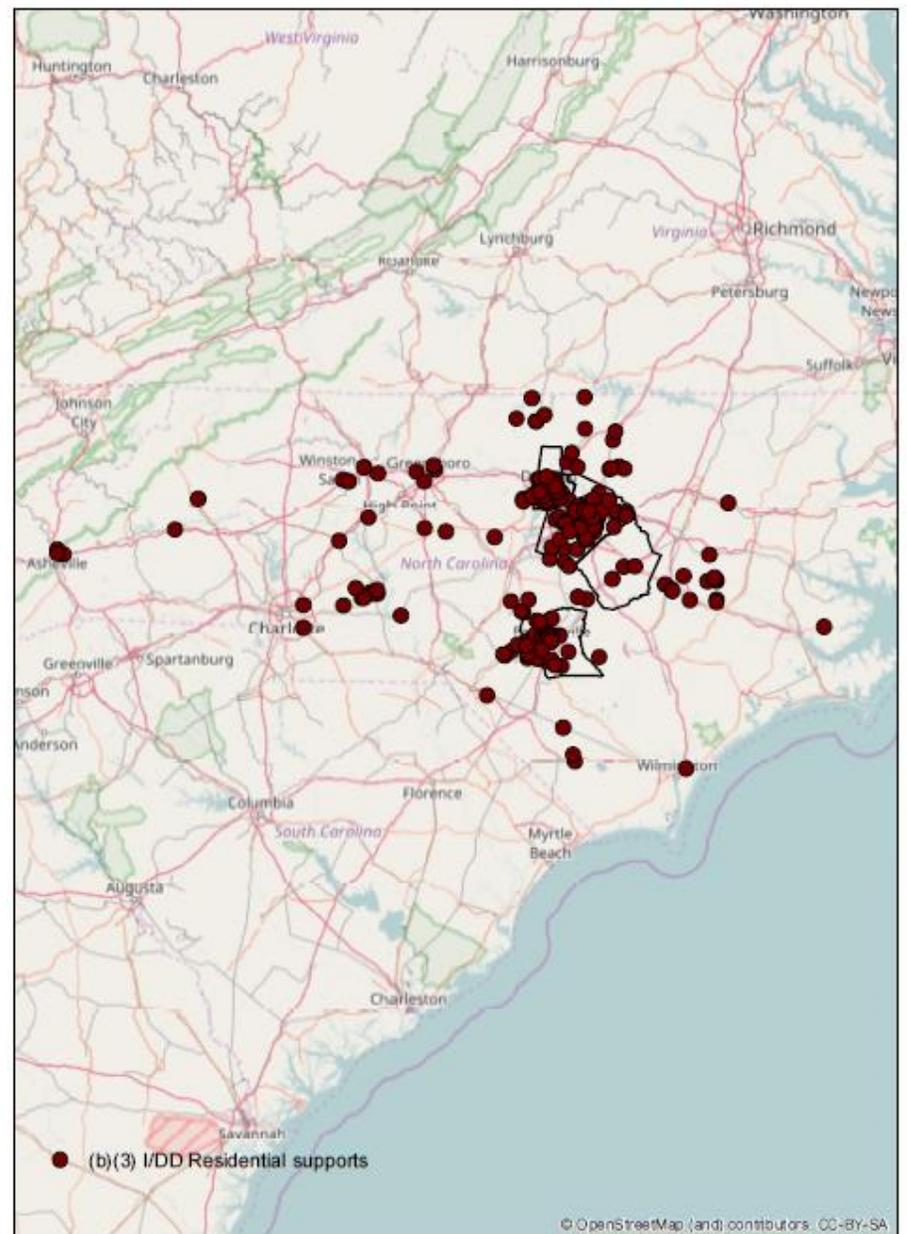
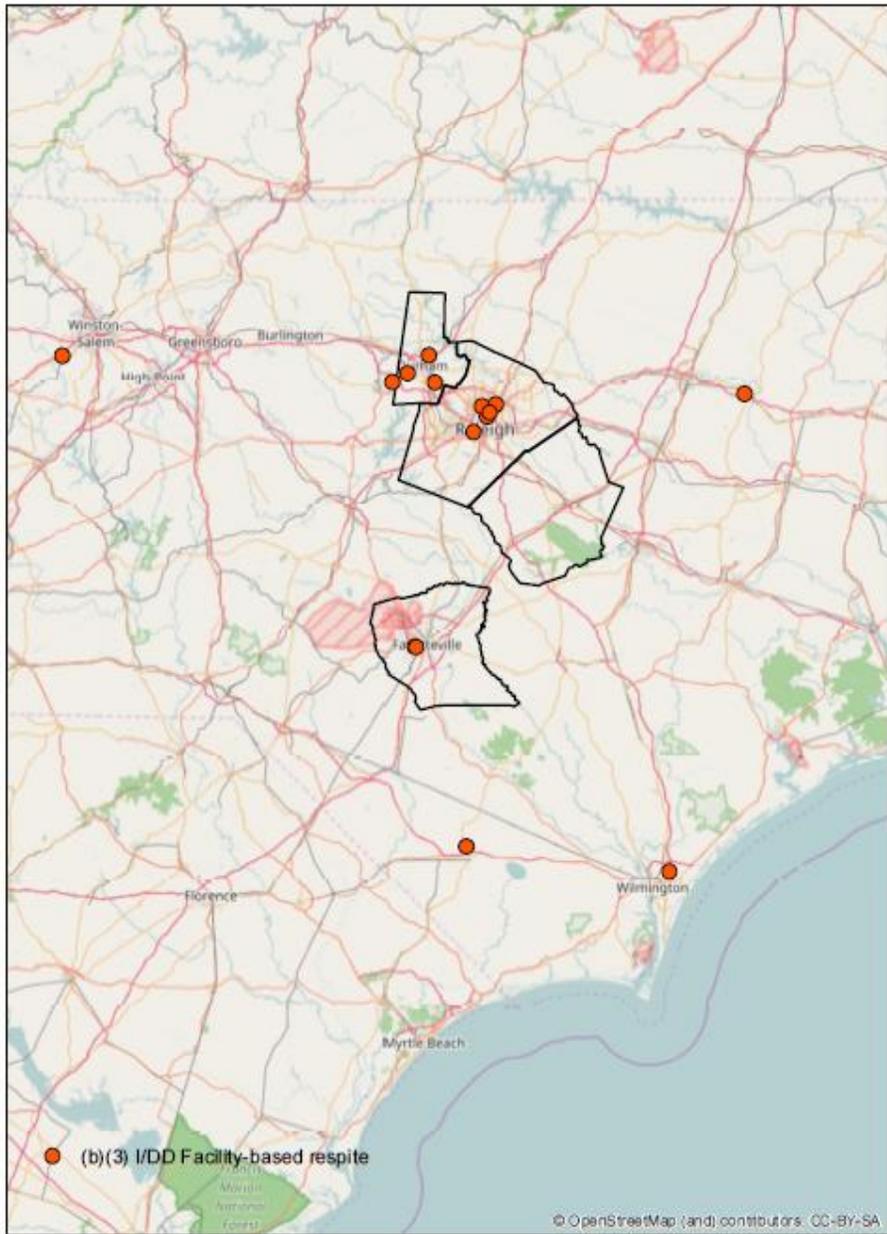
# SPECIALIZED SERVICES

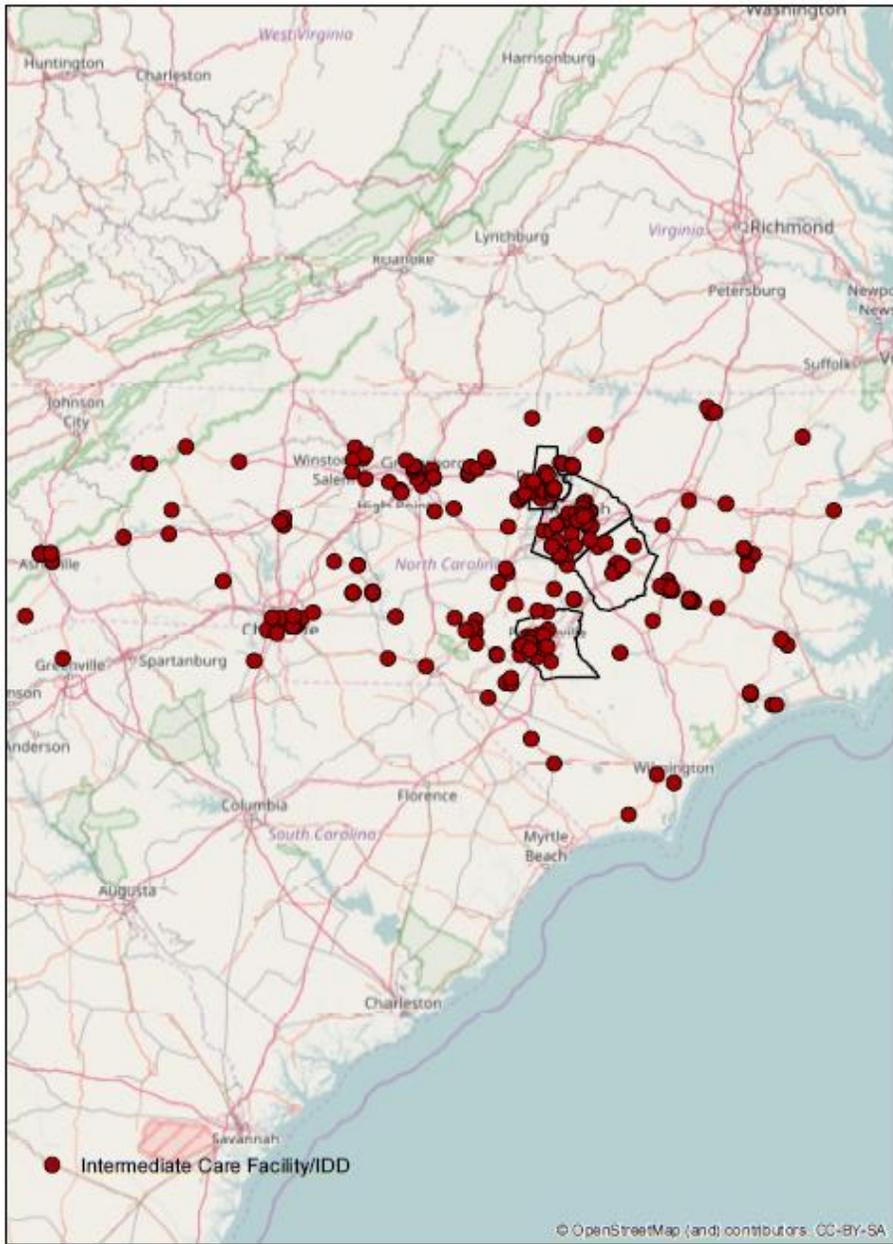




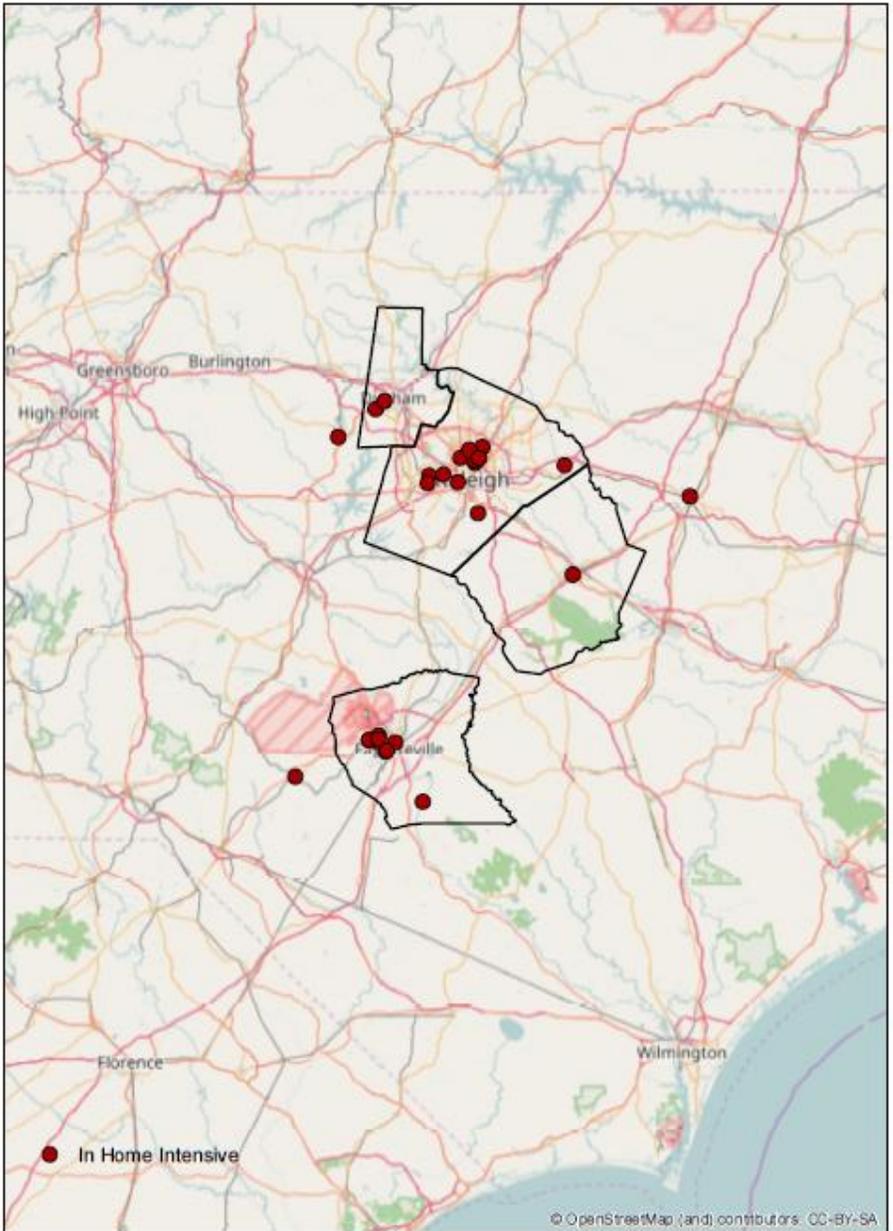
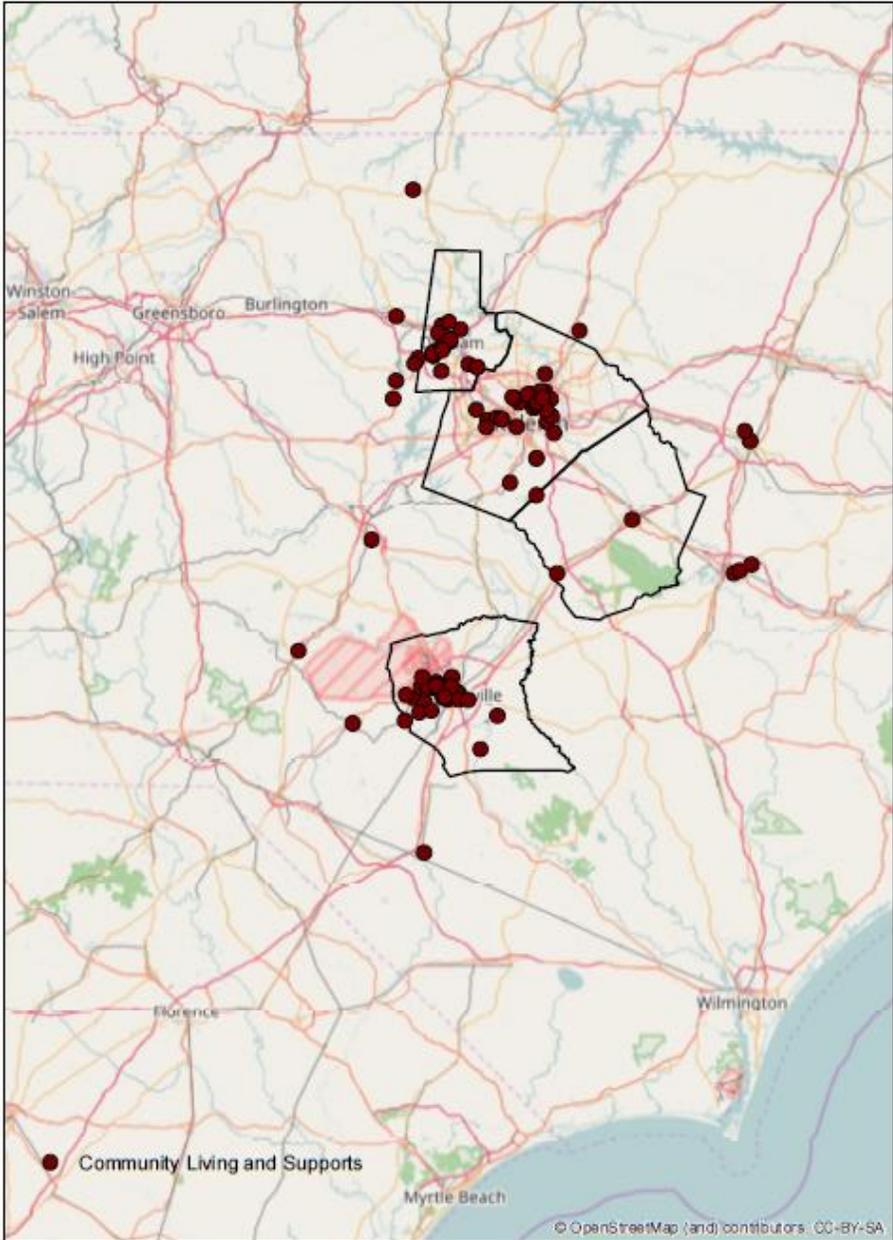


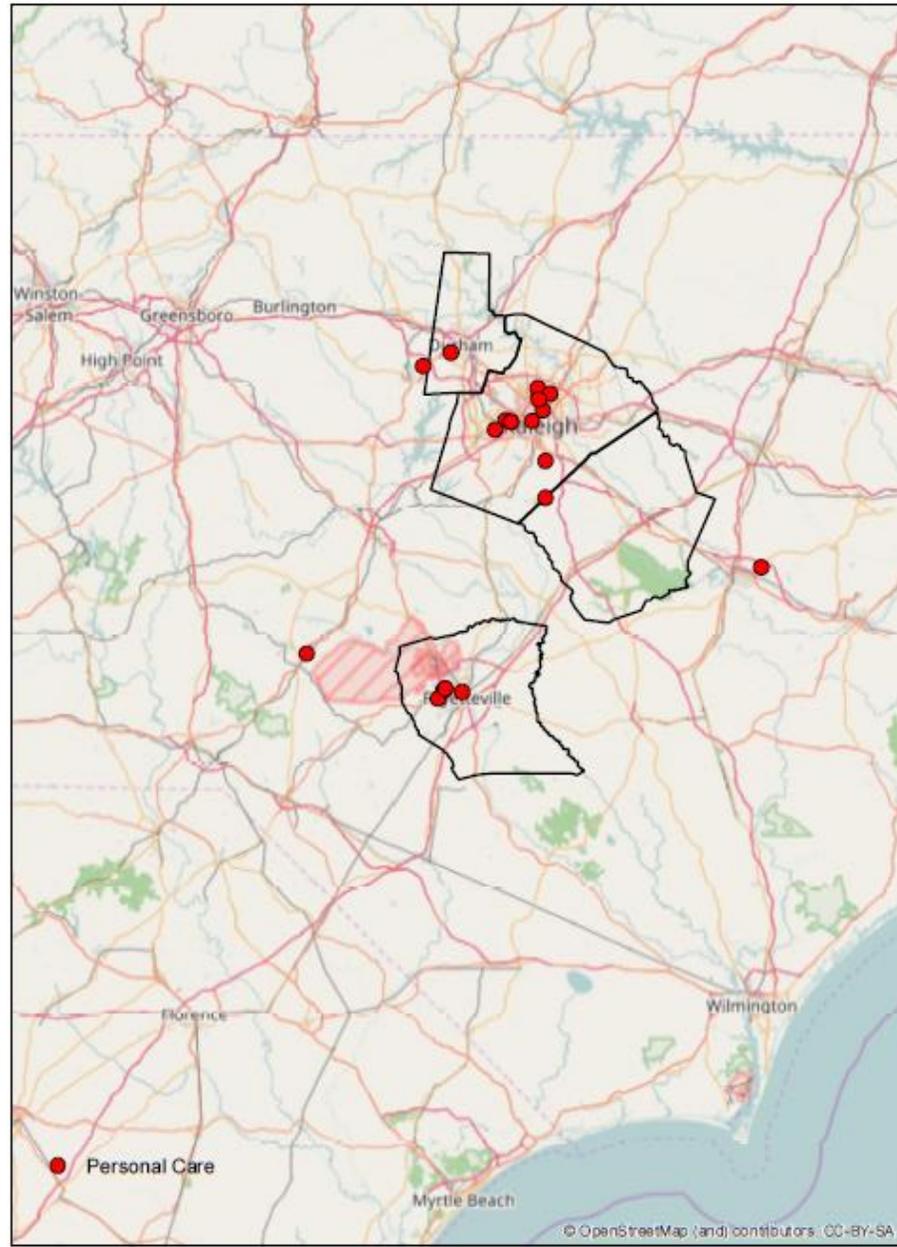
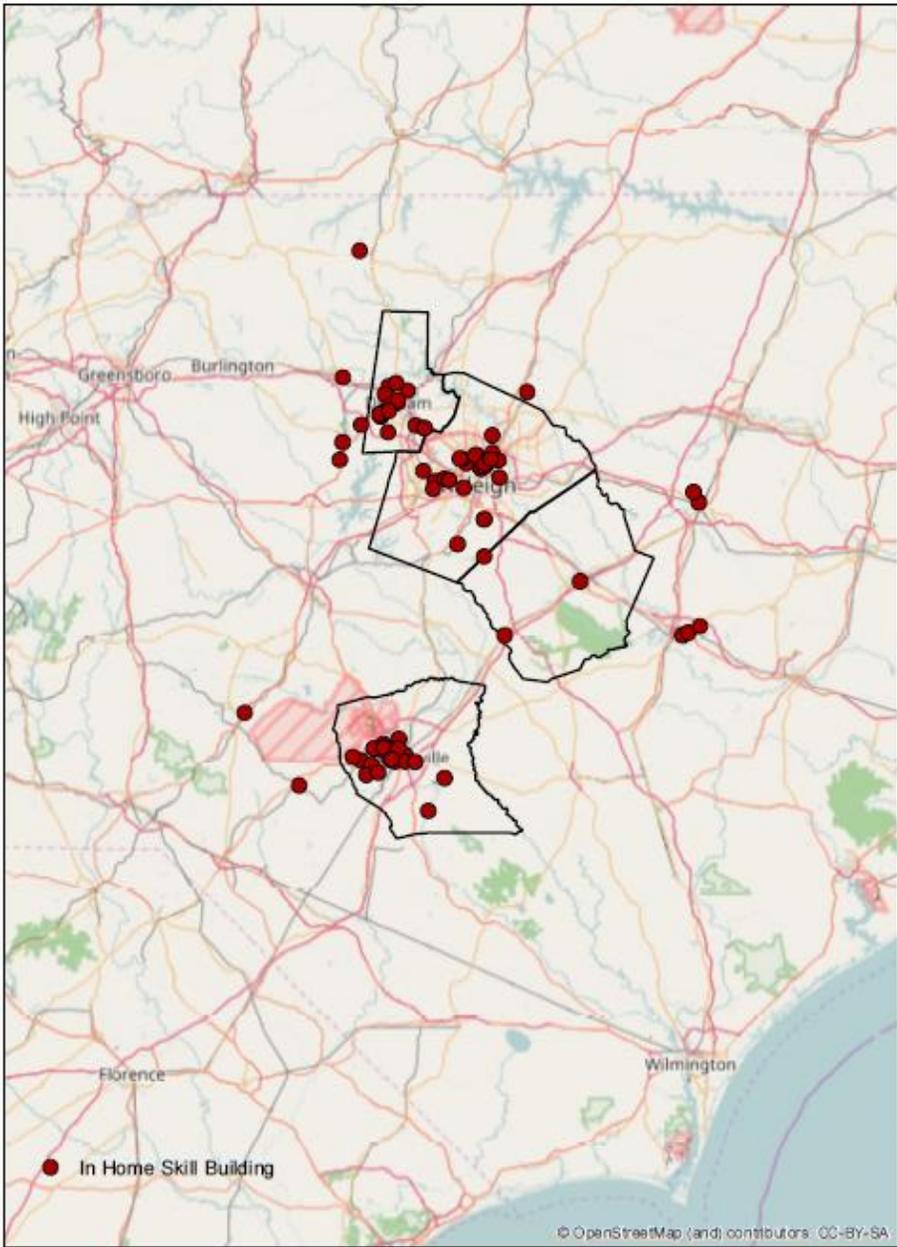


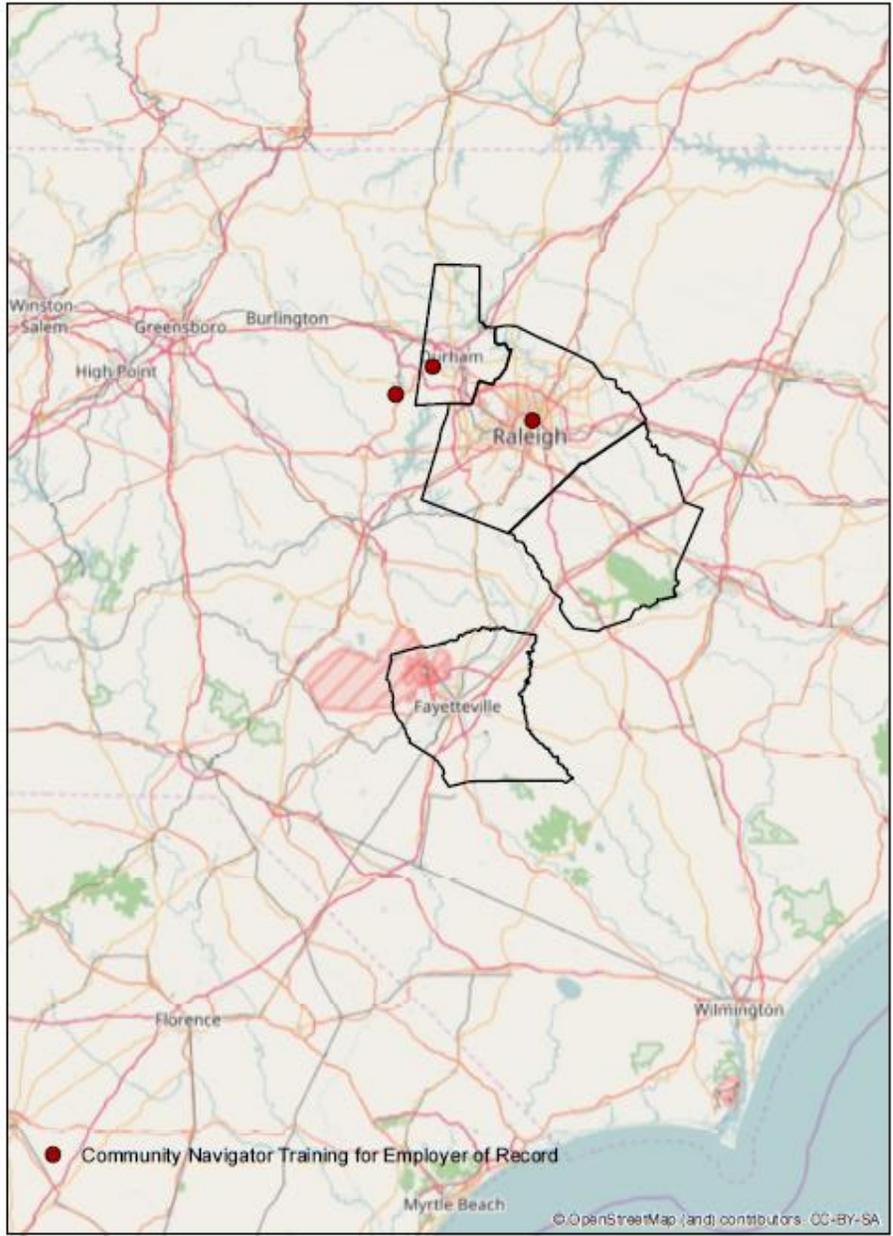
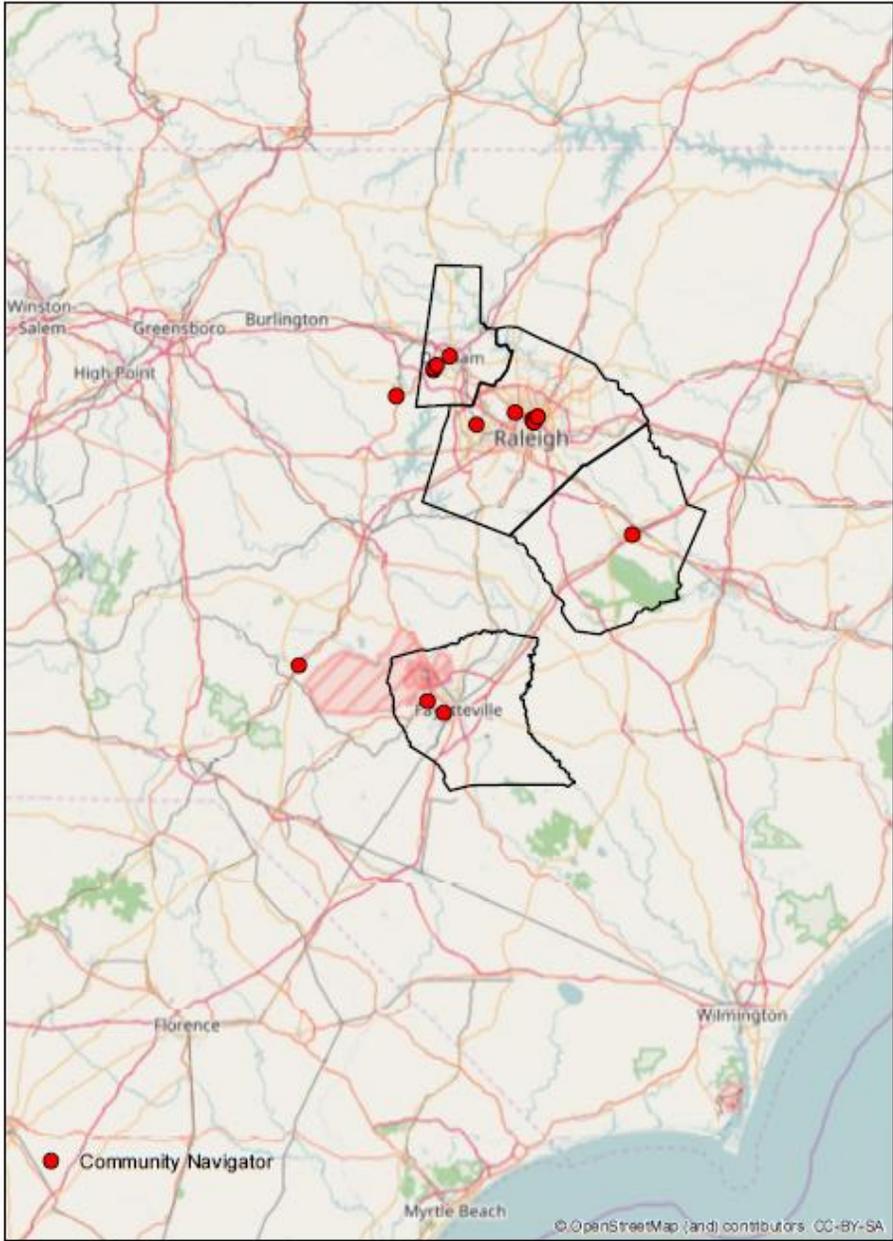


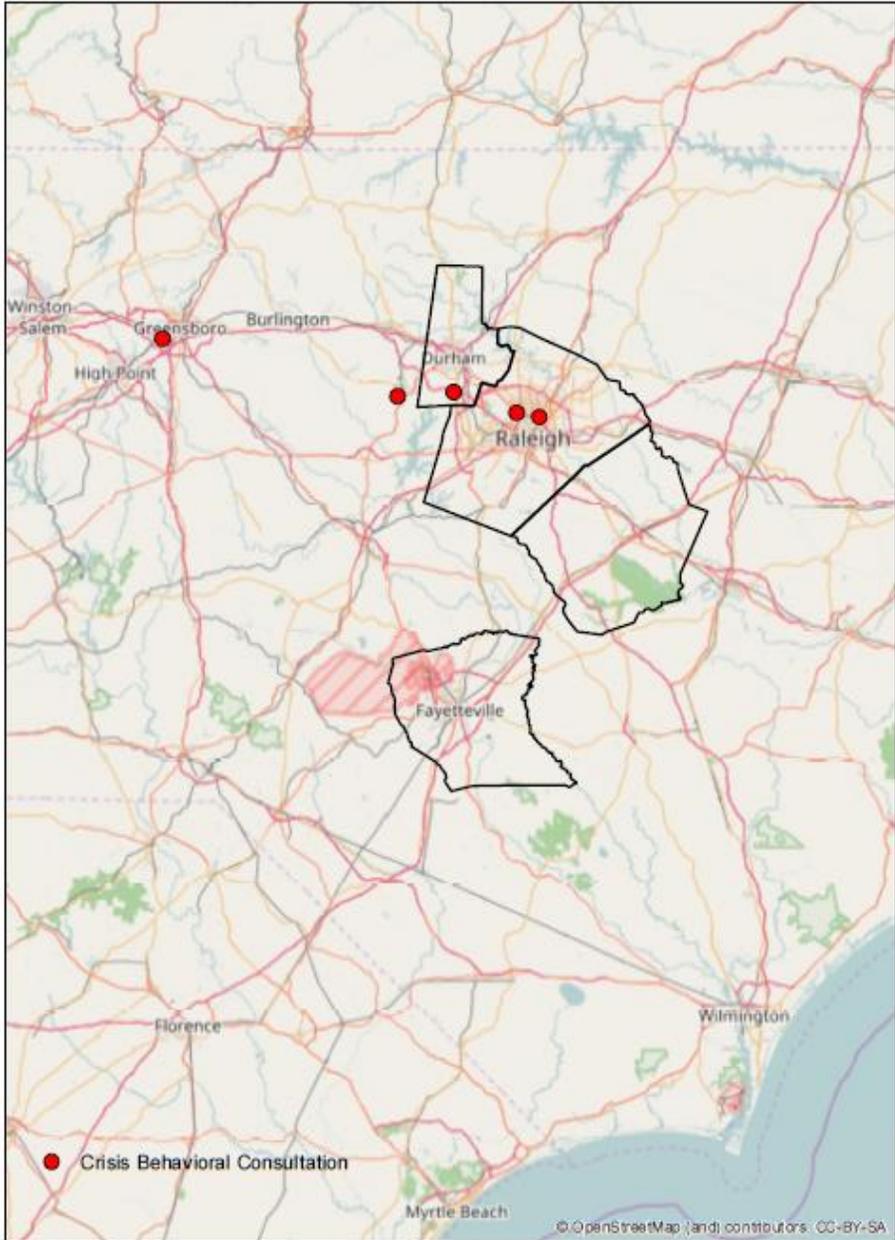
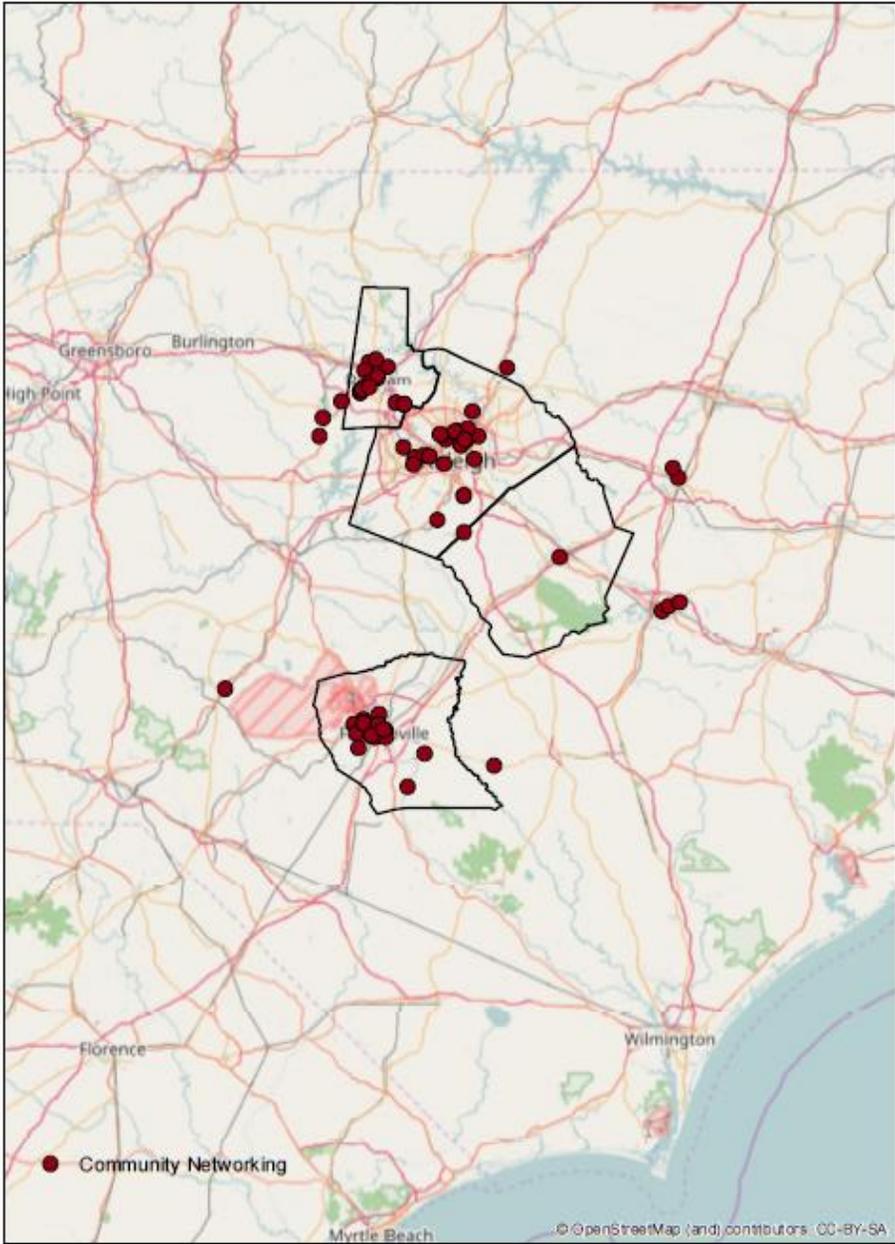


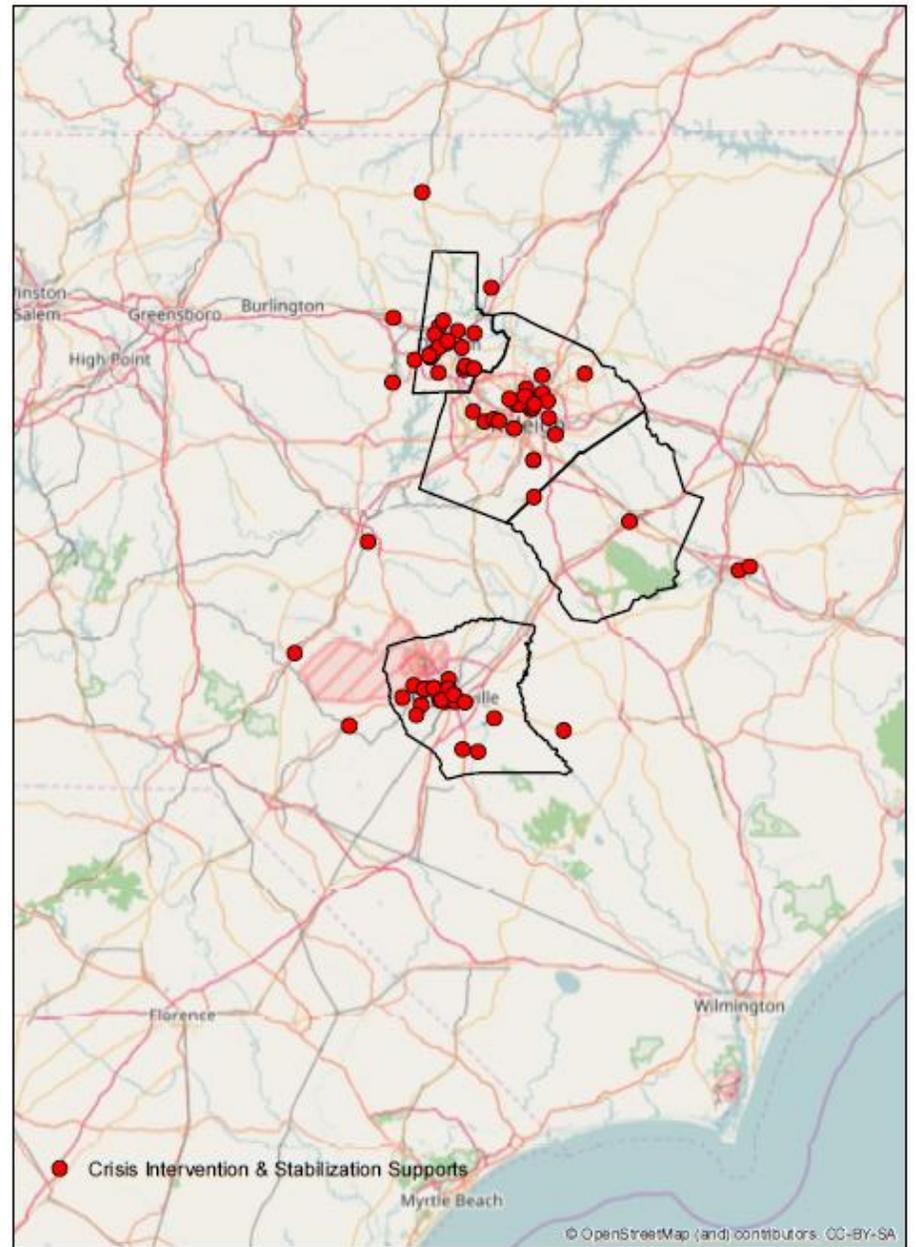
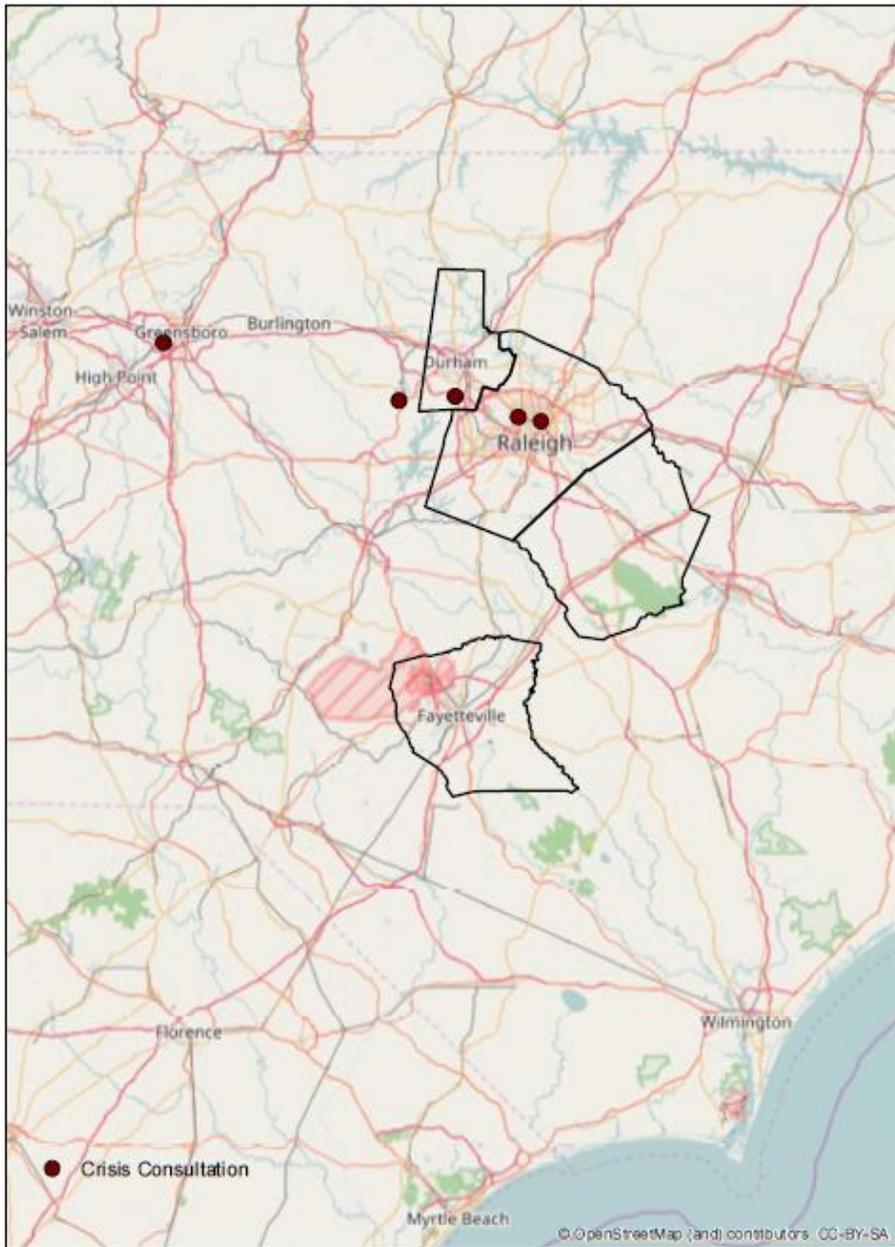
# C-WAIVER SERVICES (GROUP A)

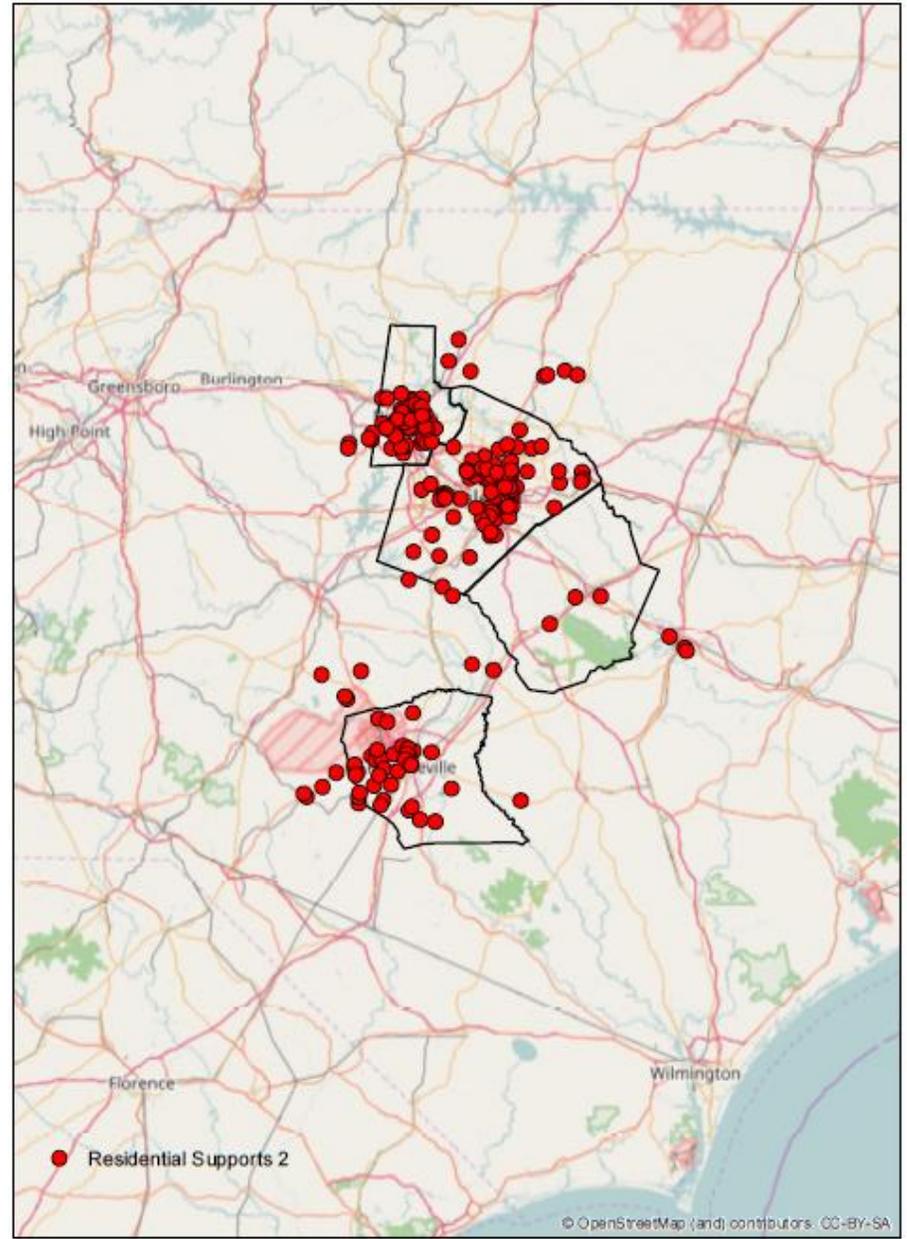
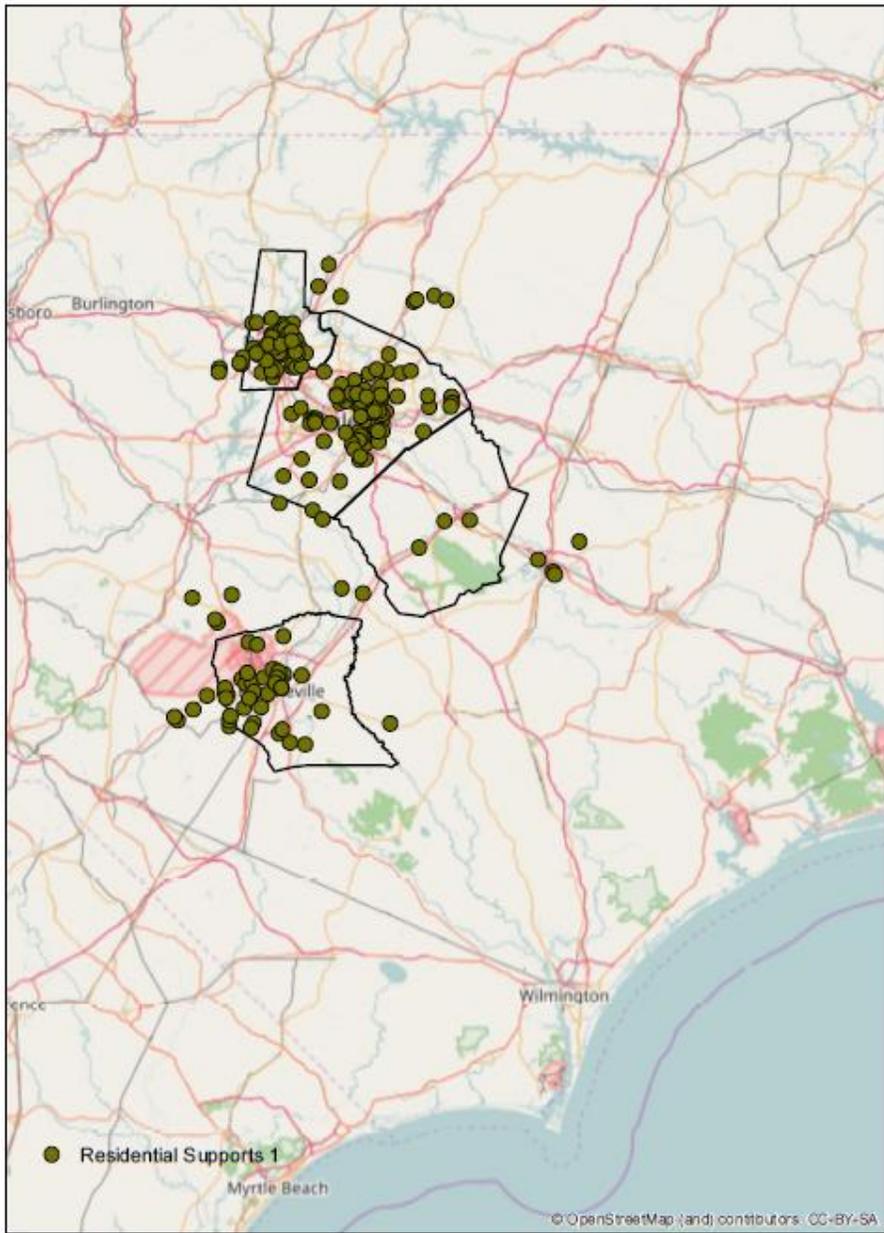


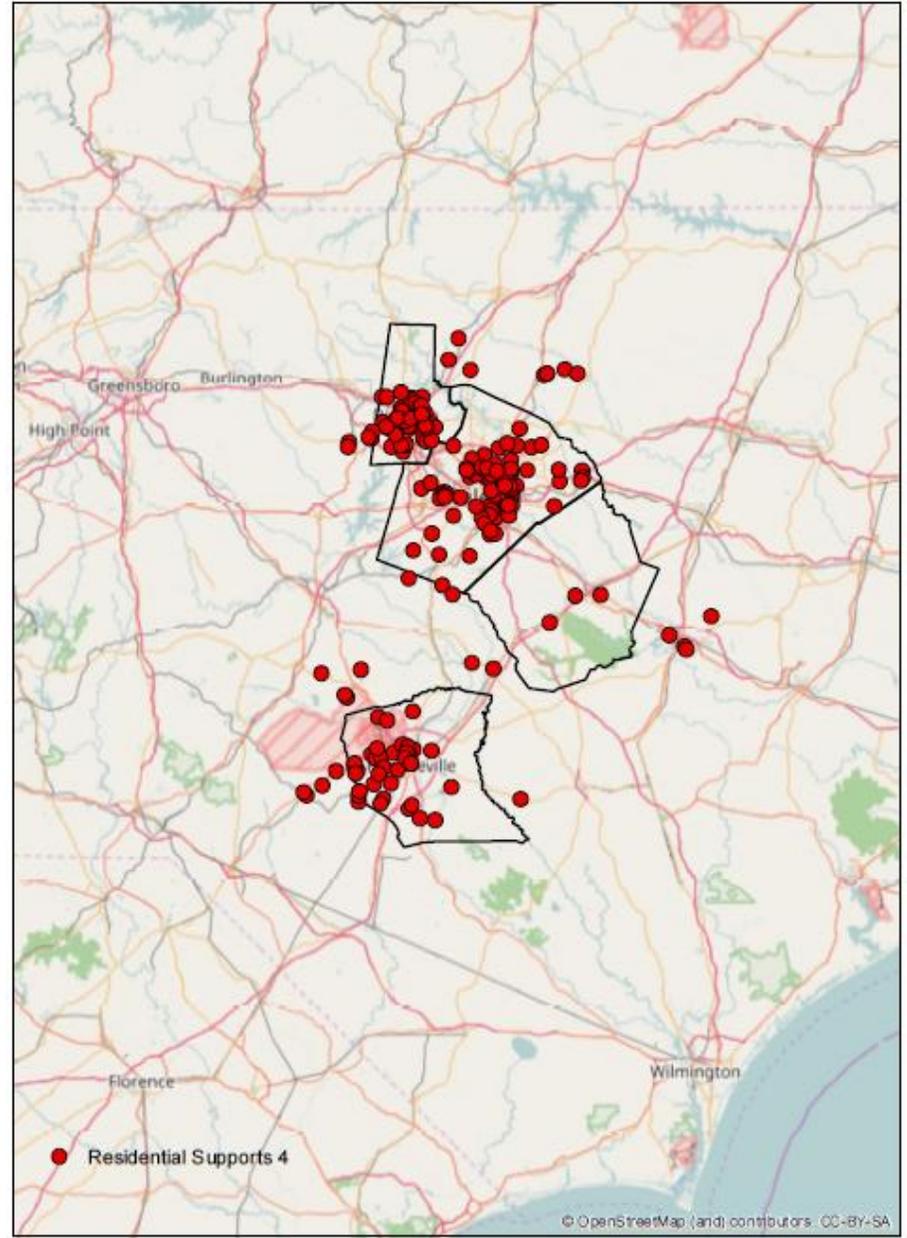
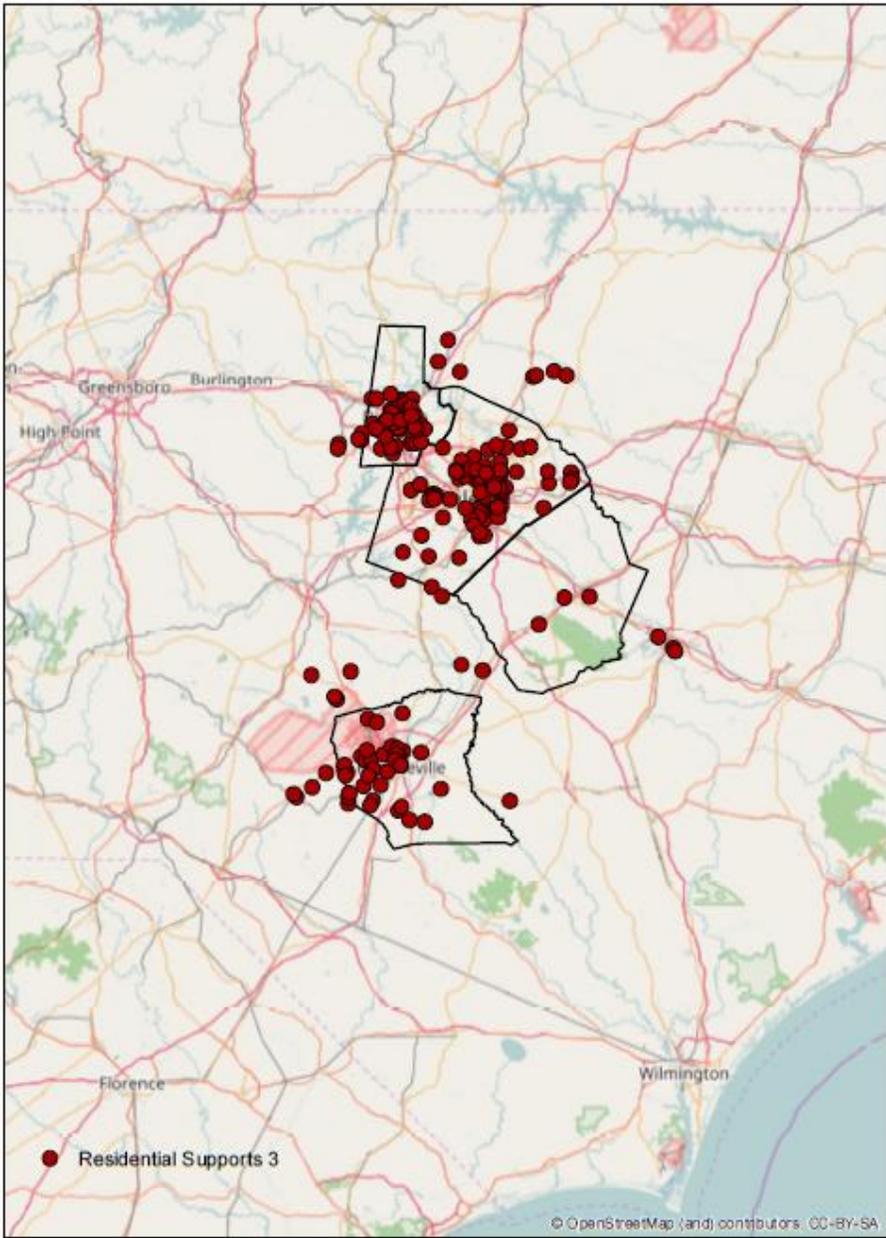


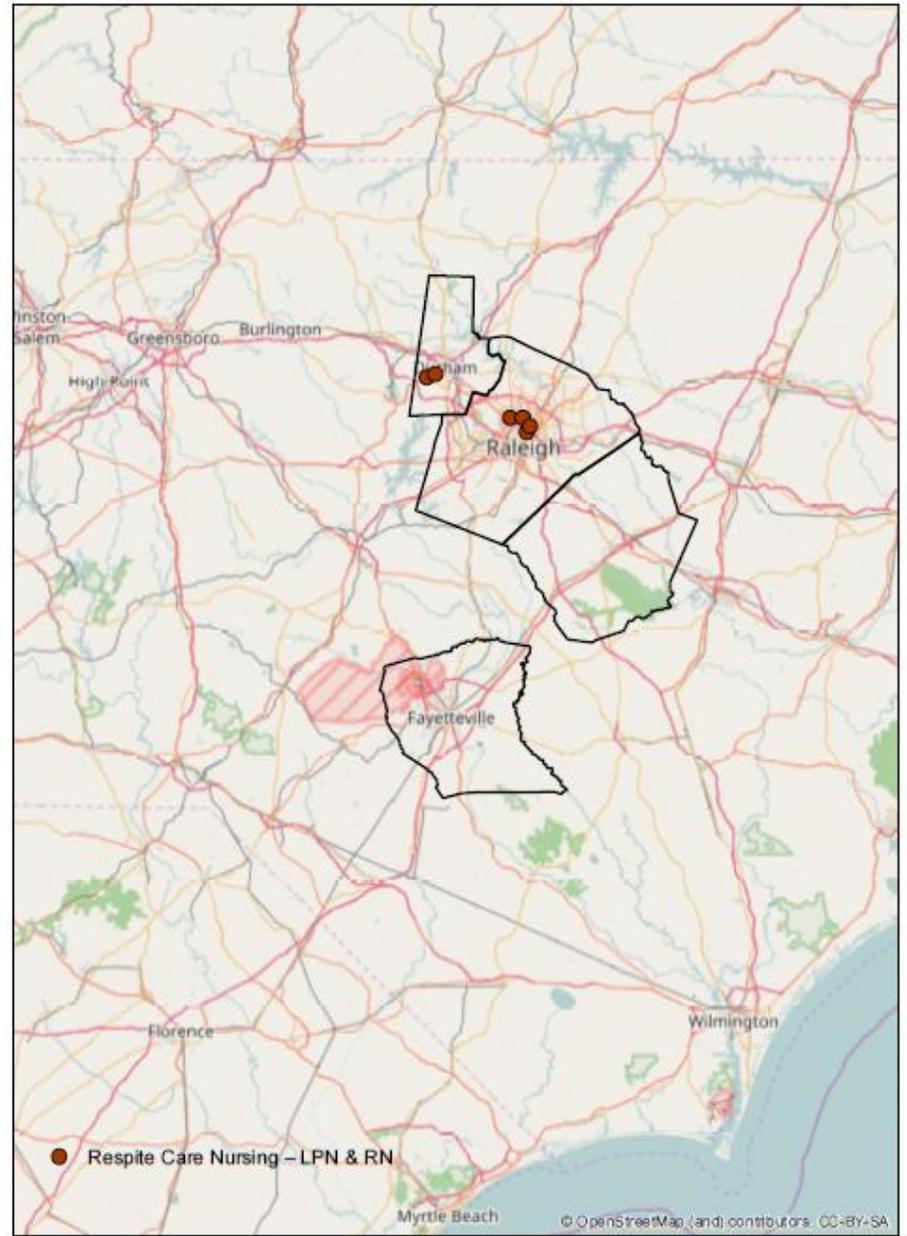
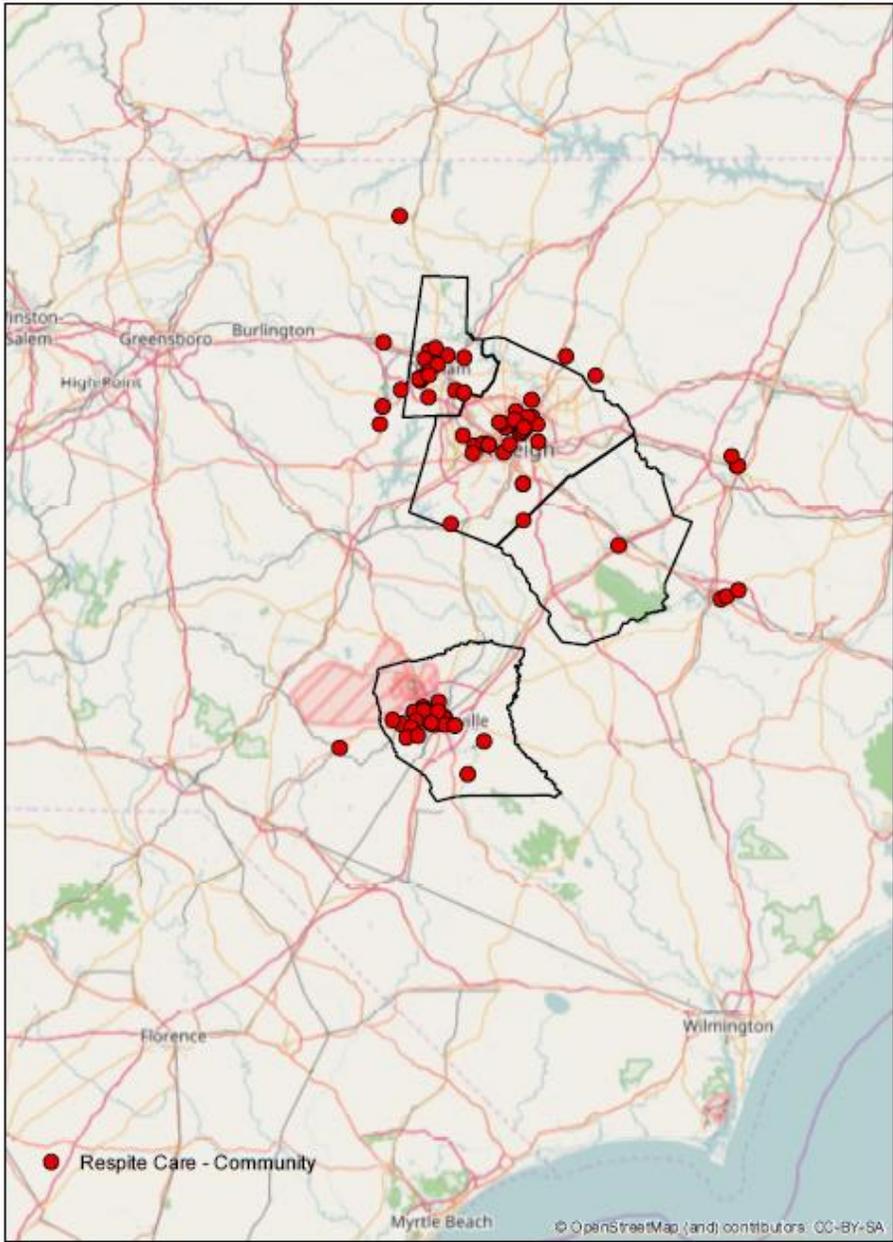


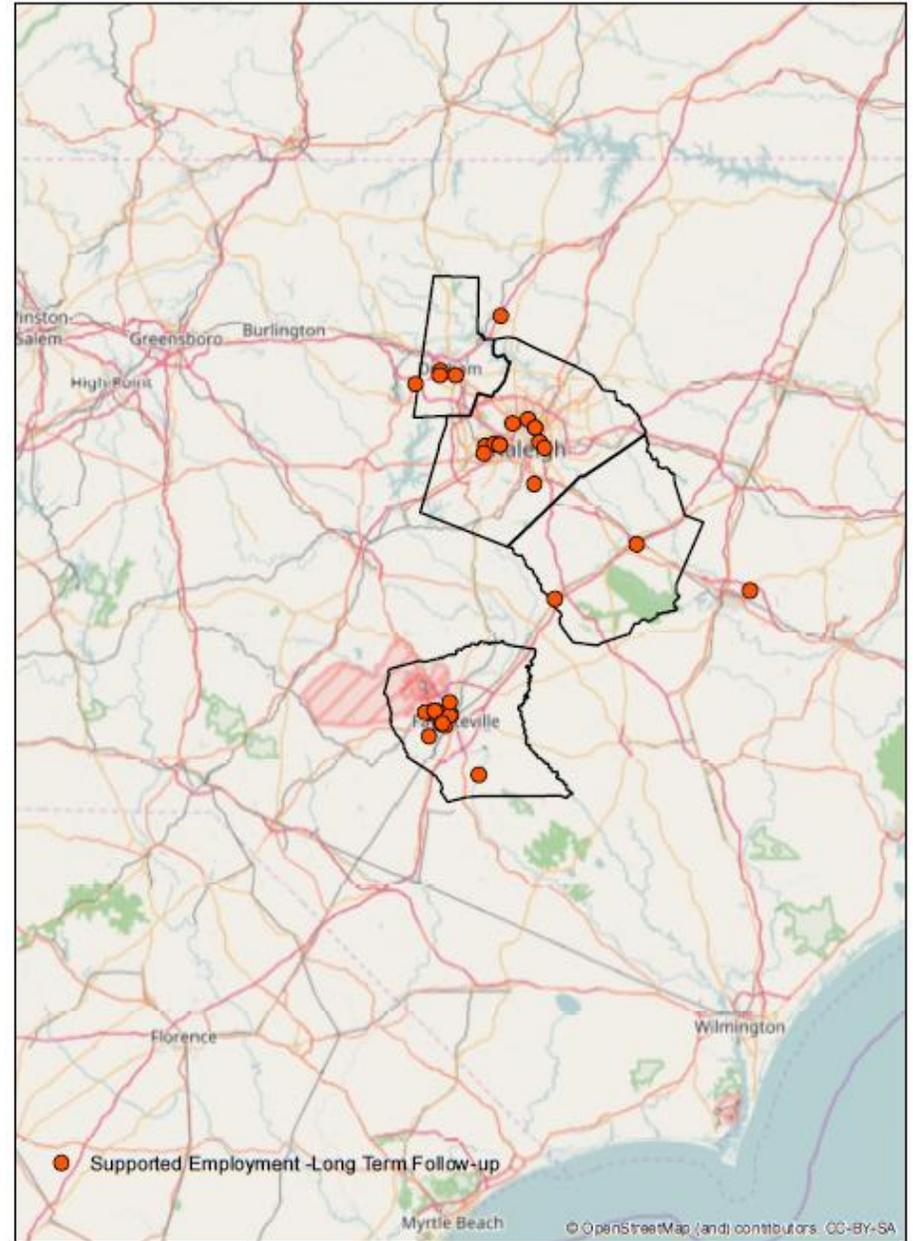
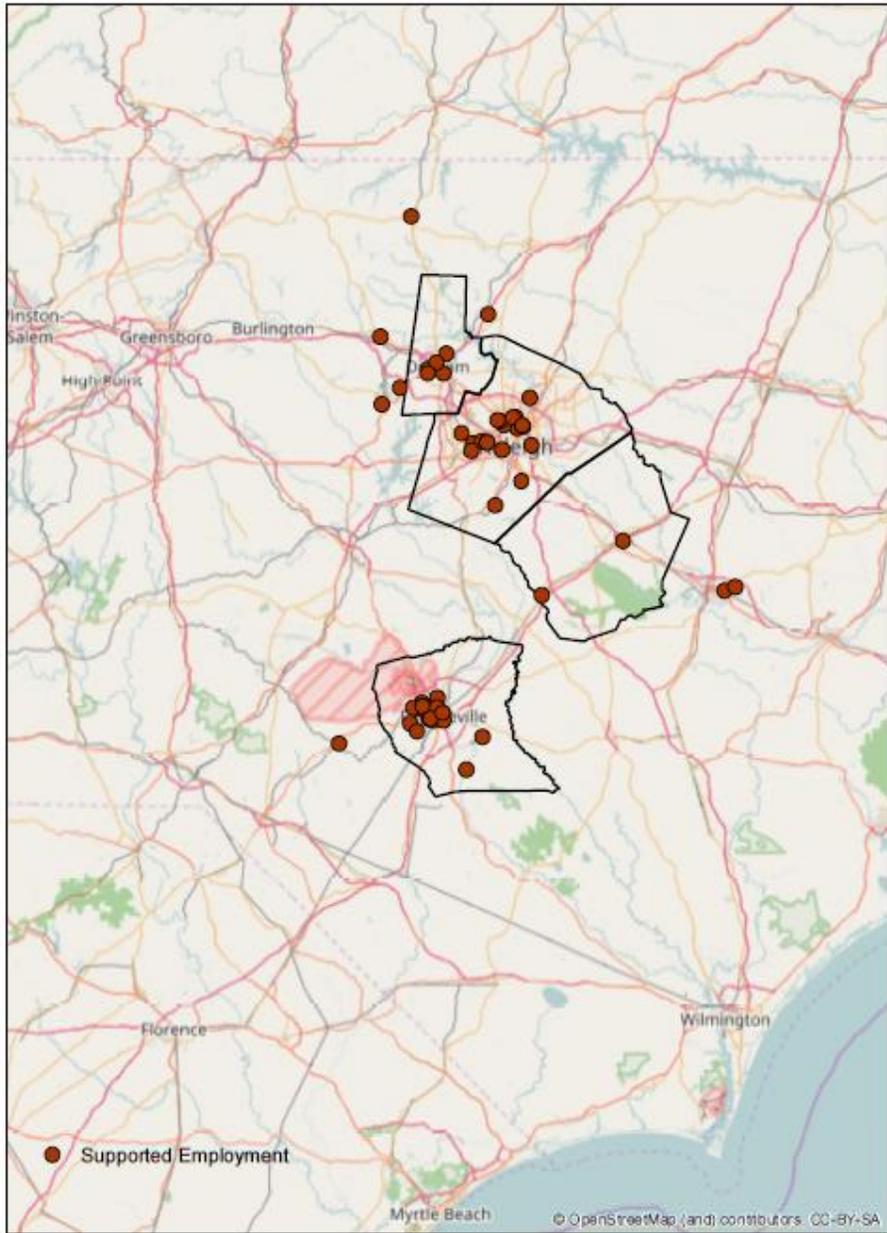


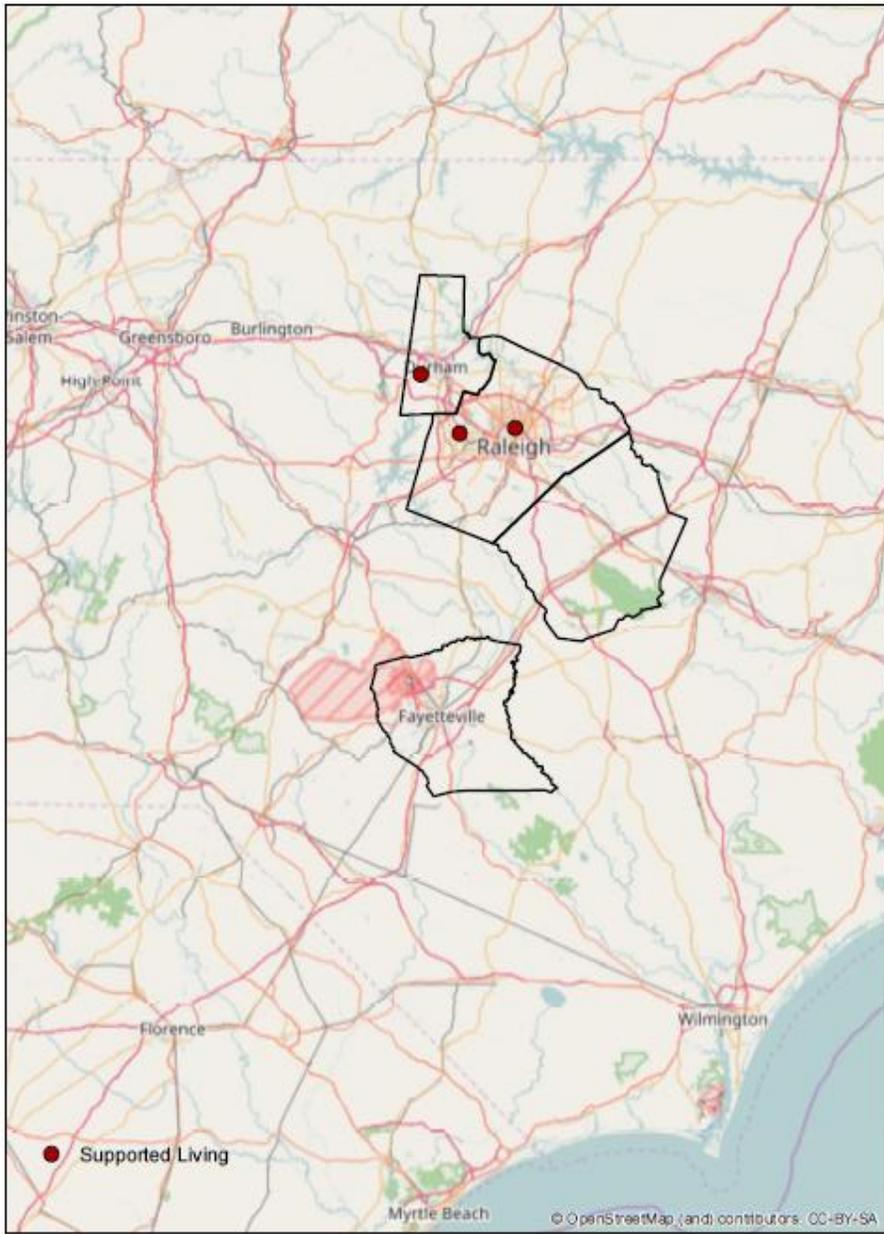




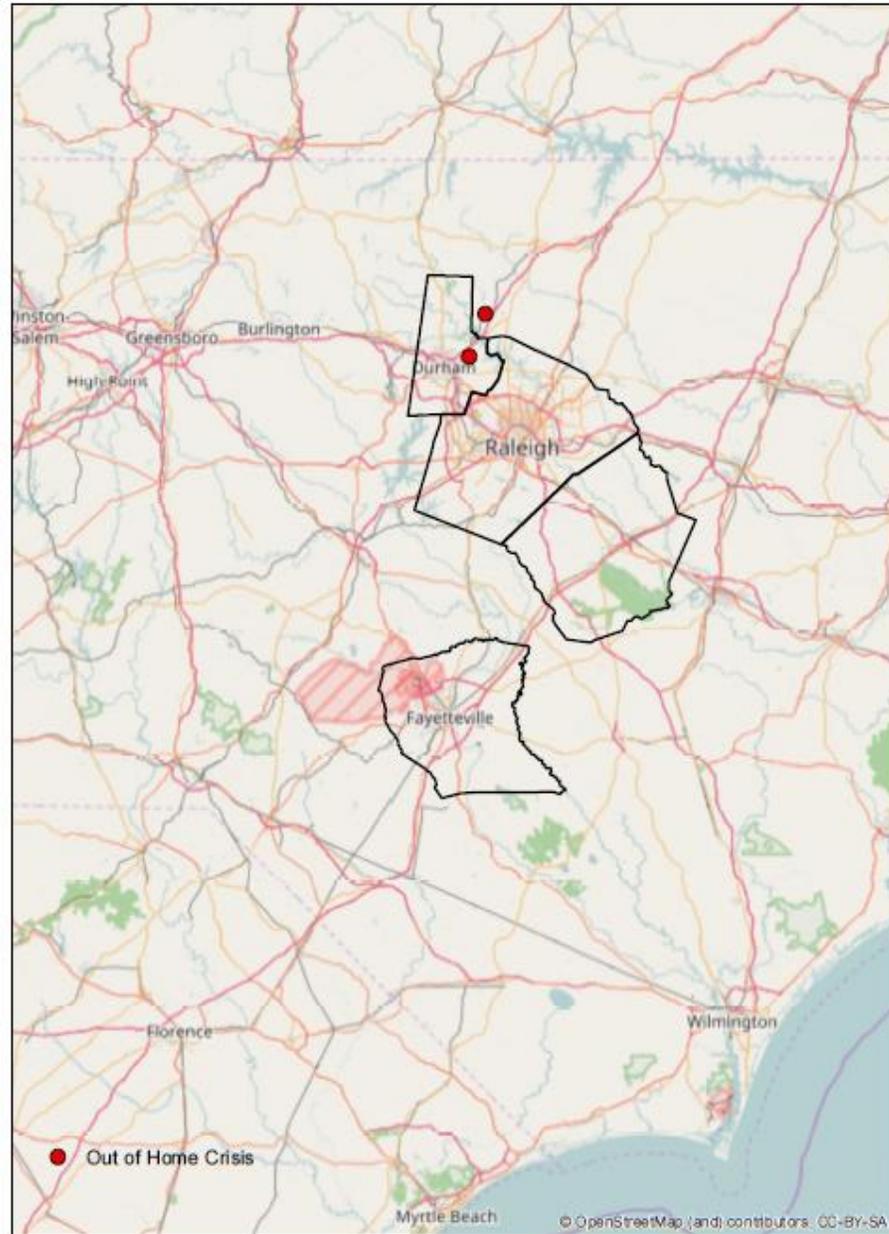
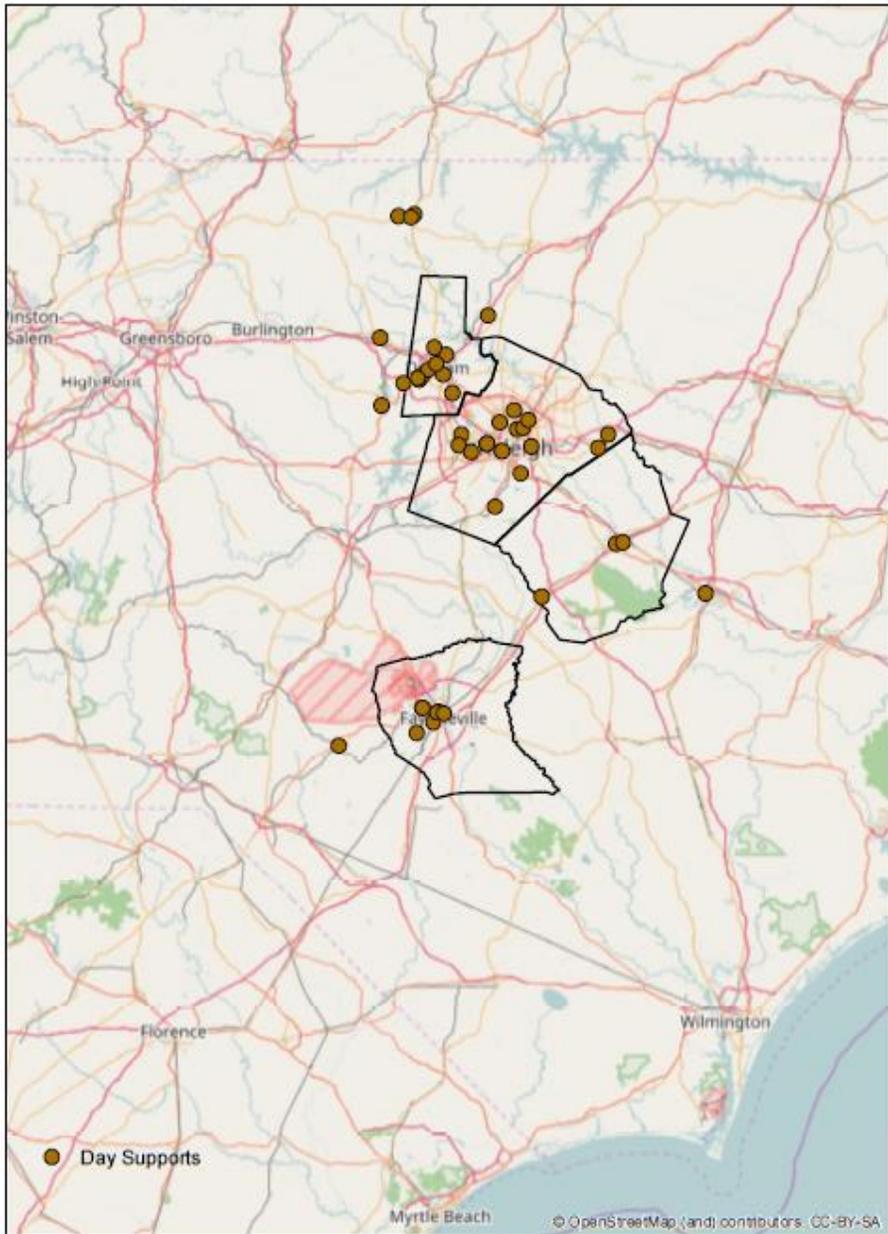


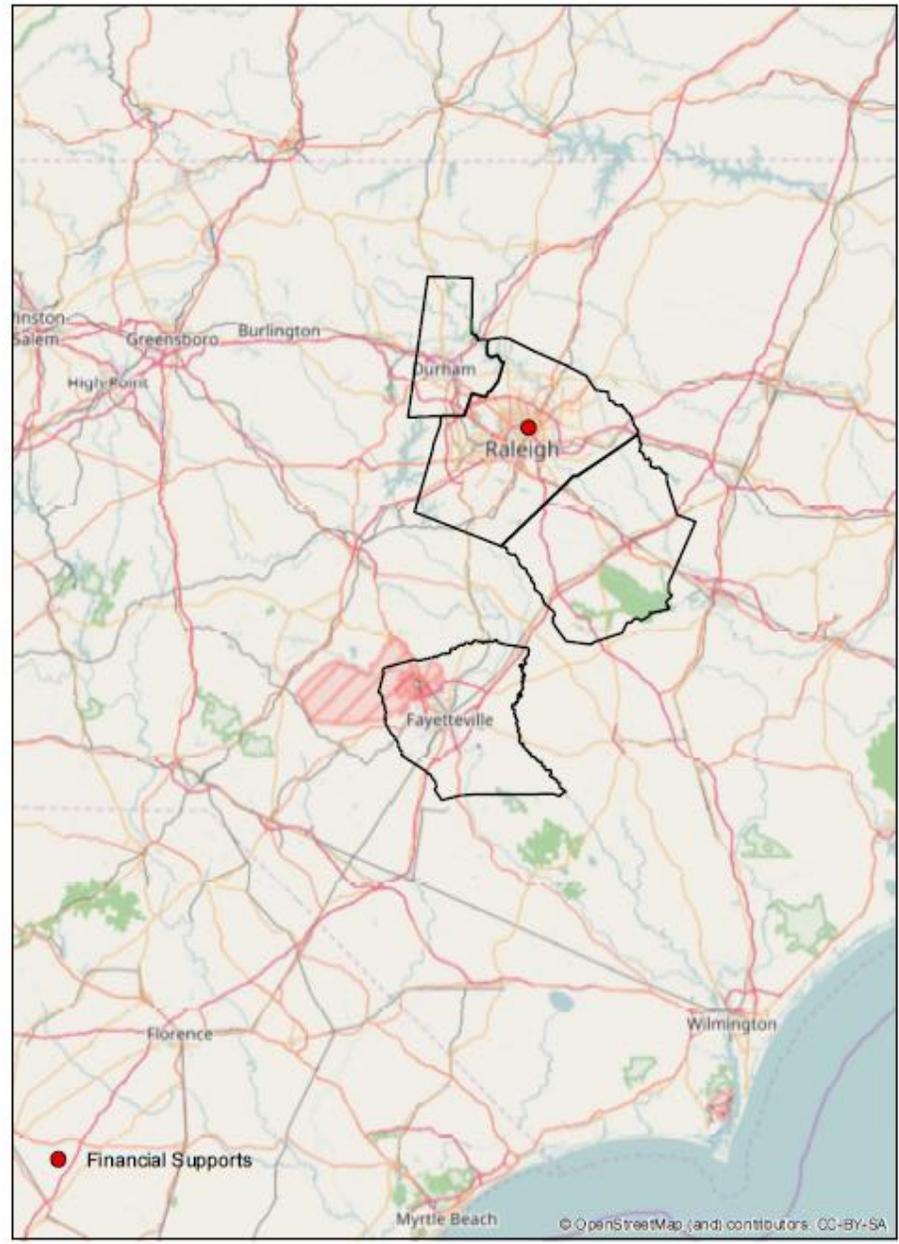
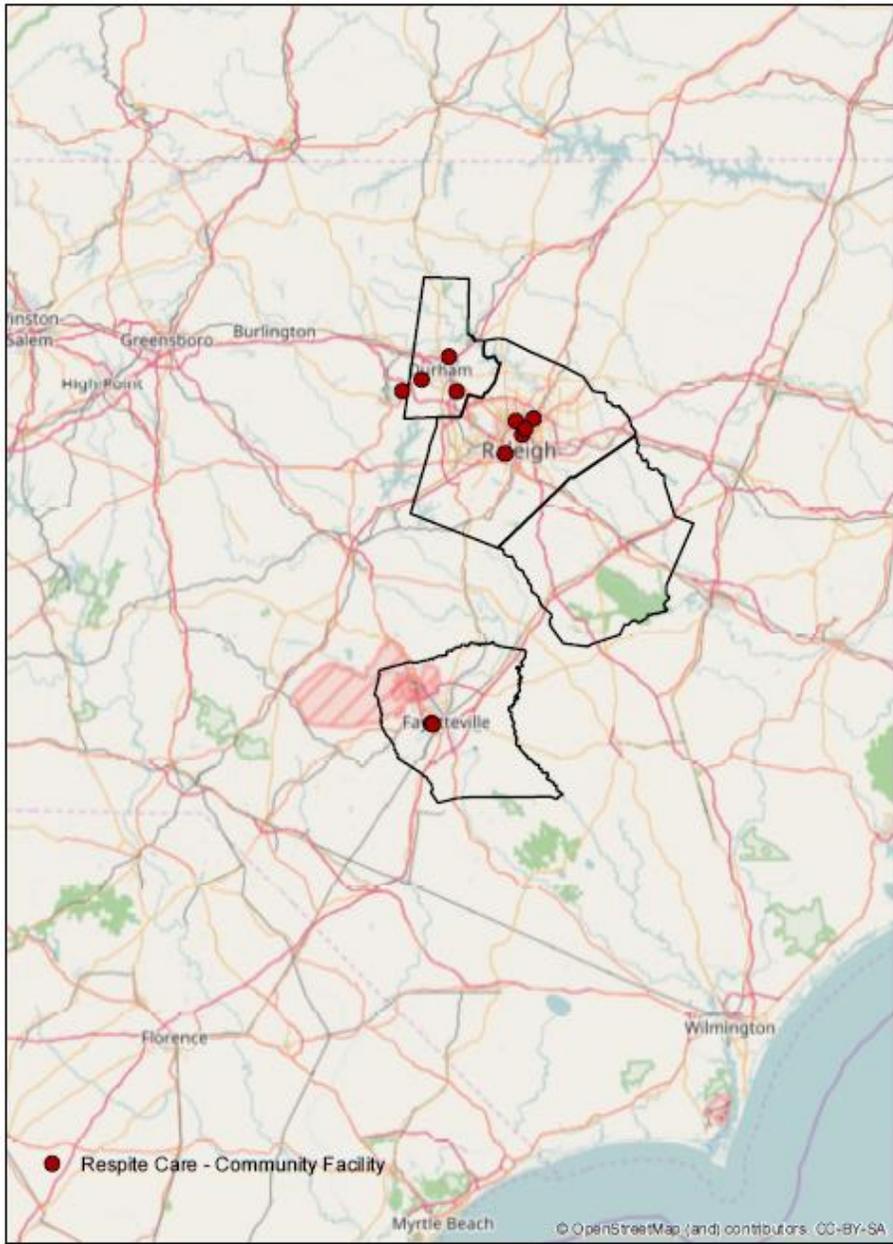


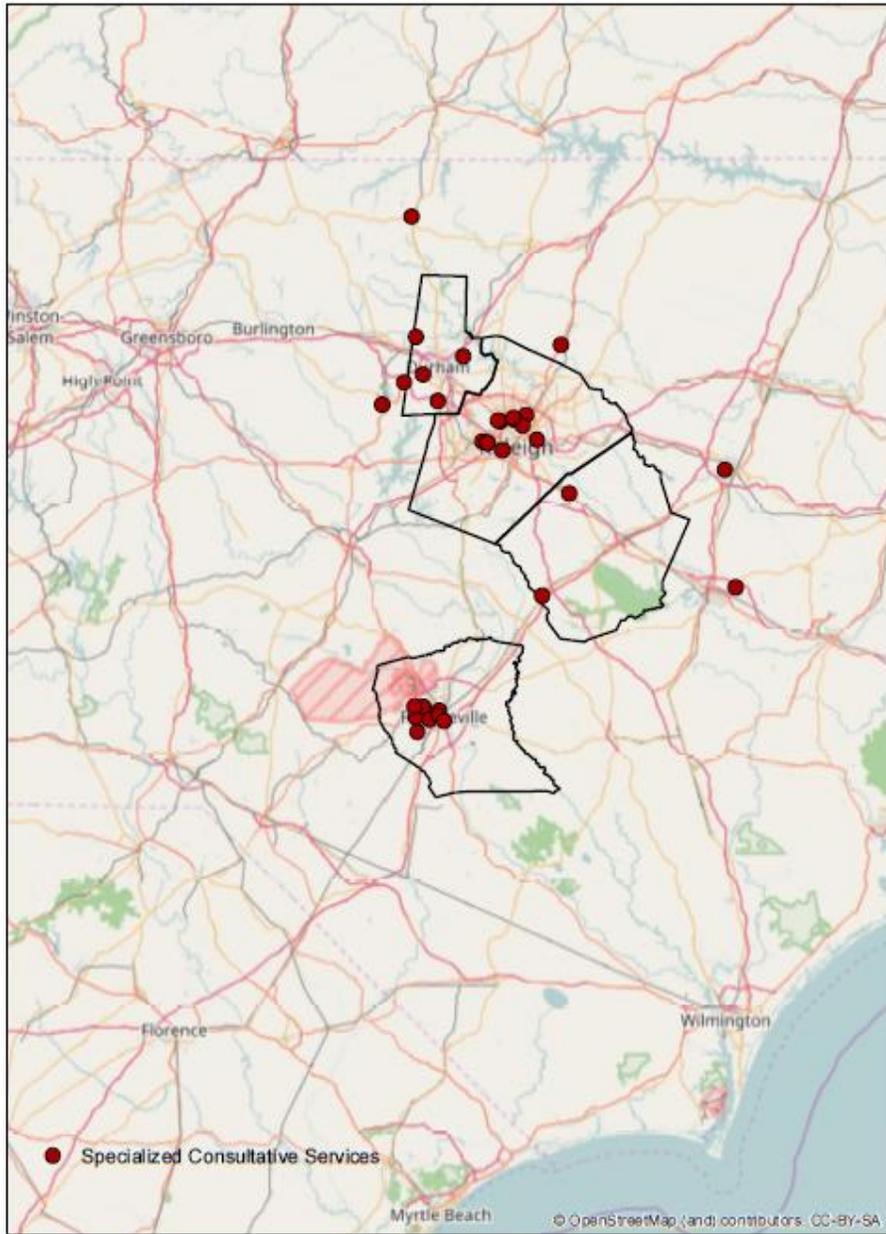




# C-WAIVER SERVICES (GROUP B)







## Appendix B: Stakeholder and Staff Survey Questions

Alliance Behavioral Healthcare is conducting its annual assessment of service needs and gaps and is requesting feedback from the community about service needs, gaps and priorities. In addition to electronic surveys that will be administered in January 2017, we are encouraging collective responses from local community organizations, committees, collaboratives and other stakeholder groups that would like to provide input.

The questions below are recommended as a framework for a collective group response, although groups are welcome to submit feedback in other formats.

**Please send responses to Carlyle Johnson at [cjohnson@alliancebhc.org](mailto:cjohnson@alliancebhc.org) by Feb. 1, 2017.**

Group Name and Scope (e.g., counties covered, organizations represented, mission and goals):

Date of Meeting:

Number of participants:

Submitted by (name and e-mail contact information):

Group Feedback:

1. Describe the population(s) with which the group is most familiar.
2. Identify any groups or populations that you believe are underserved, have special needs or have difficulty obtaining needed care.
3. For each population, what are the most significant service needs and gaps in your community? Please note whether these gaps affect specific communities, populations or funding sources (e.g., Medicaid vs. uninsured).
4. What are the most significant barriers to accessibility of these services?
5. Describe some situations in which the system worked well to meet consumer needs. What was most helpful and what would we need to do to replicate these successes?
6. Has your group prepared any written reports, surveys, or other documents in the past year that discuss community needs and service gaps? Are you aware of any other documentation of community needs that has been prepared by other organizations? If so, please provide additional information and/or send copies by e-mail.
7. Do you have any other feedback that may help Alliance understand community needs, service gaps and priorities for network development?
8. What actions or strategies would you recommend as Alliance priorities for the upcoming year to help address these needs and gaps?

## Appendix C: Community Feedback

The process for soliciting community feedback included multiple approaches, including input provided through an on-line survey, stakeholder meetings and collective feedback from consumer, provider, stakeholder and staff groups. Additional details about the survey methodology are contained in Section One, parts IV and V. The tables below provide summaries of survey data, focus group and stakeholder feedback data.

### Survey Responses:

The survey was conducted during the month of January 2017 and yielded a total of 512 responses. The following provides a breakdown of submissions by respondent group:

Consumer and Family .....	84
Provider .....	246
Stakeholder .....	80
Staff .....	102
TOTAL .....	512

Analysis of responses by county indicates that, although all counties are represented in each respondent group, Johnston representation is relatively low for stakeholders while Cumberland had much lower participation from consumers, families and stakeholders than in past years. Note that provider counts are duplicated because many providers are present in multiple counties.

County	Consumers & Families	Providers	Stakeholders
Cumberland	4	57	5
Durham	20	105	17
Johnston	13	59	3
Wake	45	160	53
Other	2	13	0

### **Feedback from Consumer, Stakeholder, Provider and Staff Groups:**

Input was solicited from multiple community groups and collaboratives in addition to individual input provided through the on-line survey. The following groups submitted feedback regarding community needs, gaps and priorities (abbreviations are for reference in reviewing subsequent tables):

- Consumer and Family Advisory Committee (CFAC)
- Alliance Provider Advisory Committee (APAC), including local PAC meetings in each county
- Cumberland County Community Collaborative for Children & Families (Cumberland CCC&F)
- Wake County Community Collaborative for Children & Families (Wake CCC&F)
- Alliance Hospital Partners Collaborative (Hospital Partners)
- Cumberland, Durham and Wake Crisis Collaboratives (Crisis Collabs)
- Cumberland and Durham Judicial Stakeholders (SH)
- Durham Criminal Justice Advisory Committee (CJAC)
- Durham and Wake Juvenile Justice SA/MH Partnerships (JJSAMHP)
- Johnston Department of Social Services (DSS)
- Partnership for a Healthy Durham (PHD)
- Therapeutic Foster Care Collaborative (TFC)
- Substance Use Disorders Provider Collaborative (SUD)
- Alliance MH/SA Care Coordinators (MHSA CC)
- Alliance Access/Call Center Staff (Access)
- Alliance Clinical Operations
- Alliance Board Services Committee

## Access Rankings for Each Age/Disability Group

The following tables summarize survey feedback about service access and include listings of services with lowest accessibility ratings. Accessibility ratings were calculated by combining scores of “Unable to get service” and “Able to get service with much difficulty,” and representing as a % of total responses for each item. Services are listed in order, starting with the lowest overall rating of service accessibility. Services were also ranked for those rated as “Unable to get service,” and the most inaccessible of these services were added to the list if not already represented by the prior analysis. Several services were rated lower for specific respondent groups, and these rankings are noted in the Comments column. Consistent with the survey design, service rankings were developed for Intellectual and Developmental Disabilities (IDD), Child Mental Health and Substance Use Disorders (Child MH/SUD), Adult Mental Health and Substance Use Disorders (Adult MH/SUD), and Traumatic Brain Injuries (TBI).

### Child and Adult IDD Service Access Rankings

Service category	Comments
Institutional care (ICF/IID)	
Inpatient psychiatric treatment for dually diagnosed	
Residential options (Group Living, Supervised Living, Residential Supports, Semi- and/or independent living)	
Services to support development and implementation of behavior plans (Specialized Consultative Service, Behavior Plan Development)	
Supports to provide modifications to assist with increased independent functioning (Vehicle Adaptations, Home Modifications, Augmentative Communication Devices, Specialized Equipment and Supplies)	
Crisis Services (including residential, facility-based crisis, hospital diversion, NC START and mobile crisis services)	Priority area for consumers & families, Johnston and Wake respondents
Services to provide relief to primary caretakers (Respite, Crisis respite, emergency and planned respite)	Priority area for providers, Cumberland and Wake respondents
Services to provide meaningful structured daily activities (e.g., Day Supports, Day Activity, Developmental Day, Adult Developmental Vocational Program, Leisure, recreational & retirement services)	Priority area for Durham, Cumberland and Johnston respondents

Other service needs noted:

- Case Management
- Services for dually diagnosed (MI/IDD)
- Services for young children (0-5)

## Child MH/SUD Service Access Rankings

Service category	Comments
Services to provide relief to primary caretakers (Respite, Crisis respite, emergency and planned respite)	
Outpatient treatment of opioid abuse (e.g., medication-assisted treatment for opioid addiction) for adolescents and young adults	
Services for transition age youth (adolescents 16-21)	
Therapeutic secure residential treatment (Psychiatric Residential Treatment Facility (PRTF), Level IV)	
Residential treatment (group homes)	
Services for youth engaged in sexual harm	Priority for Cumberland, Durham
Intensive outpatient treatment for substance use (e.g., substance abuse intensive outpatient and comprehensive outpatient treatment programs)	Priority for stakeholders, Wake
Mental health and substance abuse services that are coordinated with schools	Priority for stakeholders, providers, Cumberland
Short-term daily structured programs to support behavioral and emotional stability (e.g., day treatment, partial hospitalization)	Priority for stakeholders, Durham
Inpatient psychiatric treatment	Priority for Cumberland, Johnston
Child psychiatry and medication management	Priority for Cumberland, Johnston
Crisis services	Priority for Cumberland

### Other service needs noted:

- Services for dually diagnosed (MI/IDD), with specific focus on autism
- Level IV group homes
- Services for young children (0-5)
- Specialty treatment for sex offenders, eating disorders

## Adult MH/SUD Service Access Rankings

Service category	Comments
Services to provide relief to primary caretakers (Respite, Crisis respite, emergency and planned respite)	
Services to address and support the needs of the geriatric community	
Short-term residential treatment for substance abuse (e.g., transitional living, half-way houses, housing with supports)	
Short-term daily structured programs to support behavioral and emotional stability (e.g., partial hospitalization)	
Services to assist with vocational and educational needs (Supported Employment, Long Term Vocational Supports)	
Outpatient treatment of opioid abuse (e.g., medication-assisted treatment for opioid addiction)	Priority for Johnston
Longer-term structured daily activity programs (e.g., Psychosocial Rehabilitation, Drop In Centers)	Priority for consumers & families, Johnston, Durham
Inpatient psychiatric treatment	Priority for Johnston
Training on skills necessary to promote recovery (e.g., Wellness/Illness Management and Recovery, Wellness Recovery Action Plan)	Priority for Cumberland
Support by peers who have personal experience with mental illness or substance use (Peer Supports)	Priority for stakeholders

Other service needs noted:

- Housing, including options for individuals released from incarceration, elderly, housing options for individuals receiving medication assisted treatment, and supported housing resources
- Dual diagnosis services
- Longer-term residential treatment for SUD

## TBI Service Access Rankings

Service category	Comments
Services for support with personal care and self-help needs (Personal Assistance, Personal Care)	
Services to provide meaningful structured daily activities (e.g., Day Supports, Day Activity, Developmental Day, Adult Developmental Vocational Program, Leisure, recreational & retirement services)	
Services to develop daily living skills (Individual Support, Developmental Therapy, In-Home Skill Building, Community Networking)	
Services to provide relief to primary caretakers (Respite, Crisis respite, emergency and planned respite)	
Outpatient psychotherapy (individual, group, family)	
Residential options (Group Living, Supervised Living, Residential Supports, Semi- and/or independent living)	

Other service needs noted:

- Broader system development, including TBI-specific services and development of provider capacity and expertise

## Service Gaps

The table on the next page provides a summary of the most frequently reported service gaps identified by stakeholder groups, which are grouped into the following categories:

1. **Housing:** includes need for more availability of affordable housing as well as services such as supported housing and transitional housing. There were also significant concerns about the quality of group homes, capacity of these facilities to serve individuals with complex needs, and group homes refusal to accept consumers back at their facilities after crisis or inpatient visits. Other: nutritional training for group homes; underutilization of ILI; ready to rent classes.
2. **Access / availability of appointments:** need for improved accessibility of current providers and/or more providers, including those willing to serve outlying areas and to accept complex cases. Increased availability of in-home treatment options, expanded hours of appointments, and for IDD, availability during summer and after school.
3. **Medication access for uninsured**
4. **Medication Assisted Treatment:** evidence-based MAT for individuals with substance use disorders, especially for the uninsured
5. **Respite Services:** includes respite for individuals with mental illness, peer respite and medical respite
6. **Continuum for justice-involved:** Expanded service continuum for justice system involved, including jail transition services, improved coordination of care and step-down services for higher needs violent Juvenile offenders. Several groups also recommended addition of a Forensic ACTT team.
7. **Inpatient capacity and access:** includes inpatient psychiatric beds for all ages, dual diagnosis capacity, and reduced waits for CRH beds
8. **Housing for individuals with substance use disorders (SUD):** includes adult recovery homes, transitional living and halfway houses
9. **SUD Withdrawal Management continuum:** improved capacity and access to effective withdrawal management services, improved access to ADATC on weekends, longer length of stay for transition to aftercare, and social detox for cocaine
10. **System navigation and information:** need for clarification of services, how to access care and navigate the system, more information about provider availability, capacity and expertise, with several respondents noting questions about NCSTART access
11. **Cross-disability fluency and expertise:** need for improved provider network capacity to serve individuals with co-occurring conditions
12. **Case Management:** including new providers of case management for complex child funding
13. **Adolescent SUD continuum:** includes local residential treatment and services for children younger than 16
14. **Innovations waiting list**

## Stakeholder Feedback on Service Gaps

	CFAC	APAC	Cumberland CCC&F	Wake CCC&F	Hospital Partners	Cumb. Crisis Collab.	Durham Crisis Collab.	Wake Crisis Collab.	Cumberland Judicial SH	Durham Judicial SH	Durham CJAC	Durham JJSAMHP	Wake JJSAMHP	Johnston DSS	PHD	TFC Collaborative	SUD Collaborative	MH/SA CC	Access	Clinical Operations	Services Committee
Housing	✓	✓			✓	✓	✓	✓		✓	✓				✓					✓	✓
Access / availability of appointments	✓	✓			✓		✓		✓			✓	✓	✓		✓		✓	✓		
Medication access for uninsured	✓			✓	✓		✓	✓		✓	✓							✓	✓		
Medication Assisted Treatment	✓					✓	✓	✓	✓	✓							✓		✓		
Respite services	✓	✓		✓		✓	✓	✓								✓		✓			
Inpatient capacity and access	✓					✓	✓	✓	✓								✓			✓	
Continuum for justice-involved	✓	✓					✓		✓	✓								✓			
Housing for individuals with SUD			✓				✓	✓		✓							✓	✓			
System navigation and information		✓			✓		✓			✓						✓			✓		
Cross-disability fluency and expertise	✓	✓		✓									✓					✓		✓	
Case Management	✓	✓		✓				✓								✓				✓	
Adolescent SUD continuum				✓			✓			✓			✓				✓				
Innovations waiting list	✓	✓																✓	✓		
SUD Withdrawal Management continuum	✓	✓					✓										✓				

Other service gaps include: residential services, residential placement for adolescents, access to psychiatrists, particularly with child and IDD expertise, ACTT capacity, and specialized services for elderly and transition age youth

## Stakeholder Feedback on Populations Identified as Underserved

	AMH/SA Survey	CMH/SA Survey	IDD Survey	TBI Survey	CFAC	APAC	Cumberland CCC&F	Wake CCC&F	Hospital Partners	Cumb. Crisis Collab.	Durham Crisis Collab.	Wake Crisis Collab.	Cumb. Judicial SH	Durham Judicial SH	Durham CJAC	Durham JJSAMHP	Wake JJSAMHP	Johnston DSS	PHD	TFC Collaborative	SUD Collaborative	MH/SA CC	Access	Clinical Operations	Services Committee
Uninsured / underinsured	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Non-English speaking	✓	✓	✓		✓	✓	✓			✓		✓	✓	✓			✓	✓	✓			✓	✓	✓	
Transition Age Youth, including youth aging out of foster care		✓	✓		✓	✓	✓		✓	✓		✓								✓		✓			✓
Dually Diagnosed (IDD/MI & SUD/MI)	✓	✓	✓		✓	✓	✓	✓									✓	✓				✓	✓	✓	
Sex offenders, sexually aggressive youth and youth sex offenders							✓	✓				✓		✓		✓	✓					✓			
Individuals with IDD		✓	✓			✓	✓			✓						✓			✓			✓			✓
LGBTQ (including transgender youth)	✓	✓			✓											✓	✓		✓	✓		✓			
Elderly	✓		✓		✓	✓						✓							✓						
Homeless	✓						✓		✓	✓				✓					✓						
Veterans (including homeless veterans)					✓		✓		✓										✓					✓	
Individuals connected to criminal justice system										✓				✓		✓			✓						

Others listed: Deaf and Hard of Hearing, adolescents with first episode psychosis, adolescents needing SUD treatment, TBI, individuals with complex needs and comorbid medical needs

## Summary of Barriers

	AMH/SA Survey	CMH/SA Survey	IDD Survey	TBI Survey	CFAC	APAC	Cumberland CCC&F	Wake CCC&F	Hospital Partners	Cumb. Crisis Collab.	Durham Crisis Collab.	Wake Crisis Collab.	Cumberland Judicial SH	Durham Judicial SH	Durham JJSAMHP	Wake JJSAMHP	Johnston DSS	PHD	TFC Collaborative	SUD Collaborative	MH/SA CC	Access	Services Committee
Funding limitations and lack of insurance coverage	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓		✓	✓
Transportation	✓	✓			✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
System navigation challenges and information about services	✓	✓	✓	✓	✓		✓		✓		✓			✓				✓				✓	✓
Timely access to care / waiting lists for services / service hours	✓	✓	✓	✓			✓		✓		✓	✓		✓				✓	✓		✓		
Language barriers / need for bilingual/bicultural services or interpretation	✓				✓			✓				✓		✓	✓		✓				✓	✓	
Dual eligible	✓				✓																		
Housing and residential	✓	✓			✓	✓					✓	✓		✓							✓		
IDD waiting list			✓		✓																✓	✓	
Local inpatient beds	✓	✓								✓		✓										✓	
Group homes not taking clients back											✓	✓											
Affordable medication						✓					✓	✓											
Transition between levels of care						✓														✓			
Availability of qualified staff			✓	✓																			