Network Adequacy and Accessibility Analysis

Combined Report for 2020 and 2021

July 1, 2021

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Supplementary Documentation: Geographic Access Maps Supplement

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Introduction

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 Calendar Year 2019 and 2020 and was initially scheduled to be submitted as two separate reports to the North Carolina Department of Health and Human Services by July 1, 2020 and July 1, 2021 as required by DHHS-MCO contracts. Due to the COVID-19 pandemic, DHHS has suspended numerous LME-MCO contractual requirements, including timelines for submission of this report. This document was prepared as combined report to provide an updated analysis of community needs and gaps for use in strategic planning purposes, application for NCQA accreditation, and preparation for our goals of transitioning to a Tailored Plan.

This report includes a summary of the previous two years' network development initiatives, 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 Access Plan for the upcoming fiscal year.

The preparation of this report has provided an opportunity to review the status of the FY20 Network Access Plan, obtain additional community input and identify strategic goals for network development. The following analysis provides a summary of information obtained through this process and the themes and objectives that have emerged as highest priority actions. 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, and in consideration of the significant upcoming system changes associated with Medicaid Transformation and the ongoing challenges as a result of the COVID-19 pandemic.

Section One
Network Availability and Accessibility

I. Access and Choice Standards and Data

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:

Service Category	Services Covered	Access and Choice Standard
Outpatient	Psychiatric care, medication management, evaluations, and individual, group and family psychotherapy	Choice of TWO (2) providers within **30 miles /30 minutes**
Location-Based (two sections)	Services that are facility or site-based, such as Psychosocial Rehabilitation, Partial Hospitalization, Child and Adolescent Day Treatment, and SA Intensive Outpatient Treatment	**Section A**: Choice of TWO (2) providers within **30 miles or 30 minutes** **Section B:** Access to ONE (1) provider within **Alliance catchment area**
Community / Mobile	Services in home and community settings such as Supported Employment, Peer Support and Intensive In-Home services	Choice of TWO (2) providers within **Alliance catchment area**
Crisis (two sections)	Facility-Based Respite, Facility-Based Crisis and Non-Hospital Detoxification services	**Section A**: Access to ONE (1) provider within **Alliance catchment area** **Section B**: Choice of TWO (2) providers within **Alliance catchment area**
Inpatient	Inpatient psychiatric care for all ages	Access to ONE (1) provider within **Alliance catchment area**
Specialized	Specific list of services, most of which are residential services	Choice of TWO (2) provider locations within **Alliance catchment area**
C-Waiver (two sections, Medicaid only)	Services that are covered through the Innovations / 1915(c) waiver	Section A: Choice of TWO (2) providers within **Alliance catchment area** Section B: Access to ONE (1) provider within **Alliance catchment area**

Although the counties comprising Alliance Health'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 outpatient and location-based services within a 30-mile radius or 30-minute drive time for any consumer residing in the Alliance catchment area. Geographic access is evaluated using geo-mapping software to identify the number and percentage of Medicaid and Non-Medicaid members for whom access and choice standards are met.

The geographic access and provider choice standards for the current report reflect numerous changes from those of the previous analysis. Multiple services were moved into new categories, several categories were divided into subgroups with different standards, and the adequacy standards for several groups were made more stringent. Standards for Non-Medicaid services also changed to align with the higher standards of Medicaid services (see summary of changes in **Appendix B**). As a result, several new gaps have emerged:

- New services: Peer Support (Non-Medicaid), Ambulatory Detox (Medicaid and Non-Medicaid), Facility-Based Crisis-Child (Medicaid and Non-Medicaid)
- Change in categories resulting in higher standard: Partial Hospitalization (Medicaid and Non-Medicaid), Psychiatric Residential Treatment Facility (Non-Medicaid)
- Non-Medicaid services with new, higher standards: Psychosocial Rehabilitation, SACOT, Opioid Treatment

Standards were met for all services in Outpatient, Inpatient and C-Waiver categories, and for all services within the following categories except for those listed below:

DHHS Category	Areas Not Met (Medicaid-Funded)
Location-Based	Partial Hospitalization
Crisis Services	Ambulatory Detox Facility-Based Crisis-Child
Specialized	(b)(3) I/DD Facility-Based Respite

DHHS Category	Areas Not Met (Non-Medicaid Funded)
Location-Based	Psychosocial Rehabilitation Child and Adolescent Day Treatment Partial Hospitalization SA Comprehensive Outpatient Treatment Opioid Treatment
Community/Mobile	Peer Support
Crisis Services	Ambulatory Detox Facility-Based Crisis-Child
Specialized	Psychiatric Residential Treatment Facility Residential Treatment Level 2: Therapeutic Foster Care Residential Treatment Level 2: Other than Therapeutic Foster Care

A. Outpatient Services

2020

	Medicaid				Non-Medicaid Funded			
Categories	**# of providers accepting new Medicaid consumers**	**# of enrollees with choice of two providers within 30 miles/ minutes**	**# of Medicaid enrollees**	**% (# of enrollees with choice/# of enrollees)**	**# of providers accepting new non-Medicaid funded consumers**	**# of consumers with choice of two providers within 30 miles/minutes**	**# of consumers**	**% (# of consumers with choice/# of consumers)**
Reside in urban counties	633	302,966	302,966		86	17,621	17,621	
Reside in rural counties	N/A	N/A	N/A		N/A	N/A	N/A	
Total (standard = 95%)	633	302,966	302,966	100%	86	16,740	16,740	100%
Adults (age 18+)	633	158,427	158,427		86	16,604	16,604	
Children (age 17 and younger)	633	144,539	144,539		86	1,017	1,017	
Total (standard = 95%)	633	287,817.7	287,817.7	100%	86	16,740	16,740	100%

2021

Choice of Two	Medicaid				Non-Medicaid Funded			
Categories	**# of providers accepting new Medicaid consumers**	**# of enrollees with choice of two providers within 30/45 miles/ minutes**	**# of Medicaid enrollees**	**% (# of enrollees with choice/# of enrollees)**	**# of providers accepting new non-Medicaid funded consumers**	**# of consumers with choice of two providers within 30/45 miles/minutes**	**# of consumers**	**% (# of consumers with choice/# of consumers)**
Reside in urban counties	782	263,199	263,199		87	15,825	15,825	
Reside in rural counties	N/A		N/A		N/A	N/A	N/A	
Total (standard = 95%)	782	250,039	250,039	100%	87	15,034	15,034	100%
Adults (age 18+)	782	122,022	122,022		87	14,828	14,828	
Children (age 17 and younger)	782	141,177	141,177		87	997	997	
Total (standard = 95%)	782	250,039	250,039	100%	87	15,034	15,034	100%

B. Location-Based Services

Group A, 2020

	Medicaid				Non-Medicaid Funded			
Location-based Services	# of providers accepting new Medicaid consumers	# and % of enrollees with choice of two providers within 30 miles/minutes of their residences		Total # of Medicaid enrollees	# of providers accepting new non-Medicaid funded consumers	# and % of consumers with choice of two providers within 30 miles/minutes of their residences		Total # of consumers
		#	%			#	%	
Psychosocial Rehabilitation	23	158,427	100%	158,427	8	8,058	**79.81%**	10,096
Child and Adolescent Day Treatment	10	143,102	99.01%	144,539	1	0	**0%**	841
Partial Hospitalization	4	218,698	**72.19%**	302,966	0	0	**0%**	16,473
SA Intensive Outpatient Program	23	302,966	100%	302,966	11	5,551	100%	5,551
SA Comprehensive Outpatient Treatment	16	302,780	99.94%	302,966	5	3,730	**67.2%**	5,551
Opioid Treatment	8	158,065	99.77%	158,427	6	4, 4,356	**78.68%**	5,536

Group A, 2021

	Medicaid				Non-Medicaid Funded			
Location-based Services	# of providers accepting new Medicaid consumers	# and % of enrollees with choice of two providers within 30/45 miles/minutes of their residences		Total # of Medicaid enrollees	# of providers accepting new non-Medicaid funded consumers	# and % of enrollees with choice of two providers within 30/45 miles/minutes of their residences		Total # of consumers
		#	%			#	%	
Psychosocial Rehabilitation	23	122,022	100%	122,022	8	7,100	**79.22%**	8,962
Child and Adolescent Day Treatment	13	139,842	99.05%	141,177	1	0	**0%**	836
Partial Hospitalization	4	186,114	**70.71%**	263,199	0	0	**0%**	14,841
SA Intensive Outpatient Program	22	263,199	100%	263,199	11	5,284	100%	5,284
SA Comprehensive Outpatient Treatment	16	263,100	99.96%	263,199	4	3,976	**75.25%**	5,284
Opioid Treatment	8	121,724	99.76%	122,022	6	3,861	**76.56%**	5,043

Group B, 2020

	Medicaid				Non-Medicaid Funded			
Location-based Services	# of providers accepting new Medicaid consumers	# and % of enrollees with access within the LME-MCO catchment area to at least one provider agency		Total # of Medicaid enrollees	# of providers accepting new non-Medicaid funded consumers	# and % of consumers with access within the LME-MCO catchment area to at least one provider agency		Total # of consumers
		#	%			#	%	
SA Non-Medical Community Residential Treatment	3	302,966	100%	302,966	3	5,551	100%	5,551
SA Medically Monitored Community Residential Treatment	1	302,966	100%	302,966	1	5,551	100%	5,551
SA Halfway House – Female					2	5,551	100%	5,551
SA Halfway House – Male					1	5,551	100%	5,551

Group B, 2021

	Medicaid				Non-Medicaid Funded			
Location-based Services	# of providers accepting new Medicaid consumers	# and % of enrollees with access within the LME-MCO catchment area to at least one provider agency		Total # of Medicaid enrollees	# of providers accepting new non-Medicaid funded consumers	# and % of enrollees with access within the LME-MCO catchment area to at least one provider agency		Total # of consumers
		#	%			#	%	
SA Non-Medical Community Residential Treatment	3	263,199	100%	263,199	3	5,284	100%	5,284
SA Medically Monitored Community Residential Treatment	1	263,199	100%	263,199	1	5,284	100%	5,284 5,284
SA Halfway House - Female					2	5,284	100%	5,284
SA Halfway House - Male					1	5,284	100%	5,284

C. Community/Mobile Services
2020

	Medicaid					Non-Medicaid-Funded		
	# of providers accepting new Medicaid consumers	# and % of enrollees with choice of two provider agencies within the LME-MCO catchment area		Total # of Medicaid enrollees	# of providers accepting new non-Medicaid consumers	# and % of enrollees with choice of two provider agencies within the LME-MCO catchment area		Total # of Consumers
Community/Mobile Service		#	%			#	%	
Assertive Community Treatment Team	9	158,427	100%	158,427	7	10,096	100%	10,096
Community Support Team	11	158,427	100%	158,427	8	15,632	100%	15,632
Intensive In-Home	28	144,539	100%	144,539	9	841	100%	841
Multi-systemic Therapy	6	144,539	100%	144,539	5	841	100%	841
(b)(3) MH Supported Employment	10	302,966	100%	302,966				
(b)(3) I/DD Supported Employment	13	302,966	100%	302,966				
(b)(3) Waiver Community Guide	10	302,966	100%	302,966				
(b)(3) Waiver Individual Support (Personal Care)	5	302,966	100%	302,966				
(b)(3) Waiver Peer Support	32	302,966	100%	302,966				
(b)(3) Waiver Respite	35	302,966	100%	302,966				
I/DD Supported Employment Services (non-Medicaid-funded)					9	836	100%	836
Long-term Vocational Supports (non-Medicaid-funded)					11	667	100%	667
MH/SA Supported Employment Services (IPS-SE) (non-Medicaid-funded)					6	15,632	100%	15,632
I/DD Non-Medicaid-funded Personal Care					22	836	100%	836
Day Supports					2	836	100%	836
Peer Support					0	0	**0%**	836
Transition Management Service					2	836	100%	836

2021

	Medicaid					Non-Medicaid-Funded		
	# of providers accepting new Medicaid consumers	# and % of enrollees with choice of two provider agencies within the LME-MCO catchment area		Total # of Medicaid enrollees	# of providers accepting new non-Medicaid consumers	# and % of enrollees with choice of two provider agencies within the LME-MCO catchment area		Total # of Consumers
Community/Mobile Service		#	%			#	%	
Assertive Community Treatment Team	10	122,022	100%	122,022	7	8,962	100%	8,962
Community Support Team	11	122,022	100%	122,022	8	14,005	100%	14,005
Intensive In-Home	28	141,177	100%	141,177	9	836	100%	836
Multi-systemic Therapy	6	141,177	100%	141,177	5	836	100%	836
(b)(3) MH Supported Employment	9	263,199	100%	263,199				
(b)(3) I/DD Supported Employment	12	263,199	100%	263,199				
(b)(3) Waiver Community Guide	10	263,199	100%	263,199				
(b)(3) Waiver Individual Support (Personal Care)	5	263,199	100%	263,199				
(b)(3) Waiver Peer Support	32	263,199	100%	263,199				
(b)(3) Waiver Respite	35	263,199	100%	263,199				
I/DD Supported Employment Services (non-Medicaid-funded)					8	988	100%	988
Long-term Vocational Supports (non-Medicaid-funded)					10	825	100%	825
MH/SA Supported Employment Services (IPS-SE) (non-Medicaid-funded)					6	14,005	100%	14,005
I/DD Non-Medicaid-funded Personal Care					22	988	100%	988
Day Supports					6	988	100%	988
Peer Support					0	988	**0%**	988
Transition Management Service					2	988	100%	988

D. Crisis Services

Group A, 2020

	Medicaid				Non-Medicaid Funded			
Crisis Service	# of providers accepting new Medicaid consumers	# and % of enrollees with access within the LME-MCO catchment area to at least one provider agency		Total # of Medicaid Enrollees	# of providers accepting new Non-Medicaid consumers	# and % of consumers with access within the LME-MCO catchment area to at least one provider agency		Total # of Consumers
		#	%			#	%	
Ambulatory Detox	0	0	0%	302,966	0	0	**0%**	5,551
Facility-Based Crisis – child	0	0	0%	144,539	0	0	**0%**	1,010
Facility-Based Respite					1	17,309	100%	17,309
Mobile Crisis Management	2	302,966	100%	302,966	2	17,309	100%	17,309

Group A, 2021

	Medicaid				Non-Medicaid Funded			
Crisis Service	# of providers accepting new Medicaid consumers	# and % of enrollees with access within the LME-MCO catchment area to at least one provider agency		Total # of Medicaid Enrollees	# of providers accepting new Non-Medicaid consumers	# and % of consumers with access within the LME-MCO catchment area to at least one provider agency		Total # of Consumers
		#	%			#	%	
Ambulatory Detox	0	0	0%	263,199	0	0	**0%**	5,284
Facility-Based Crisis - child	0	0	0%	141,177	0	0	**0%**	999
Facility-Based Respite					1	15,829	100%	15,829
Mobile Crisis Management	2	263,199	100%	263,199	2	15,829	100%	15,829

Group B, 2020

	Medicaid				Non-Medicaid Funded			
Crisis Service	# of providers accepting new Medicaid consumers	# and % of enrollees with choice of two provider agencies within the LME-MCO catchment area		Total # of Medicaid Enrollees	# of providers accepting new Non-Medicaid consumers	# and % of consumers with choice of two provider agencies within the LME-MCO catchment area		Total # of Consumers
		#	%			#	%	
Facility-Based Crisis – adults	2	158,427	100%	158,427	2	16,299	100%	16,299
Detoxification (non-hospital)	1	0	0%*	302,966	1	0	**0%***	5,551

*This service is available, but providers have elected to bill detox services as FBC instead of using NHD billing codes.

Group B, 2021

	Medicaid				Non-Medicaid Funded			
Crisis Service	# of providers accepting new Medicaid consumers	# and % of enrollees with choice of two provider agencies within the LME-MCO catchment area		Total # of Medicaid Enrollees	# of providers accepting new Non-Medicaid consumers	# and % of consumers with choice of two provider agencies within the LME-MCO catchment area		Total # of Consumers
		#	%			#	%	
Facility-Based Crisis - adults	2	122,022	100%	122,022	2	14,830	100%	14,830
Detoxification (non-hospital)	1	0	0%	263,199	1	0	**0%**	5,284

*This service is available, but providers have elected to bill detox services as FBC instead of using NHD billing codes.

E. Inpatient Services

2020

	Medicaid				Non-Medicaid-Funded			
Service	# of providers accepting new Medicaid consumers	# and % of enrollees with access within the LME-MCO catchment area to at least one provider agency		Total # of Medicaid Enrollees	# of providers accepting new Non-Medicaid consumers	# and % of consumers with access within the LME-MCO catchment area to at least one provider agency		Total # of Consumers
		#	%			#	%	
Inpatient Hospital – Adult	7	158,427	100%	158,427	4	15,362	100%	15,362
Inpatient Hospital – Adolescent/Child	4	144,539	100%	144,539	1	841	100%	841

2021

	Medicaid				Non-Medicaid-Funded			
Service	# of providers accepting new Medicaid consumers	# and % of enrollees with access within the LME-MCO catchment area to at least one provider agency		Total # of Medicaid Enrollees	# of providers accepting new Non-Medicaid consumers	# and % of consumers with access within the LME-MCO catchment area to at least one provider agency		Total # of Consumers
		#	%			#	%	
Inpatient Hospital – Adult	7	122,022	100%	122,022	5	14,005	100%	14,005
Inpatient Hospital – Adolescent/Child	4	141,177	100%	141,177	1	836	100%	836

F. Specialized Services

2020

Service – choice of two provider agencies within the LME-MCO catchment area	Number Provider Locations with Current Medicaid Contract	Number Provider Locations with Current Contract for Non-Medicaid Funded Services
MH Group Homes		26
Psychiatric Residential Treatment Facility	14	**0**
Residential Treatment Level 2: Therapeutic Foster Care	22	**0**
Residential Treatment Level 2: other than Therapeutic Foster Care	6	**0**
Residential Treatment Level 3	21	
Residential Treatment Level 4	1	
Child MH Out-of-home respite		2
I/DD Respite		8
(b)(3) I/DD Out-of-home respite	19	
(b)(3) I/DD Facility-based respite	**0**	
(b)(3) I/DD Residential supports	63	
Intermediate Care Facility/IDD	75	

2021

Service – choice of two provider agencies within the LME-MCO catchment area	Number Provider Locations with Current Medicaid Contract	Number Provider Locations with Current Contract for Non-Medicaid Funded Services
MH Group Homes		25
Psychiatric Residential Treatment Facility	13	**0**
Residential Treatment Level 2: Therapeutic Foster Care	22	**0**
Residential Treatment Level 2: other than Therapeutic Foster Care	5	**0**
Residential Treatment Level 3	24	
Residential Treatment Level 4	1	
Child MH Out-of-home respite		2
I/DD Respite		8
(b)(3) I/DD Out-of-home respite	22	
(b)(3) I/DD Facility-based respite	**0**	
(b)(3) I/DD Residential supports	65	
Intermediate Care Facility/IDD	80	

G. C-Waiver Services

Group A, 2020

C-Waiver Services-Choice of two providers					
			# and % of enrollees with choice of two provider agencies within the LME/MCO catchment area		
Services	**Adult**	**Child**	#	%	**Total # of C-Waiver Enrollees**
Community Living and Supports	✓	✓	1,752	100 %	1,752
Community Navigator	✓	✓	1,752	100 %	1,752
Community Navigator Training for Employer of Record	✓	✓	1,752	100 %	1,752
Community Networking	✓	✓	1,752	100 %	1,752
Crisis Behavioral Consultation	✓	✓	1,752	100 %	1,752
In Home Intensive	✓	✓	1,752	100 %	1,752
In Home Skill Building	✓	✓	1,752	100 %	1,752
Personal Care	✓	✓	1,752	100 %	1,752
Crisis Consultation	✓	✓	1,752	100 %	1,752
Crisis Intervention & Stabilization Supports	✓	✓	1,752	100 %	1,752
Residential Supports 1	✓	✓	1,752	100 %	1,752
Residential Supports 2	✓	✓	1,752	100 %	1,752
Residential Supports 3	✓	✓	1,752	100 %	1,752
Residential Supports 4	✓	✓	1,752	100 %	1,752
Respite Care – Community	✓	✓	1,752	100 %	1,752
Respite Care Nursing – LPN & RN	✓	✓	1,752	100 %	1,752
Supported Employment	16 & older		1,586	100 %	1,586
Supported Employment – Long Term Follow-up	16 & older		1,586	100 %	1,586
Supported Living	18 & older		1,476	100 %	1,476

Group A, 2021

C-Waiver Services-Choice of two providers					
			# and % of enrollees with choice of two provider agencies within the LME/MCO catchment area		
Services	**Adult**	**Child**	#	%	**Total # of C-Waiver Enrollees**
Community Living and Supports	✓	✓	1,793	100%	1,793
Community Navigator	✓	✓	1,793	100%	1,793
Community Navigator Training for Employer of Record	✓	✓	1,793	100%	1,793
Community Networking	✓	✓	1,793	100%	1,793
Crisis Behavioral Consultation	✓	✓	1,793	100%	1,793
In Home Intensive	✓	✓	1,793	100%	1,793
In Home Skill Building	✓	✓	1,793	100%	1,793
Personal Care	✓	✓	1,793	100%	1,793
Crisis Consultation	✓	✓	1,793	100%	1,793
Crisis Intervention & Stabilization Supports	✓	✓	1,793	100%	1,793
Residential Supports 1	✓	✓	1,793	100%	1,793
Residential Supports 2	✓	✓	1,793	100%	1,793
Residential Supports 3	✓	✓	1,793	100%	1,793
Residential Supports 4	✓	✓	1,793	100%	1,793
Respite Care - Community	✓	✓	1,793	100%	1,793
Respite Care Nursing – LPN & RN	✓	✓	1,793	100%	1,793
Supported Employment	16 & older		1,665	100%	1,665
Supported Employment – Long Term Follow-up	16 & older		1,665	100%	1,665
Supported Living	18 & older		1,556	100%	1,556

Group B, 2020

C-Waiver Services – Access to at least one provider					
			# and % of enrollees with choice of two provider agencies within the LME/MCO catchment area		
Services	**Adult**	**Child**	#	%	**Total # of C-Waiver Enrollees**
Day Supports	✓	✓	1,752	100 %	1,752
Out of Home Crisis	✓	✓	1,752	100 %	1,752
Respite Care - Community Facility	✓	✓	1,752	100 %	1,752
Financial Supports	✓	✓	1,752	100 %	1,752
Specialized Consultative Services (at least one provider of one of multiple services)	✓	✓	1,752	100 %	1,752

Group B, 2021

C-Waiver Services – Access to at least one provider					
			# and % of enrollees with choice of two provider agencies within the LME/MCO catchment area		
Services	**Adult**	**Child**	#	%	**Total # of C-Waiver Enrollees**
Day Supports	✓	✓	1,793	100%	1,793
Out of Home Crisis	✓	✓	1,793	100%	1,793
Respite Care - Community Facility	✓	✓	1,793	100%	1,793
Financial Supports	✓	✓	1,793	100%	1,793
Specialized Consultative Services (at least one provider of one of multiple services)	✓	✓	1,793	100%	1,793

II. Medicaid Quantitative Availability Analysis

Alliance has established standards for behavioral health practitioner and provider availability for Medicaid-funded services and evaluates network sufficiency as a ratio of practitioners to members or provider service sites to members. For purposes of establishing access and availability standards, a distinction is made between *practitioners* and *providers*:

- **Practitioners** are licensed or certified professionals who provide behavioral health services, including licensed practitioners in areas of Psychiatry, Psychology, Counseling, Addictions, Social Work and Allied Health. Licensed practitioners may work as employees of a provider organization or may contract directly with the MCO as a Licensed Independent Practitioner.

- **Providers** are institutions, organizations that provide behavioral health services, including corporations, partnerships, agencies, group practices, hospitals and other legally recognized entities.

Network Sufficiency of Practitioners:
The following table summarizes Alliance network availability by practitioner category, in comparison to our network standards for each group. Access standards are expressed as a ratio of practitioners to members, with the added requirement that 95% of members must have access to the practitioner within 30 miles or 30 minutes driving time. As the data show, we currently meet standards for all practitioner categories

Practitioner Category	Practitioner to Member Ratios			Access < 30 miles/minutes		
	Standard	Performance	Met	Standard	Performance	Met
Psychiatrists and Physicians (MD/DO)	1:2,000	1:360	Met	95%	100%	Met
Non-MD prescribers (Nurse Practitioners, Physician Assistants)	1:2,000	1:260	Met	95%	100%	Met
Doctoral level Licensed Psychologists (LP)	1:3,000	1:2,831	Met	95%	100%	Met
Master's Level Practitioners	1:1,000	1:163	Met	95%	100%	Met
Licensed Psychological Associates (LPA)		1:5,315	Met	95%	100%	Met
Licensed Clinical Social Worker (LCSW/LCSWA)		1:244	Met	95%	100%	Met
Licensed Clinical Mental Health Counselors (LCMHC/LCMHCA)		1:543	Met	95%	100%	Met
Licensed Marriage and Family Therapists (LMFT/LMFTA)		1:3,330	Met	95%	100%	Met
Licensed Clinical Addiction Specialists (LCAS/LCASA)		1:743	Met	95%	100%	Met

Quantitative Analysis

- As the table above shows, Alliance has exceeded practitioner to member ratio goals for each practitioner type.
- We also exceeded the geographic distance and travel time standards for each category, which indicates that all members have a choice of at least two practitioners of each type within 30 miles driving distance and 30 minutes driving time.
- Within the Masters Level Practitioners category, we have set the standard to reflect the aggregate number of master's level clinicians rather than specific licensure subcategories, but have reported the subcategories above to show the composition of our network within this category.

Qualitative Analysis

- Since all of the standards were met, a detailed barriers analysis is not needed at this time. No additional actions needed at this time.
- The table above shows that we have an adequate number of psychiatrists, non-MD prescribers, doctoral level psychologists and masters level practitioners across the Alliance catchment area.

Next steps

- Alliance will continue monitoring provider and practitioner availability at least annually, and will address network gaps as needed throughout the year.
- Although the behavioral health provider network is closed to enrollment for most services, we have maintained Alliance has kept the network open for areas of identified need, including psychiatrists, ABA providers, and Spanish speaking providers.

Network Sufficiency of Providers:

In addition to Alliance standards for network sufficiency of *practitioners*, we have established similar standards for *provider* sufficiency as a ratio of members to providers. Alliance performance on these access standards is consistent with the results discussed in the previous section, and results are available in **Appendix A**.

III. Geographic Access Maps Overview

Geographic Access Maps for 2020 and 2021 reports are provided in the **Geographic Access Maps Supplement** (provided as a separate document) for Medicaid and Non-Medicaid funded services listed in these requirements, except for outpatient services. Geo maps for 2020 and 2021 show provider agencies with Alliance contracts as of 4/1/2020 and 4/1/2021, respectively, and include services in the following categories:

1. **Location-based services** – one geo map for each Medicaid and Non-Medicaid funded location-based service. Provider locations are shown with a **radius of 30 miles**.

2. **Community/Mobile Services** – one geo map for each Medicaid and Non-Medicaid funded community/mobile service that shows provider locations within the **Alliance catchment area**.

3. **Crisis Services** – one geo map for each Medicaid and Non-Medicaid funded crisis service that shows provider locations within the **Alliance catchment area**.

4. **Inpatient Services** – one geo map for each Medicaid and Non-Medicaid funded inpatient service that shows provider locations within the **Alliance catchment area**.

5. **Specialized Services** – one geo map for each Medicaid and Non-Medicaid funded specialized service that shows provider locations within **North Carolina**.

6. **C-Waiver services** – one geo map for each **C-Waiver residential** and **day supports** service that shows provider locations within the **Alliance catchment area**.

7. **Additional Opioid Services**: one geo map for prescribers of Buprenorphine that the LME/MCO has a contract with that addresses opioid use disorder needs for person in the LME/MCO network.

IV. Access to Care for Emergent, Urgent and Routine Services

As required by the Alliance contracts with DMA and DMH/DD/SAS, Alliance monitors and ensures consumer access to emergent, urgent and routine care. The timely access requirements for each category are as follows:

- Emergent: service provided within two hours of referral
- Urgent: service provided within 2 calendar days of referral
- Routine: service provided within 14 calendar days of referral

Alliance staff work closely with providers to ensure timely access to care, and the provider network includes service models such as walk-in clinics, two Behavioral Health Urgent Care sites, and Mobile Crisis Management services that help achieve timely access to care. We are also working with providers to develop integrated behavioral health/primary care services that promote improved behavioral health screening, referral and member engagement in care. Alliance Care Coordinators also assist with referrals from critical community locations such as hospital EDs, inpatient and crisis facilities, and schools in Wake County through the school-based care coordination team.

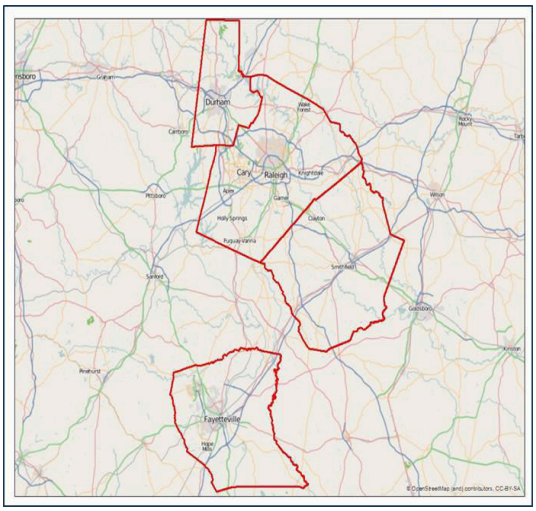
Member access is monitored most closely for individuals who contact our Access & Information Center, since Alliance has information about the date and time of the service request and can track the timeliness of initiation of care. Individuals who choose to call our Access & Information Center receive 24/7/365 live assistance by qualified Alliance staff, who are able to provide information about service availability and can schedule appointments with providers directly through the "slot scheduler" online database of provider appointments. Alliance Access staff link Members to the appropriate services requested, with a goal of meeting the timeframes specified by the state.

Alliance has established protocols for screening and triaging callers in order to collaborate with the network of providers to meet this need. The Access Center uses an Appointment Availability Dashboard which provides a real time view of network appointment availability and capacity. In the event that there may be a limited number of timely appointments available, the Access Center outreach to providers to have them enter additional availability into the scheduler system. In FY 2020, our Access Center was able to schedule routine appointments with providers within 6.4 days of a callers request for services.

Individuals who present directly to our provider agencies may choose to call the provider to make an appointment or show for walk-in hours. Information about providers in our network are available on our webpage using the Provider Search Tool or printed in the New Member Handbook. For those who contact providers directly, Alliance monitors timeliness of onset of care through provider monitoring and response to member complaints, and we have expanded monitoring to include regularly scheduled check-in calls by Provider Network Development Specialists (PNDS), who contact a selected sample of providers each month. During these check-in calls, the PNDS confirms provider directory access, status of referral acceptance, and appointment availability, including timeliness of intake appointments and follow-up appointments including medication management. Alliance also evaluates consumer access and develops quality improvement strategies through the Access to Care Quality Improvement Plan.

Section Two
Accommodation

I. Description of Service Region and Demographics



Alliance Health comprises Cumberland, Durham, Johnston and Wake Counties and covers roughly 2,565 square miles with a total population of 1,978,097. 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.

Table 1: Population and Growth

County	Population	Square Miles	Persons per Square Mile	Projected Population Growth 2020-2030
Cumberland	335,509	652	515	0.6%
Durham	321,488	286	1,124	14.3%
Johnston	209,339	791	265	27.0%
Wake	1,111,761	835	1,331	19.7%
Alliance Total	1,978,097	2564	771	

2019 U.S. Census Bureau Estimate, NC OSBM, Projected Population Change in NC Counties, 2020-2030

Growth. All counties except Cumberland in the Alliance area anticipate significant growth over the next ten years, and with the exception of Cumberland, all counties are expected to grow at a rate that exceeds the state growth rate. For all but Cumberland, over half of the population growth is accounted for by in-migration, and Cumberland's rate of growth is offset by out-migration. 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.

Age and Sex. Compared to NC and US averages, all Alliance counties have above average proportions of children under 5 years of age, and a lower than average population over the age of 65. This may reflect the results of in-migration of younger residents. The median ages for each county show an upward trend, consistent with national demographic trends of an aging overall population. Population sex distributions for Johnston and Wake are close to the NC average, with Cumberland showing a higher % of males and Durham demonstrating a higher % of females than the NC average.

Table 2: Age and Sex by County

County	% under 5	% under 18	% 18-65	% 65+	% Female
Cumberland	7.5%	24.7%	63.1%	12.2%	50.4%
Durham	6.3%	20.4%	66.0%	13.6%	52.3%
Johnston	6.2%	25.2%	61.2%	13.6%	51.0%
Wake	6.0%	23.6%	64.4%	12.0%	51.4%
NC	5.8%	21.9%	61.4%	16.7%	51.4%
US	6.0%	22.3%	61.2%	16.5%	50.8%

Source: US Census Bureau, 2019 QuickFacts

Members Served. Alliance providers served 46,098 Medicaid enrollees and 17,885 Non-Medicaid members in calendar year 2019, as summarized in the following table:

Table 3: Members Served by County

County	**Medicaid**	**Non-Medicaid**
Cumberland	14,389	3,483
Durham	9,120	4,039
Johnston	5,761	1,917
Wake	17,109	8,463
TOTAL	46,098	17,885

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. For the population of individuals speaking a language other than English at home, Durham and Johnston had the highest percentages who speak English 'less than very well.'

Although the primary non-English language spoken in all counties 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. Billing data from the Alliance language line vendor for the current year indicate that most

foreign language calls to the Call Center have been in Spanish (92%), followed by Arabic (3%), Vietnamese (2%) and a smaller number of calls (<10) in Portuguese, Mandarin, Russian, French, Nepali and Swahili.

Table 4: Language

County	Language other than English spoken at home	Spanish	% Speaking English Less than 'Very Well'
Cumberland	11.6%	7.0%	27.9%
Durham	18.6%	11.8%	53.2%
Johnston	13.0%	11.1%	42.9%
Wake	17.2%	8.3%	37.8%
NC	11.8%	7.6%	41.8%
US	21.6%	13.4%	39.9%

Source: American Community Survey, 5-year Estimates, 2019

Income and Poverty. Census data indicate that economic barriers remain challenges for many individuals throughout the Alliance catchment area. Although all but Cumberland exceed the state average for median income, the per capita income for both Cumberland and Johnston counties falls below the state average, and all counties but Wake exceeded the state average for % in poverty, with the highest rates of poverty being in Cumberland County, which also had the highest rate of children in poverty. Poverty data varied by racial breakdown. Consistent with overall NC economic disparity data, Latinx, Black and American Indian populations represented the highest numbers in poverty, although the relative impact on each group varied by county.

Table 5: Income and Poverty

County	Median Income*	Per Capita Income	% in poverty
Cumberland	$46,875	$24,936	18.0 %
Durham	$60,958	$35,398	14.0%
Johnston	$59,865	$27,924	12.5%
Wake	$80,591	$40,982	8.0%
NC	$54,602	$30,783	13.6%
US	$62,843	$34,103	10.5%

**Median household income in 2019 dollars, 2015-2019*
Source: US Census Bureau, 2015-2019 American Community Survey 5-year estimates

Table 6: Poverty by race/ethnicity

	Cumberland	Durham	Johnston	Wake	NC
Black	23.9%	19.8%	18.7%	15.4%	23.5%
White	12.7%	7.7%	8.2%	5.8%	10.6%
Latinx	20.7%	30.6%	32.1%	23.1%	28.5%
Asian	10.2%	19.1%	7.9%	8.9%	11.9%
American Indian	30.3%	16.4%	20.9%	10.7%	25.1%
Total Population	17.0%	13.5%	11.7%	8.4%	14.1%

Source: County economic snapshots, NC Justice Center, www.ncjustice.org/publications/county-economic-snapshots-2020/

Health Insurance. The highest rates of uninsured for individuals under 65 are in Johnston and Durham counties, both of which exceeded the state average. All counties but Wake exceeded the US average for % of the population without insurance.

Table 7: Health Insurance

County	Population under 65 without health insurance
Cumberland	10.7%
Durham	12.6%
Johnston	13.6%
Wake	10.0%
NC	13.4%
US	9.5%

Source: US Census Bureau, 2019 QuickFacts

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.

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.

Additional health data for each county are available in **Appendix C**.

Education. With the exception of Johnston, all Alliance counties have higher population rates of high school graduates, and Wake and Durham exceed the state average high school graduation rate. Wake and Durham also exceed the state average for % of the population with a Bachelor's degree of higher. For the high school data, the population % rate reflects the overall educational attainment of the adult population, which includes individuals who received an education in a particular county as well as those who have moved to the county. In contract, the graduation rate reflects the most recent graduation rates for each county school system.

The education rates are relevant considerations in understanding other measures, trends and disparities regarding socioeconomic variables such as poverty, home ownership, access to insurance and healthcare and social determinants of health.

Table 8: Education

County	% HS Graduates	% Bachelor's degree or higher	High School Graduation Rate
Cumberland	91.0%	25.5%	83.8%
Durham	88.4%	48.2%	82.9%
Johnston	86.9%	22.9%	93.5%
Wake	93.0%	52.8%	89.9%
NC	87.8%	31.3%	86.5%

Sources: Percent of individuals age 25 years or older 2013-2017, US Census Quickfacts; NC Justice Center; HS Graduation rate: County Health Rankings and 4-year Cohort Graduation Rate Report, ncpublicschools.org

Homeless population and housing instability. Three of the four Alliance counties have higher rates of homelessness than the surrounding region, and rates of homelessness in Alliance counties were highest in Cumberland, followed by Durham, Wake and Johnston, based on the 2018 North Carolina Point-in-Time Count of People Experiencing Homelessness. The 2018 PIT count showed a 3.4% increase in homelessness compared to 2017, but North Carolina's overall rate of homelessness has declined by 24% since 2010.

Table 9: Homelessness

Continuum of Care	Ave. # homeless	# Homeless per 10,000
Fayetteville / Cumberland	372	11.2
Durham City & County	338	10.8
Johnston	27*	n/a
Raleigh/Wake	983	9.2
NC	9,268	9

National Alliance to End Homelessness, https://endhomelessness.org

**based on 2018 Point-in-Time County from NC Balance of State Continuum of Care*

One contributing factor to housing instability is the cost of renting and home ownership. The following data show an increased housing cost burden, rate of severe housing problems and rate of eviction for Cumberland and Durham counties in comparison to the NC average, while rent burden is highest in Johnston and Cumberland counties. Affordable housing is consistently reported to be a significant barrier for many Alliance members, and Alliance is taking numerous actions to address this critical social determinant of health.

Table 10: Affordable Housing

	Cumberland	Durham	Johnston	Wake	NC
Rent Burden	30.5%	29.9%	31.9%	28.5%	30.3%
People paying more than 30% of income toward rent	52.7%	49.0%	50.0%	49.1%	52.9%
Severe Housing Cost Burden: % paying more than 50% of household income on housing	17%	15%	11%	11%	13%
Severe Housing Problems	16%	17%	13%	14%	16%
Fair market rent for a two-bedroom unit	$893	$1,055	$1,086	$1,026	$1,086
Eviction Filing Rate	14.0%	17.9%	7.4%	10.1%	10.9%
Eviction rate	7.0%	5.1%	4.2%	3.3%	4.6%

Sources:NC Justice Center County economic snapshots ,www.ncjustice.org/publications/county-economic-snapshots-2019/; Eviction Lab: 2016 eviction statistics, https://evictionlab.org, Robert Wood Johnson Foundation, County Health Rankings, www.countyhealthrankings.org

Special Populations

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, all Alliance counties have a higher percentage of Hispanic/Latino population, with Durham and Johnston having the highest percentage of Alliance counties. In contrast to community demographics, claims data reveal disparities between community demographics and race/ethnicity of members served. Disparities are most pronounced for African-American Medicaid enrollees, who have a higher service penetration in all counties than their community demographic representation.

Table 11: Community Race and Ethnicity

County	White	Black	Asian	American Indian	Hispanic/ Latino
Cumberland	51.1%	39.1%	2.7%	1.9%	12.1%
Durham	54.0%	36.9%	5.5%	0.9%	13.7%
Johnston	78.8%	17.0%	0.9%	0.9%	14.1%
Wake	67.9%	21.0%	7.7%	0.8%	10.4%
NC	70.6%	22.2%	3.2%	1.6%	9.8%

Will not equal 100% due to more than one race being reported. Source: US Census Bureau, 2019 QuickFacts

Table 12: Medicaid Race

County	White	Black or African-American	American Indian / Native American	Pacific Islander	Asian	Other	Unknown
Cumberland	44.1%	50.3%	2.2%	0.4%	0.4%	0.0%	2.7%
Durham	36.8%	58.9%	0.4%	0.1%	0.3%	0.0%	3.5%
Johnston	75.7%	22.6%	0.3%	0.1%	0.2%	0.0%	1.2%
Wake	52.8%	42.4%	0.4%	0.2%	0.9%	0.0%	3.3%

Source for Tables 12-15:Alliance Microstrategies report for Medicaid enrollees served in 2020

Table 13: Non-Medicaid Race

County	White	Black or African-American	American Indian / Native American	Pacific Islander	Asian	Other	Unknown
Cumberland	53.0%	38.7%	2.4%	0.3%	0.4%	4.1%	1.0%
Durham	41.8%	42.1%	0.6%	0.1%	0.4%	12.8%	2.2%
Johnston	80.3%	15.6%	0.2%	0.0%	0.1%	3.2%	0.5%
Wake	57.6%	32.1%	0.5%	0.1%	1.0%	6.4%	2.3%

Table 14: Medicaid Ethnicity

County	Hispanic / Latino	Non-Hispanic	Unknown
Cumberland	7.1%	87.0%	5.9%
Durham	12.4%	81.9%	5.7%
Johnston	13.3%	81.9%	4.8%
Wake	15.0%	80.8%	4.2%

Table 15: Non-Medicaid Ethnicity

County	Hispanic / Latino	Non-Hispanic	Unknown
Cumberland	5.6%	92.7%	1.8%
Durham	19.6%	78.6%	1.8%
Johnston	10.8%	87.0%	2.2%
Wake	10.2%	88.3%	1.5%

People with Traumatic Brain Injuries. Alliance Health is currently the sole LME-MCO in North Carolina to be implementing services for traumatic brain injuries through a Medicaid waiver. In the past year, we have taken many steps to identify individuals with traumatic brain injuries (TBI) in the Alliance catchment area, and are working with providers to educate them about identification of individuals with prior TBI. Additional information about TBI services and network development for this population is available in **Section Four.**

People with Physical Disabilities. Alliance catchment counties vary considerably in regard to rates of disability, with relatively low rates in Wake and Durham and higher than state average rates in Cumberland.

Table 16: Disabilities

County	Disability	Hearing	Vision	Cognitive	Ambulatory	Self-Care	Independent Living
Cumberland	17.0%	4.8%	3.5%	8.2%	9.3%	3.2%	7.0%
Durham	8.9%	2.7%	1.7%	3.6%	5.4%	1.9%	4.1%
Johnston	12.6%	3.2%	1.9%	4.5%	8.5%	1.6%	5.9%
Wake	8.7%	2.2%	1.7%	3.8%	4.3%	1.4%	4.0%
NC	13.2%	3.6%	2.4%	5.4%	7.5%	2.7%	6.0%
US	12.7%	3.6%	2.3%	5.2%	6.9%	2.6%	5.9%

Source: US Census Bureau, 2019 American Community Survey 1-year Estimates Subject Tables

People with Visual and Hearing Impairments
As shown in Table 16, Cumberland County has significantly higher rates of individuals with visual impairments and those who are deaf or hard of hearing, a pattern that is consistent with its overall higher rate of individuals with disabilities.

Veterans, Military Members and their Families. 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 most recent NC Veterans Annual Report (2015), 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 13% of its residents having served in the military, compared to the NC state average of 6.7%. 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 Veterans Plan that provides additional information about current and planned initiatives to improve services for the military/veterans population. This document as well as other Veterans resources are available at: https://www.alliancebhc.org/consumers-families/veterans-resources/

Pregnant Women with Substance Use Disorders. Perinatal substance use is recognized as a global health problem, and epidemiological surveys show that, although many women quit or reduce substance use during pregnancy, a significant number continue to use tobacco, alcohol, cannabis, stimulants, opiates and other substances throughout their pregnancy, contributing to negative outcomes for both mother and child. Current prevalence data are limited, and there are barriers to self-reporting of substance use such as stigma and criminalization of SUD that may lead to attenuation of community estimates. Available data suggest that rates of opioid use in pregnancy have been increasing, and Alliance has been working with our provider network to increase availability of services for pregnant women that include evidence-based treatment of opioid use disorder for pregnant women. Available services include outpatient perinatal/maternal services, Medication Assisted Treatment programs, and specialized residential services for women and their children.

People who identify as LGBTQ. According to the UCLA School of Law Williams Institute, 4.0% of North Carolina residents identify as LGBTQ. Additional demographic information about the LGBTQ population for North Carolina are as follows:

- Gender: 61% female, 39% male
- Average age: 36.3 (compared to average non-LGBT age of 48.3)
- % with income < 24,000: 30%
- % with children: 26%
- Race/ethnicity:
    - 58% White
    - 22% Black
    - 11% Latino/a
    - 6% more than one race

Compared to non-LGBTQ persons, LGBTQ residents have a higher rate of unemployment (8% compared to 6%) and food insecurity (29% compared to 16%), as well as lower rates of insurance (21% uninsured compared to 14% for non-LGBTQ) and lower income.

Since most national and state surveys do not ask questions about sexual orientation and gender identify, it is difficult to estimate the number of LGBTQ individuals for specific counties or to obtain more detailed demographic and health information. Research studies suggest that many LGBTQ individuals face health disparities associated with societal stigma, discrimination, social isolation, and trauma due to experiences of violence and victimization. These factors may contribute to adverse health outcomes and barriers to accessing healthcare and social supports.

Sources: Williams Institute, https://williamsinstitute.law.ucla.edu , Office of Disease Prevention and Health Promotion, www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

People who are in Jails or Prisons

Alliance Health works collaboratively with local, State and Federal correctional systems to coordinate care for individuals who are being discharged from each system. Numerous studies find high rates of behavioral health conditions among individuals who are involved with the criminal justice system, and collaborative efforts between these systems and LME-MCOs are important opportunities to improve engagement in post-release care and to prevent adverse outcomes such as overdose, hospitalization and reincarceration. Table 17 summarizes the prevalence of Alliance catchment residents within the NC state correctional system. While the rank order of county data for individuals involved in the correctional system are consistent with the relative populations of each county, Cumberland has the highest percentage of the population in prison (42 per 10,000), followed by Durham (35 per 10K), Johnston (30 per 10K) and Wake (20 per 10K). Counties follow the same rank order with respect to relative involvement in the community corrections system.

Table 17: People who are in jails or prisons.

County	Prison	Community Corrections	Probation	Parole
Cumberland	1,391 (3.82%)	2,886 (3.05%)	2,360 (2.87%)	598 (3.95%)
Durham	1,094 (3.01%)	2,268 (2.39%)	1,892 (2.30%)	435 (2.87%)
Johnston	589 (1.62%)	1,292 (1.36%)	1,075 (1.31%)	244 (1.61%)
Wake	2,235 (6.14%)	5,638 (5.95%)	4.725 (5.75%)	1,065 (7.04%)
TOTAL	5,309 (14.6%)	12,084 (12.8%)	10,052 (12.2%)	2,342 (15.5%)

Source: North Carolina Department of Public Safety, custom offender report www.ncdps.gov
Percentages listed above reflect the county's % of total state count for each category

Youth in the Juvenile Justice System

Similar to the pattern observed for adults, counties vary with respect to rates of youth involvement with the juvenile justice system. As with adults, Cumberland County has the highest rate of involvement for three of four categories of juvenile justice involvement, while Johnston had the highest rate for the fourth, the Detention Admission Rate. For the category of 'undisciplined rate,' all counties were below the NC average, and for the 'delinquent rate' category, only Cumberland exceeded the state average. On the admission rates for detention and Youth Development Centers, however, all but Wake exceeded the average state admission rates.

Table 18: Youth in Juvenile Justice System

County	Undisciplined Rate	Delinquent Rate	Detention Admission Rate	YDC Commitment Rate
Cumberland	0.52	20.65	3.48	0.71
Durham	0.26	9.87	1.9	0.46
Johnston	0.31	8.95	6.7	0.55
Wake	0.42	6.7	0.55	0.03
NC	1.45	16.18	1.46	0.18

Source: NC Department of Public Safety, 2018 County Databook, https://www.ncdps.gov/documents/2018-county-databook

II. Access Barriers and Underserved Populations

Feedback about access barriers and populations that are considered to be underserved was obtained through the online survey of consumers, stakeholders, providers and staff. Survey respondents identified the following barriers to accessing care that affect a broad range of populations and demographic groups:

- Lack of reliable transportation to appointments
- Lack of insurance (uninsured and underinsured)
- Homeless/housing issues
- Limited information about how to obtain services
- Availability of qualified staff
- Cost of medication
- Limited service quality and choice
- Long waits for appointments
- Language barriers

Most of the identified barriers for 2020-21 have been high priorities in past years, suggesting that the following areas remain persistent challenges to engagement in care:

Table 19: Multi-Year Trends in Reported Access Barriers

	2020-21	2019	2018	2017	2016
Limited transportation	1	1	Yes	Yes	Yes
Access to safe and affordable housing	2	3	Yes	Yes	Yes
Lack of funding / insurance coverage	3	2	Yes	Yes	Yes
Services not available nearby	4	4	Yes	Yes	Yes
Limited information about how to access services	5	5	Yes	Yes	Yes

Stakeholders also identified the following groups as being underserved populations that face more significant challenges in accessing care:

- People who are Dually Diagnosed (IDD/MI, SUD/MI or SUD/IDD)
- Individuals with IDD who are not on Innovations waiver
- People with Traumatic Brain Injuries
- People who are court-involved or in jails/prisons
- Complex/co-occurring medical
- Youth in the juvenile justice system
- Veterans, military members & families

As demonstrated above for barriers, survey results have yielded consistent results for underserved populations, as shown in Table 20.

Table 20: Multi-Year Trends in Reported Underserved Populations

Underserved Population	2020-21	2019	2018	2017
Dually Diagnosed (IDD/MI, SUD/MI or SUD/IDD)	1	1	Yes	Yes
IDD on Innovations waiver waitlist	2	2	Yes	Yes
Traumatic Brain Injuries	3	3	Yes	Yes
Justice system involvement (including individuals being discharged from jails and prisons)	4	4	Yes	Yes
Complex or chronic medical problems	5	5	Yes	Yes

In addition to barriers experienced by multiple populations, those identified as underserved face additional population-specific barriers. For example:

People who are dually diagnosed often face challenges such as lack of provider training, expertise and capacity to serve dually diagnosed individuals as well as system level barriers tied to funding streams and service eligibility. Alliance's new Care Team Model is designed to begin addressing some of these challenges**.**

Individuals with IDD who are on Innovations Waiver waitlist report challenges due to limited waiver funding as well as limited state funding to serve individuals on the waitlist. Additional challenges for many in the IDD population include limited availability of specialized services and lack of qualified staff for authorized services.

People with Traumatic Brain Injuries face limited resource availability, lack of specialized expertise and provider training, difficulty navigating system of care, and limited funding for uninsured. Other challenges are described in the next section on TBI.

People who are court-involved or in jails/prisons have multiple barriers to obtaining care, including limited access to behavioral healthcare within correctional settings, difficulty coordinating aftercare arrangements, and barriers to employment and housing due to criminal records.

Individuals with complex/co-occurring medical problems often face challenges in navigating the healthcare system, difficulty accessing specialized medical and behavioral health expertise, difficulty with transportation and limited access to healthcare for uninsured. The new Care Team Model is designed to help address many of these challenges.

Veterans may face barriers accessing care for those without VA healthcare benefits and sometimes report gaps in services or difficulty finding specialized care.

III. Community Supports Related to Social Determinants of Health

There is a growing recognition of the significant role of social determinants of health such as poverty, transportation access, housing and food insecurity as contributors to health outcomes. Alliance has been developing plans for addressing social determinants of health as an LME-MCO, and this area will remain an important are of focus in preparation for management of whole person care as a tailored plan.

Available demographic data suggest variability between counties in the prevalence and impact of specific social determinants, with higher than NC average rates of food insecurity particularly in Cumberland and more significant transportation challenges in Durham, based on national rankings of all US counties on multiple health and demographic variables. However, information sources for this data source may have limited scope to fully evaluate SDOH for our members, so additional efforts are in process.

Table 21: County Health Rankings on SDOH Variables

	Cumberland	Durham	Johnston	Wake	NC
Food insecurity: % of population who lack adequate access to food	19%	17%	12%	12%	15%
Limited access to healthy foods	13%	7%	2%	5%	7%
Food environment index (measure of access to healthy food and food insecurity, ranges from low of 0 to high of 10)	6.0	6.9	8.3	8.0	6.7

Source: *Robert Wood Johnson Foundation, County Health Rankings, www.countyhealthrankings.org*

As one step in gaining a better understanding of the experience of our members, Alliance care coordinators have been administering the Social Needs Assessment developed by Virginia Commonwealth University. We also incorporated several questions from this tool into our community survey to assess member and family experiences with employment, housing, transportation and food insecurity related barriers.

The Community Needs Survey also included stakeholder questions about perceived availability of resources in their communities to address the following social determinants of health:

- Employment
- Food insecurity
- Housing
- Transportation

The following table provides a summary of member and family survey responses:

Table 22: Member and Family SDOH Responses

Member & Family Experience (past 12 months)	Total Responses	Yes Responses	% Yes
Had to eat less than you felt you should because you did not have enough food	153	29	19%
Utility company shut off your service because you could not pay your utility bill	153	16	10%
You were worried about not having stable housing	153	33	21%
You needed to see a doctor but could not do so because of cost	151	28	19%
You had to go without healthcare because you did not have a way to get to your appointment	152	18	12%

The survey also included one additional question about transportation that asked members and families how often transportation was available when needed. Of the 157 respondents, 25% reported that transportation was either never, rarely or only sometimes available.

Stakeholder feedback results on social determinants of health are as follows:

Table 23: Stakeholder SDOH Responses

	% Inadequate	% Inadequate or Limited	% Good / Very Good
Employment	15%	69%	7%
Food Insecurity	11%	60%	13%
Housing	45%	87%	2%
Transportation	22%	74%	7%

One concern regarding interpretation of these results is the low response rate for members and families and the potential for under-representation in the survey sample by members who are adversely impacted by social determinants such as housing. The responses nonetheless suggest that social determinants are perceived as having a significant impact, and in combination with other survey data and demographic data, it is clear that this area should remain an area of high priority. See additional discussion and details in the Network Access Plan section.

Section Three
Acceptability

I. Methodology for Consumer and Family Input

The process for soliciting consumer and family feedback included use of on-line and hard copy surveys. Feedback was solicited through an internet-based survey using SurveyMonkey®. The survey included questions about access to care, barriers, populations with limited accessibility, and gaps in the service array. Member and family respondents were also asked several additional questions regarding service access, communication preferences and social determinants of health.

Surveys were administered anonymously and no identifying information was required. Survey links were posted on the Alliance website and were distributed to multiple member, provider and stakeholder e-mail lists. A request was sent to all Alliance staff requesting that links be forwarded to community contacts, and hardcopy versions of the survey were posted on the Alliance webpage for download by providers and stakeholders. Surveys were available in both English and Spanish.

Survey questions are provided in **Appendix G**.

II. Service Needs and Gaps Identified by Consumers & Family Members

The following identified gaps are applicable for multiple age and disability groups:

- Information about resources and assistance with system navigation, including education and outreach to members
- Services for individuals with dual diagnoses
- Individualized services for those with complex behavioral health and medical conditions
- Relief for primary caretakers / Respite

The following areas were identified as service gaps that may also be categorized as service barriers or underserved populations and have already been included above:

- Services to address transportation challenges
- Services for individuals with I/DD on Innovations waitlist
- Additional service capacity to improve timely access and provide choice (including extended hours)
- Housing/housing supports
- Services for uninsured
- Availability of qualified staff

With regard to specific age/disability groups, survey responses did not provide sufficient information to allow breakdown into subgroups.

Additional information about member and family feedback is available in **Appendix D**.

III. Methodology for Stakeholder Input

The process for soliciting stakeholder feedback included the following approaches:

1. **Community Survey.** As described above, the online survey solicited responses from members, family members, providers, stakeholders and staff. This year's survey also solicited feedback from Peer Support Specialists given their perspective as providers with lived experience of mental illness and/or addiction.

2. **Collective feedback from community workgroups, collaboratives and committees.** Alliance staff contacted existing groups such as crisis collaboratives, System of Care collaboratives, NAMI chapters and provider collaboratives and requested that they distribute electronic survey links to their membership. The electronic survey allowed respondents to identify group affiliation when completing the surveys, enabling analysis of group responses to survey questions.

   The list of community stakeholder input sources is provided in **Appendix D**.

IV. Service Needs and Gaps Identified by Stakeholders

The following identified gaps are applicable for multiple age and disability groups:

- Information about resources; education and outreach to members
- Services to address transportation challenges
- Housing/housing supports, and services for individuals who are homeless
- Services for uninsured
- Additional service capacity to improve timely access and provide choice Services for court-involved or those in prisons/jails

The following areas were identified as service gaps that may also be categorized as service barriers or underserved populations and have already been included above:

- Services for IDD on waitlist
- Services for dually diagnosed
- Services for individuals with Traumatic Brain Injuries

The following areas were identified as gaps for specific age/disability groups:

- **Adult Mental Health**: Service access for uninsured, availability of enhanced services such as ACTT and CST; housing assistance, transportation resources, availability of medication for uninsured, case management
- **Child Mental Health**: Case management, adequate and accessible crisis continuum for youth, residential treatment, respite and support for caregivers, family support services, and services for young children, including inpatient
- **Adult and Child I/DD:** services for individuals with autism spectrum diagnosis, services for individuals on the Innovations waitlist, respite, case management, day programs, housing resources, qualified staff and staff retention
- **Substance Use Disorders**: services for adolescents, services for uninsured, housing, residential treatment, transportation, case management, broader array of SUD services, programs that support recovery
- **Traumatic Brain Injuries:** case management, employment assistance, housing and housing supports, assistance with transportation challenges, residential treatment options and programs that support development of life skills, and independent living

Additional information about member and family feedback is available in **Appendix D**.

V. Service Needs and Gaps Identified by State Survey Respondents

Additional consumer and family survey input was obtained through the following State surveys for 2019 and 2020:

- Child Experience of Care and Health Outcomes (Child Medicaid ECHO Report): consumer satisfaction survey administered by NC Division of Medical Assistance (DMA) and the Carolinas Center for Medical Excellence (CCME).
- Adult Experience of Care and Health Outcomes (Adult Medicaid ECHO Report): adult version of the consumer satisfaction survey described above
- Mental Health and Substance Use Services Consumer Perception of Care Report: annual assessment of consumer satisfaction and perceptions of quality and outcomes of publicly funded Mental Health (MH) and Substance Use (SU) services. The main component of the survey is the nationally standardized *Mental Health Statistical Improvement Project* (MHSIP) survey.

Alliance has reviewed each survey through its Continuous Quality Improvement committees and has identified areas for improvement that align with other priorities listed above. Specific priority objectives identified through review of these surveys include:

Adults:

- Ensure that members feel that:
    - They are better able to deal with daily problems
    - Clinicians spend enough time with the member
    - Members are involved in treatment
    - They are helped by treatment

- Ensure that members feel that clinicians:
    - Show respect
    - Spend enough time
    - Provide a safe environment for treatment
    - Provide sufficient information and explanations

Youth/Child & Family

- Ensure that guardians feel that
    - Child is better able to accomplish things
    - They are given as much information as wanted to manage conditions
    - Child has someone to talk to when troubled
    - Child is helped by treatment

- Ensure that guardians feel that clinicians:
    - Show respect
    - Listen carefully
    - Provide sufficient information and explanations
    - Discuss goals for treatment completely
    - Get urgent treatment when needed

These survey results, in addition to member grievance data and Out-of-Network request data, have been summarized in the 2021 Member Experience Report, which is being tracked and implemented through the CQI Member Experience Subcommittee. See **Appendix F** for a more comprehensive analysis of survey results.

Section Four
Special Populations

The following section provides an update on Alliance activities regarding two statewide initiatives that are the result of legal settlements: Transitions to Community Living Initiative (TCLI) and Children with Complex Needs. For each topic, answers are provided to specific questions from DHHS about the overall status of Alliance activities, the sufficiency of our service array, gaps and needs, obstacles and barriers encountered, and actions being taken.

I. Transitions to Community Living Initiative (TCLI)

A. Community-Based Supportive Housing Slots

The following summarizes service gaps, obstacles, and recent activities and projects for the primary TCLI requirements for Community-Based Housing:

a. **Identification and engagement of eligible individuals**: Alliance continues to have a steady volume of referrals through RSVP who are category 4 and 5. Referrals for Category 2 and 3 are lower which makes it difficult to increase transitions from ACH's. TCL staff caseloads are high or at capacity so there is a barrier for individual assignment. Additional staffing is being pursued to address this concern. Alliance is also seeing an increase in referrals of members with barriers in cognitive functioning or with recommendations from discharge for 24/7 supervision. These members with complex support needs are challenging and require significant assessment, documentation, and interview information to determine eligibility status. This is not a fast process.

b. **Transition of individuals to community-based supported housing:** Especially with the pandemic, Alliance has experienced a harder time with assisting members in obtaining their vital documents, especially while at the SPH's. The absence of an ID card makes it difficult to access hotels and of course sign leases and delays the process. This year, Alliance started three bridge housing programs that provides support during community transition and also gives us the flexibility to work on securing vital documents. Two programs are located in Durham County and one in Wake County. A fourth program is expected to open the first quarter of FY22 in Cumberland County. Currently, there are seven dedicated beds for TCLI; however, TCLI has access to additional beds as needed. One program, Community Transition Recovery Program (CTRP), is for members with high and complex behavioral health needs who are transitioning from psychiatric hospitals, crisis centers or have rehousing needs after hospitalization. CTRP is a comprehensive program with nursing, case management, peer support, and

clinical staff. Housing availability is extremely limited in Wake/Durham counties.

Access to "targeted units" is difficult due to the lack of a real-time inventory availability. While we have made tremendous strides in accessing private units through the TCL Voucher, we are at capacity with current vendors and the inventory is very low or non-existent in some of our Counties. Alliance has increased access to mainstream vouchers. There are 33 in Durham County, 62 in Cumberland County, and 15 Housing Choice Vouchers in Wake County all with an Olmstead preference. There have been challenges with utilization and transferring those on the TCLV. A few reasons are: the extensive documentation; some TCLV units are over fair market rents; and the lack of housing inventory willing to take vouchers. Nevertheless, Alliance continues to prioritize moving members from the state to the federal subsidies. Another challenge is the dual responsibilities of the transition coordination staff. They are faced with the challenge of balancing new moves and rehousing individuals who have separated from housing – especially those evicted from their units due to lease violations. As the number of members requiring rehousing increases over the settlement it decreases housing options. Alliance is working in many ways to decrease separation rates as well as address tenancy concerns with rehousing. Additionally, Alliance has been working on connecting members with services which can sometimes pose as a challenge. This is still a barrier with providers being able to conduct CCA's in institutionalized settings. This creates a delay in getting individuals assesses and referred to the appropriate level of service. Alliance has added Assertive Engagement to provider contracts to help address this concern but CCA's continue to pose a barrier.

c. **Transition of individuals within 90 days of assignment:** The pandemic has posed new barriers to transitioning but Alliance is continuing to assist individuals to moving into PSH during this past fiscal year. Barriers to 90 day transitions continues with individuals with significant criminal histories/needs for private housing, past evictions, the increasing need for accessible and first floor units, increasing need for medical/physical/health supports, acquiring vital documents, individuals seeking housing outside Alliance's catchment area, and connectivity to providers and services. Alliance continues to address these barriers on an individual basis and works closely with the providers and all departments within Alliance to create positive outcomes. Alliance continues to work diligently to find housing for all TCL members even when the 90 day benchmark is not attained.

d. **Support of individuals' housing tenure and ability to maintain supportive community-based housing:** Alliance Transition/Care Coordination is required (per DMH/DMA contracts) for 90 days post-transition. The TCL & Care Coordination team steps back and the expectation is that ongoing support services are delivered by provider agencies. However, this presents many challenges and as of late we are experiencing housing separations. TCL Team needs staff capacity to provide ongoing support and monitoring of the contracted TCL providers as it relates to tenancy supports in housing, negotiating and troubleshooting issues with landlords, and rehousing individuals. Alliance TCL staff also routinely have to check in with providers to get updates on members and there are usually tenancy issues that have been occurring unbeknownst to us. Ideally, Alliance TCL staff should be informed immediately when serious tenancy issues are occurring so we can assist the member or the provider, or intervene with the landlord. Just getting updates and concerns about members from providers has been a recurring challenge for Alliance TCL staff.

   In response Alliance created a Supportive Housing department to address challenges with separations and to build provider competency surrounding tenancy. The program offers regular trainings and technical assistance to the providers. A round table discussion is held each month with the clinical leadership to address barriers and develop training strategies to support providers. Bi-monthly, office hours are held so providers have an opportunity to ask questions of the Supportive Housing team as they work through housing and rehousing members. Although this is a start, having additional staff would create capacity needed to do monitoring and provide better ongoing technical assistance to the providers. Another need is for onsite staff at the ISHP in hopes of reducing the separations on those properties. To help increase community tenure Alliance is also developing ways to utilize the new Care Team model to increase communication with private landlords and continues to refer to ADANC to help identify and connect members for opportunities to increase Community Inclusion. Additionally, service definitions such as Peer Supports and Individual Supports are currently being reviewed by a work group at Alliance to help engage individuals with appropriate levels of support to maintain housing.

B. IPS-Supported Employment

a. **Network capacity of IPS-SE services**: Alliance contracts with seven teams through five IPS-SE Supported Employment providers. Three providers are located in Wake County and one provider each in Cumberland and Johnston counties. Teams are distributed to cover all Alliance counties, and several teams cover multiple counties. Of the seven teams, three cover Wake, two cover Johnston, two cover Cumberland, and two cover Durham. There is a sufficient number of providers for current service need.

IPS Providers	**Community Partnerships (CPI)**	**Johnston County Industries**	**Easter Seals UCP Wake**	**Easter Seals UCP Durham**	**Easter Seals UCP Cumberland/ Johnston**	**Service Source**	**Monarch**
Counties Served	Wake Durham	Johnston	Wake	Durham	Cumberland Johnston	Cumberland	Wake
Team Composition	1 FTE Team Lead 1 FTE EPM 3 FTE ESP's	1 FTE Team Lead 1 FTE EPMs 3 FTE ESPs PA is also Benefits Counselor	1 FTE Team Lead 2 FTE EPMs 3 FTE ESPs	1 FTE Team Lead 1 FTE EPM 1 PT EPM 2 FTE ESP's 1 PT ESP	1 FTE Team Lead 1 FTE EPM 3 FTE ESPs Benefits Counselor is shared between teams	1 FTE Team Lead 1 PT EPM 1 FTE ESP 1 PT PA	1 FTE Team Lead 1 FTE EPM 2 FTE ESPs 1 PT PA
Waitlist	No	No	No	No	No	No	No
Fidelity	Fair	Fair	Fair	Fair	Fair	Good	Good

When we look at additional capacity of our IPS teams, we know that all of our teams are able to take referrals. Providers confirm that they are able to add FTEs to their team as caseloads reach capacity per the service definition in order to meet the need for new referrals.

b. **Service capacity requirements:** Alliance has increased the number of individuals newly enrolled in IPS-SE that meet the in/at risk of ACH over the past couple of years. Ongoing focus this year has been increasing the number of TCLI eligible individuals (all phases – In-Reach, Transition, Post-Transition) among the number of in/at-risk individuals newly served. Eligibility for State funded IPS has been limited to individuals who meet in/at-risk criteria due to continued decreases in funding availability. However, due to decreased spending in FY21, we were able to open up eligibility for State funded service to individuals who do not meet in/at-risk criteria. While we were able to expand eligibility for FY21, funding for the service remains a concern.

c. **Service gaps and needs:** We are hopeful that more of our IPS-SE providers will reach "good" fidelity. We have two of seven teams in this category – the others are in the "fair" fidelity category. We have uncoupled the rate from fidelity score and have standardized the rate at the 'good fidelity' level in an effort to provide all teams with sufficient funding to improve quality of services. There will be an alternative payment model implemented for FY22 that will be more outcome focused. Staff turnover continues to be a challenge, and FY21 has seen additional challenges around hiring staff. Some of these challenges are competition with providers of enhanced services that have higher rates of pay and effects of the pandemic—decrease in member comfort with engagement and contact, decrease in job market, and disruption of scheduling due to new limitations and needs around childcare for staff and members. Providers also cite transportation, differences between service definitions and fidelity model, uncertainty around funding availability, and developing and maintaining relationships with clinical partners as barriers to service delivery.

d. **Obstacles, barriers and initiatives.** The ability of IPS teams to bill for meeting with individuals to discuss IPS prior to authorization would be beneficial. This would increase IPS staff outreach and engagement to members who are still unsure about IPS services. TCL members often perseverate on the decision to receive IPS services, which results in the need for ongoing conversations to get connected to service. There is still significant fear regarding the potential for loss of benefits and continuous education is required. Recent, or ongoing, initiatives to increase referral of TCLI population include:
    - TCL staff have ongoing discussions regarding employment, education, and benefits counseling opportunities with all TCL members throughout the process.
    - Ongoing monthly IPS and CST Collaboratives. Members from the TCL Team continue to attend these collaboratives to provide education and updates regarding TCL in efforts to increase TCL referrals.
    - Alliance has also coordinated IPS provider presentations to CST and TMS providers to describe referral process and increase awareness of the IPS service.
    - Continued use of a TCL Referral form to identify TCL members as part of the priority population for providers.
    - Partnership with VR to create a universal referral form for direct referral from TCL team to VR and IPS provider simultaneously.
    - VR training provided to TCL team to increase awareness of all DVR

services.

- Proposed alternative payment model for IPS includes an incentive outcome payment for members who are TCL.
- This past fiscal year, Alliance continued with its quality improvement plan to increase referrals from TCL staff to IPS services.

C. Personal Outcomes and Sufficiency of Community-Based Mental Health Services

- ***Describe how the LME/MCO tracks and monitors the following personal outcomes for individuals in supportive housing:***

  At the end of May 2021 there were 443 individuals in supportive housing. Since the beginning of the Transitions to Community Living Initiative Alliance has transitioned a total of 632 individuals. The overall community tenure rate is 70%.

  Not all of the requested information for individuals living in supportive housing is readily available or currently tracked or requested. TCLI follows the individual for the first 90 days the individual is in housing, but we do not have a "post-transition" team. The provider agencies are responsible for providing tenancy support and behavioral health services once the individual moves in to their own place.

  - ***Supportive housing tenure and maintenance of chosen living arrangement*** is tracked through regular communication from the providers of tenancy support (ACTT, CST, TMS) via a monthly tenancy checklist. We do have problems obtaining checklists from all providers for all the individuals they support in TCLI supportive housing. We have recently designated one staff member to review the tenancy checklists for any areas indicated as high risk and to obtain additional information so we can assess needed interventions. In addition, we have a monthly separations deep dive to review reasons for housing separations and to review individuals at very high risk for separation. The separation reviews are helpful as the providers develop rehousing plans.
  - ***Inpatient hospital or psychiatric facility admissions and readmissions:*** we receive a report from the State psychiatric hospitals regarding all admissions regularly. We have the ability to review the information as Alliance staff work with the SPH to develop discharge plans. We are not regularly notified of psychiatric facility admissions/readmissions unless the individuals housing is in jeopardy. We rely upon our provider network to provide support to the individuals upon discharge back to their supportive housing unit.

- ***Adult care home admissions and readmissions***: individuals seeking entry into an adult care home, whether for the first time or for a readmission, are entered in the RSVP system. They must be screened for TCLI eligibility so we would know if an individual is/was currently in TCLI supportive housing. Upon entry they would be separated from housing and would enter/re-enter the In-Reach phase.
- ***Employment:*** ACTT: provider reports quarterly to LME-MCO & NCTOPPS; IPS: copy of reports that providers submit to DHHS; CST: not currently tracked but we are planning have CST submit quarterly reports as required for ACTT.
- ***School attendance/enrollment***: same as above
- ***Community integration and engagement***: this is only tracked by ACTT through NCTOPPS
- ***Natural supports network development and use of natural supports for crisis prevention and intervention***: some but not all of this data is tracked by ACTT through NCTOPPS

Use of crisis services, ***Emergency room visits and repeat visits***, and incidents of harm are not currently tracked specifically for individuals in supportive housing

2. Describe how the LME/MCO uses personal outcomes data to determine, plan, and deliver the frequency and intensity of services needed to support individuals in community-based housing.

Alliance requires that ACT and Community Support Teams use the DLA-20, and we are working to develop a plan for how to use DLA-20s to look at progress. Goals and interventions, including frequency and intensity of services, are developed as part of the person centered planning process which is completed by providers working with individuals, natural supports, and others who are supporting the individual.

3. Describe gaps and needs in the community-based mental health services provided to individuals in TCLI supportive housing. Discuss discrepancies between service capacity and service capacity requirements, and the sufficiency of services (array, intensity, frequency, quality, and effectiveness) as indicated by personal outcomes such as those listed above, not only access and choice standards.

Staff turnover and vacancies continue to be challenges, and the pandemic has exacerbated this. Providers report that there are fewer qualified applicants for open positions across the board. FY21 has also seen additional barriers to member

engagement that are pandemic related, i.e. decrease in member comfort with contact and limitations in ability to interact in the community.

Provider staffing challenges have impacted network capacity. IPS-SE providers have maintained ability to accept referrals and can meet capacity requirements. ACTT, CST, and TMS providers have had increasing difficulty with capacity due to staff vacancies and trouble hiring staff to expand teams if necessary.

Service gaps, obstacles and actions taken to resolve them

Primary service gaps for the TCLI population are community engagement, development of natural supports, and choice in daily living. We continue to emphasize the importance of tenancy, employment and community inclusion. When reviewing housing separations, the ACTT providers are included in this discussion to examine and identify contributing factors and areas of improvement. While provision of behavioral health and tenancy focused services is essential, these services do not fully address all of the needs an individual has in order to be engaged in the community. One approach to address these gaps is our pilot project with the Alliance of Disability Advocates NC (ADANC). This pilot is funded by DHHS to provide community inclusion supports and benefits counseling to TCLI recipients in the Alliance catchment area. Community inclusion Supports are provided to support individuals in identifying activities, events and opportunities for individuals to increase participation in their communities, and provide direct support to individuals so they can successfully become involved in community activities. Benefits counseling is designed to inform the individual (and guardian, payee representative, and/or natural support, if applicable) of the multiple pathways to ensuring individualized competitive and integrated employment or self-employment which results in economic self-sufficiency (net financial benefit) through the use of various work incentives.

Our challenges are two-fold – funding and provider engagement. Adequate funding is critical to support our providers in the delivery of services – primarily with TMS and IPS-SE. We plan to develop strategies to have performance based payment for providers who are supporting our TCLI individuals, and we also plan to increase provider accountability.

The expansion of TMS teams has not been extensive, in part due to the implementation of the revised CST service definition. The current TMS teams continued growth, and the need for TMS continues as individuals step down from higher levels of care. Due to funding restrictions, there is a need to further reduce reliance on TMS.

We are hopeful that more of our IPS-SE providers will reach “good fidelity”. We only have two of seven teams in this category – the others are in the “fair fidelity” category. The IPS-SE rate was uncoupled from provider fidelity score, so all

providers are now paid at the "good fidelity" rate. With additional funding, the agencies may be able to reach a higher fidelity level.

Additional steps taken to address service-specific gaps include:

- IPS-SE – Alliance is working with UNC Center for Excellence to develop an alternative payment model that will increase the use of VR milestones and provide an outcome based structure for payment. This is scheduled to launch in the first quarter of FY22. We continue to host and facilitate monthly IPS Learning Collaborative meetings to address challenges and barriers and to share successes and lessons learned.
- ACT –During FY21, we have continued to host and facilitate monthly ACT Collaborative meetings and TCL staff members attend the meetings to continue educating providers about TCLI. We have emphasized the importance of tenancy and employment, and we work with the teams to develop strategies to improve in these areas. For FY20, we used data collected via NC TOPPS. Analyzing data will help us look at trends, consider alternative methods of payment, and evaluate the impact of increased Community Inclusion, especially as it relates to community tenure.
- CST – We host and facilitate a monthly CST Collaborative that operates in similar fashion to the ACTT Collaborative.
- Tenancy Support - Development of alternative services to provide tenancy support – We are in the process of developing a scope of work for Individual Support and a scope of work for Peer Support with a Tenancy focus for FY22 that will decrease the reliance on TMS and clearly delineate the TMS and Peer Support services.

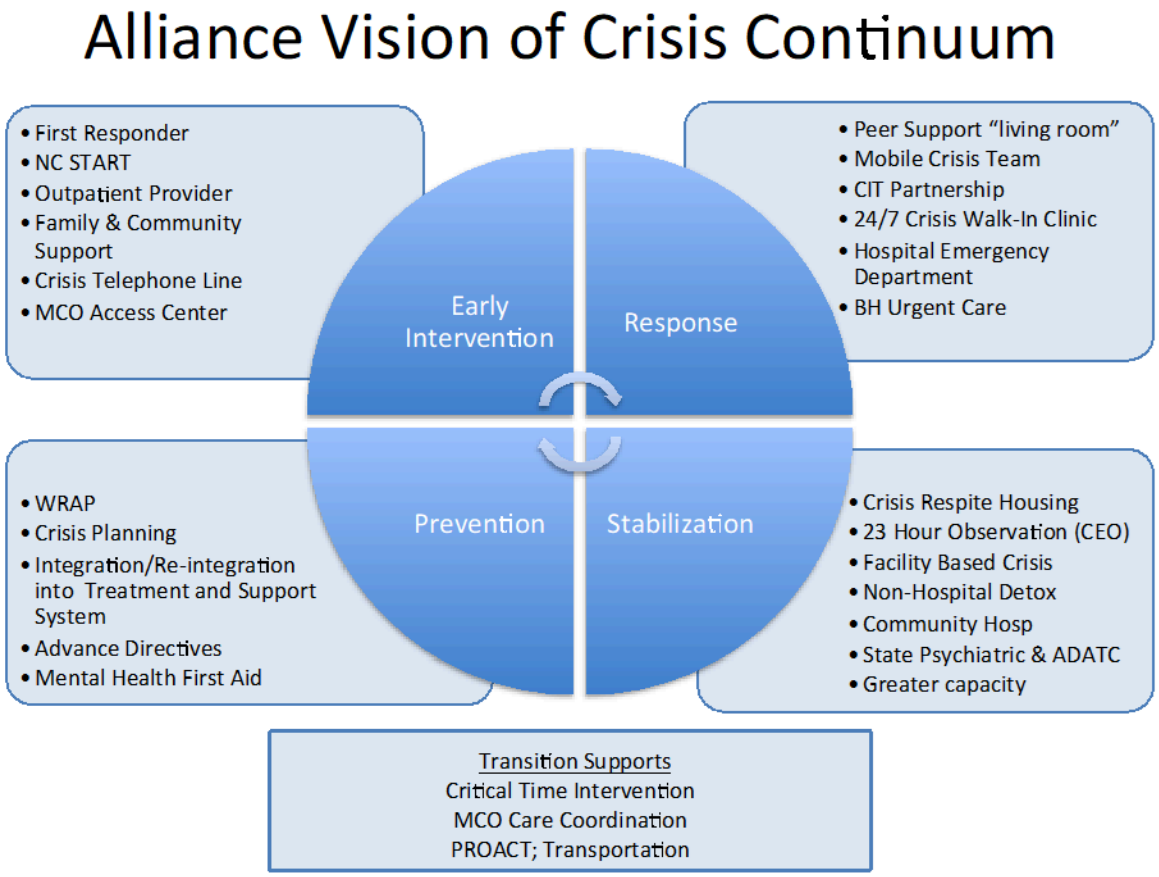
D. Crisis Services

Alliance continues to invest significant resources to expanding the crisis continuum to avoid unnecessary hospital utilization, incarceration and institutionalization. Like most other communities, ours are challenged with maintaining enough services to meet the needs. In each of our four counties, there is an active crisis collaborative that consists of hospitals, community partners, law enforcement, and crisis facilities and service providers who regularly gather to discuss and address challenges in our crisis continuum. We work together to identify needs and how to meet those needs. The current crisis continuum is organized in such a way that it provides services at the right place, right time, and with the right amount. The goal is to address crises in the least restrictive setting while ensuring that people receive the appropriate treatment to avoid future crises and/or unnecessary utilization of services that do not meet their needs. At each level, within each service, it is the expectation of the provider to consider the individual's crisis plan. As part of the contracting process, Alliance develops scopes of work for crisis services that provide detailed expectations for engagement, clinical treatment, and follow-up.

The following provides an update on the network adequacy of the LME/MCO crisis service system and its capacity to offer timely and accessible services and supports to individuals experiencing a behavioral health crisis. This scope of this summary applies both to the TCLI population as well as all individuals covered by the Alliance network. Additional information is provided about identified crisis continuum gaps and barriers, as well as actions taken to address identified gaps and barriers

<u>Network adequacy of the Alliance crisis continuum</u>

Alliance is committed to developing a comprehensive, accessible and effective crisis continuum within each of its communities, and is working to develop a crisis continuum that includes service and support components in each of four levels of care: 1) Early Intervention, 2) Response, 3) Stabilization, and 4) Prevention. The services within each level are listed in the chart below, and a more detailed overview of the Alliance crisis continuum is included in **Appendix E**.



As the tables in **Appendix E** show, there continue to be challenges with offering consistently timely response and stabilization services to all individuals experiencing a behavioral health crisis in each Alliance community. Areas of highest need include:

- Lack of inpatient psychiatric beds
- High volume at local crisis facilities
- Lack of state and county funding to expand walk-in crisis services in each county
- Frequent utilizers/familiar faces utilizing the ED for primary behavioral health care.

A continued key consideration as it relates to providing adequate and effective crisis services in the least restrictive setting is the availability of services at every point of the crisis continuum in each county. For example, individuals without insurance who face a crisis are generally able to access immediate crisis services, yet, the lack of funding for additional outpatient therapy capacity may keep them from accessing the appropriate follow-up care.

Actions taken to address gaps and barriers

During FY20 and FY21, Alliance continued to develop the crisis continuum through the initiatives described below. These actions were priorities for the Alliance Network Access Plan, and additional information is available in **Section Five** below.

- Tier III Behavioral Health Urgent Care (BHUC): this is an innovative model and increases community walk-in capacity and has expanded hours of operation. Services include brief assessments and on-site prescribers for the duration of operating hours. This service is available in Durham and Wake counties.
- Tier IV BHUC: this level of crisis care provides 24/7 services, and is now available in Cumberland, Durham and Wake counties. Recovery Innovations opened the Cumberland Recovery Response Center (CRRC) in May, 2020
- Several hospitals have added psychiatric beds during the past two years, including Holly Hill and Cape Fear Valley, which also plans to open an adolescent psychiatric unit in December, 2021.
- Alliance plans to add Mobile Outreach Response Engagement and Stabilization (MORES) to all counties in 2021. This model is a replication of Mobile Response Stabilization Services in New Jersey and elsewhere in the country, as well as in NC, Partners has been providing the service since 2018.
- Crisis residential programs for youth involved with Child Welfare, 8 boys and girls beds with Thompson's Youth and Family Focus in Charlotte (open now), and a plan for Thompsons to open a 6 bed crisis residential program in Cumberland County. The building, formerly licensed, is under renovation currently.
- Alexander Youth Network (AYN) adding 6 crisis beds for child welfare involved members on their Charlotte campus, and adding beds in Greensboro in 2022. Property has been purchased.
- The Hope Center for Youth and Family Crisis, an Alliance facility run by KidsPeace will be opening in the fall of 2021 as a Tier IV BHUC and Facility Based Crisis, with 10 adolescent beds and 6 beds for Children in Fuquay-Varina, NC.

The gaps and needs became heightened during the pandemic. There became a shortage of available psychiatric beds for youth and adults, community based crisis options, which was exacerbated by shortage of available beds at lower levels of care and youth not in school. This resulted in extraordinary numbers of youth in

emergency departments (statewide tracking in April 2020 averaged 20 youth in Emergency Departments, by November 2020 that average climbed to 70), and for those not acute enough for Emergency Departments, and involved with Child Welfare, these youth were simply dropped at DSS for them (and us) to find appropriate treatment services. This resulted in the effort to build out the child crisis system.

II. Children With Complex Needs

"Children with Complex Needs" are defined as Medicaid eligible children ages 5 to 21 with a developmental disability (including Intellectual Disability and Autism Spectrum Disorder) and a mental health disorder, who are at risk of not being able to enter or remain in a community setting due to behaviors that present a substantial risk of harm to the child or to others. The following summarizes Alliance network service gaps, access barriers, and initiatives taken to address gaps and barriers.

A. Identification & Engagement

1. **Describe service gaps and needs to identify and link CWCN to appropriate levels of service.** Based on anecdotal data many families would like to see more programs for transitional age children with autism who are leaving high school as Medicaid does not fund ABA after 21. Based on the previous report appropriate residential options, psychological services, ABA and day programs were noted as service gaps. All network remains open for ABA and psychological services. Due to limitations as a result of COVD-19 there has been an increase in families seeking NC START services. These families are being informed that NC START does not have a respite program for children as they do for members over 18. Families with young children are seeking options for planned breaks and it appears that there are limited respite options.
2. **Describe obstacles and barriers to identifying kids and linking CWCN to appropriate levels of service.** Children are identified based on the process flow attached. There are no barriers with the identification of the children. Because of how the data is collected it is established that there might be some false positives being reported. These children are showing up on the report based on claims data but not specifically because there is an official diagnostic criteria that they have met. The barrier is locating and making contact with children on the quarterly report with no billable claims. Letters are being drafted to be mailed out to these families with information on Alliance Health 24 hour access line as well as information on the I/DD eligibility process. Once a child is deemed I/DD eligible they are placed on the waitlist and a provider list is mailed with all the eligible services that are available. This is the focus of the next fiscal year to link children who are not currently engaging in services.

3. **Number of youths not receiving any recommended services**. Alliance has over 750 children on the CWCN quarterly report. Because of how we collect data there are some false positives in the mix. Please see the Process Flow that is used. In the past month the Point of Contact identified over two hundred and fifty children on the report that have not gotten any services within a 2-3 year period. There are no ED claims, no outpatient claims etc. One could assume these children are within the cohort of false positives as such they have a diagnosis that landed them on the report however they are thriving in their home environment and there hasn't been a need to engage the system. This is still yet to be determined.
4. **Describe activities for engaging families not receiving services or recommended services.** The Point of Contact for CWCN as well as staff within care coordination monitor children to learn more about their engagement in services. Often times a Family Partner might be added as a support to families. For children living in Wake County and enrolled in schools there is collaboration with the School Based Care Coordination to help resolve issues related to school and other barriers. Community Guide a B3 service is recommended to families to assist the family with identifying other programs and resources. Community Partnerships is also another resource that is utilized to assist families with basic things such as completing SSI applications, locating goods and services, following up on medical appointments etc. Our physical health nurse is also involved and will connect children with complex medical needs to CCNC for more direct physical health care management.

B. Case Management

1. **Number of youths receiving case management.** There are seven (0.9%)of children are receiving case management services
2. **Describe activities to refer and link CWCN to needed services and supports.** Twice per month 6 children are presented during CWCN case staffing. The Alliance medical team reviews medication, physical health and behavioral health concerns. Treatment recommendations are made and this is shared with the community providers and or care coordinators for those children engaged in LTS/MHSUD care coordination.
3. **Describe monitoring and follow-up activities for CWCN in regard to linkage and referral to needed services and supports**. Care coordination has active engagement with community teams to ensure that the recommendations are being addressed. Once these tasks are completed they are documented within the electronic medical records. Where there are barriers that continue to be outstanding the team will work to address the issues and provide monitoring and oversight. The Point of Contact for CWCN also provides technical assistance where there are cases that are not making sufficient progress.
4. **Describe other services and supports that have like or similar Case Management functions that are in place and would be duplicative of CM requested via EPSDT.**

High Fidelity Wrap, Multisystemic Therapy, Intensive in Home, Community Support Team all have a case management component. There are also 34 children with complex needs who are receiving Innovations Waiver services. Families are also being linked to community guide this also has a case management component. It should also be noted that children who are in TFC, Level III, and PRTF placement receive care coordination from Alliance. Children who are living at home and present at the ED are followed for the 7 Day Challenge to ensure they are connected to outpatient services. All of these services are in place and CM requested via EPSDT would be duplicative.

C. NC START

1. **What is the referral process to NC START**. All referrals are sent to the Point of Contact via email. The referral form and psychological are reviewed. The information is then added to the Excel spreadsheet. As of May 2021 Jiva now has the capacity for completion of a brief NC START assessment for each referral.
2. **How referrals are for NC START prioritized**. Referrals are prioritized by acuity and a review is done to see if the child has services in place. Where a child already has services such as ABA, IIH etc. they are encouraged to work with the current providers. Suggestions are also made for the development of behavior support plan or for the guardian to consider the use of the Murdoch Outpatient Clinic while they are on the waitlist.
3. **Number of CWCN who received NC START.** There are 69 children who received NC START services.
4. **Number of CWCN who are currently on the waitlist for NC-START**. There are 43 on the waitlist.

D. ABA

1. **Number ABA providers in the network accepting new member**s- There are 14 providers who are accepting new members.
2. **Of the total # in question 1. How many of the providers offer ABA in-home and how many offer ABA in-office, how many provide both in-home & in-office as an option**

   9 offer services in home,

   3 offer services in clinic only

   2 offer services at home, private school and day care
3. **Number of ABA requests for CWCN**—NA this information is not captured
4. **Number of CWCN approved for ABA**- In this past fiscal year 17 children were approved for ABA services
5. **Number of CWCN who received ABA service:** All approved utilized the service- 17 in total

III. Traumatic Brain Injury (TBI) Population

Identification of individuals with TBI:

As the sole North Carolina recipient of TBI waiver funding, Alliance Health is in the process of implementing network expansion and member outreach efforts to improve access to care for individuals with traumatic brain injuries. Individuals with TBI are identified through a combination of outreach efforts and a screening and referral process. When a history of TBI is noted, internal staff are able to refer members to TBI specific programming and services. Individuals who self-identify as having a TBI initiate contact through the Access Center, which operates 24 hours per day, 7 days per week. Individuals are then screened using the Ohio State University TBI pre-screening tool, which is a standardized procedure for eliciting a person's lifetime history of injury, including brain injury, via a 3-5 minute structured interview. Individuals who are identified through the pre-screen questions are referred for additional review, completed by a TBI Access Coordinator, in order to identify eligibility for potential services and supports. Further evaluation may be recommended as well as consultation with a Neuro-Resource Facilitator from the Brain Injury Association of NC (BIANC). TBI Dx is prevalent across the Alliance catchment area and appears across behavioral health populations.

TBI Services and Supports

Alliance has conducted extensive analysis of service data to begin identifying individuals with traumatic brain injuries. This analysis has found that individuals with TBIs are accessing and needing a wide range of services, similar in breadth to those who are categorized in Mental Health, Substance Use Disorder or Intellectual/Developmental Disabilities populations. Alliance is currently piloting North Carolina's first TBI Waiver. In addition, Alliance offers a TBI Case Management program and TBI Club House that offers an array of services and supports to Alliance's TBI population. Individuals with TBIs also routinely access other community systems of care and supports, including Veterans Administration medical services, privately funded healthcare, non-Medicaid provider networks (e.g., providers of neurobehavioral care who do not accept Medicaid), housing and homelessness services, medical care, primary and specialty care, crisis care providers, state-run hospitals and facilities, Skilled Nursing Facilities and healthcare services for uninsured (e.g., FQHCs). In addition, individuals with TBIs may be at higher risk of correctional system involvement.

Challenges in Service Provision:

In addition to common challenges associated with behavioral health service provision as described elsewhere in this document, service providers for traumatic brain injuries face numerous challenges that are specific to the population served. Several commonly cited challenges are lack of specialized services, limited provider understanding of TBIs, service system fragmentation, lack of natural supports for TBIs, and lack of competitive public sector service rates. With regard to the latter, there are challenges in access limited specialized

expertise when private sector rates may attract professionals to limit their availability to public sector members. Cognitive impairment including memory problems and executive functioning challenges of members may also result in difficulty attending appointments, decreased medication adherence, and increased risk of subsequent brain injury from being in at-risk environments.

Gaps and Needs of this population:

As noted elsewhere in this report, commonly reported gaps for individuals with TBIs include provider training on TBI, access to healthcare for non-Medicaid eligible; complexity of coordination of benefits, challenges in maintaining housing, barriers to qualifying for Medicaid, economic challenges (e.g., spend downs to qualify for benefits), lack of TBI specific long term planning specialists and lack of neurobehavioral level of care in NC for Medicaid. Members and families also identified gaps such as housing and housing supports, assistance with transportation challenges, Medicaid funded outpatient allied health/rehabilitative treatment, residential treatment options and programs that support development of life skills, recovery and independent living.

Member and Family Satisfaction

Current member and family satisfaction surveys have not focused sufficiently on the TBI population to enable analysis of satisfaction data. This is an important area for future development, and Alliance will be working with members and family, providers and stakeholders to develop ways to evaluate and respond to member and family satisfaction information. This year DHB completed a comprehensive TBI WAIVER family survey with results currently pending. Alliance also disseminated a TBI Waiver Care Coordination satisfaction survey and is currently reviewing results. Alliance continues to meet with TBI Waiver Stakeholder group and is placing an emphasis on ongoing engagement with TBI waiver members.

TBI-Specific Training

As a TBI waiver site, Alliance Health has worked closely with the Brain Injury Association of NC (BIANC) to develop in-person training events, an on-line training library, and fact sheets for publication on the Alliance website. On-line trainings are available on the Alliance website at the following link: https://alliancebh.academy.reliaslearning.com/. Training events are available for free to Alliance Health members, family and providers. In addition, Alliance continues to partner with experts in the field such as NC's Assistive Technology center to provide clinical trainings and resources to Alliance's TBI Waiver Provider Network, on a monthly basis.

Section Five
Network Access Plan

I. Executive Summary

On an annual basis, Alliance Health 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 network analysis includes a comprehensive review of data highlighting the characteristics and demographics of the individuals and communities within the Alliance area, review of provider network capacity and access, and input from service recipients, stakeholders, providers and Alliance staff. This report serves as the basis for the Network Access Plan, the final section of the community needs assessment that details specific priorities for addressing identified community needs and gaps.

Since the reporting period that is covered by this report is calendar years 2019 and 2020, it is important to take note of several significant events that will impact the interpretation of this report and our strategic planning efforts. First, the global COVID-19 pandemic has presented numerous challenges for our members, providers and community at large. As of the time of this report, the pandemic continues to have a broad and multi-faceted impact, resulting in adverse health outcomes, economic hardship, increased isolation and many other consequences. Since this report has been delayed due to the pandemic, the interim report relies on some information that preceded the pandemic. As a result, it is likely that our observations in this report of community gaps, barriers and underserved populations underrepresent the impact of the pandemic.

Second, we are preparing for a major transition of our Medicaid system next month that will result in the majority of our Medicaid enrollees transitioning to other managed care organizations called Standard Plans, who will manage the full array of healthcare services (medical and behavioral health) for these members. On July 1, we will be managing a much smaller number of Medicaid enrollees but will retain management for all uninsured services. The significant change in our scope for the upcoming fiscal year will have an impact on many of our performance indicators, Medicaid quantitative standards and other elements that are included in this report, and we must consider whether our observations of gaps and needs that apply to our current membership will be as relevant for our revised member population.

Third, we are applying to DHHS to become a Tailored Plan, which will enable us to continue our operation and expand to cover the full array of healthcare services for our Medicaid enrollees, including behavioral health, medical and pharmacy services. If selected, we will begin transitioning in July, 2021 in preparation for operating as a Tailored Plan on July 1, 2022. This transition will bring about significant changes to our operation, staffing, scope of work and

provider network and will be a major focus of our network access plan for the upcoming fiscal year.

Fourth, two counties, Orange and Mecklenburg, have requested to align with Alliance Health in the upcoming year and are proceeding with the formal request process. If approved, the additions of these counties to our catchment area will have a significant impact on our network development planning.

Finally, we have made significant changes to our network access plan priorities over the past year due to the impact of the pandemic. While we have continued to make progress on previously identified goals when possible, our priorities shifted for the most part to addressing the impact of the pandemic. In light of the major challenges of the past year and the significant system transformation in process for next year, the Network Access Plan in this report is modified from its usual format and focus.

A. Progress and Achievements in Addressing Service Gaps

For the 2019 and 2020 Network Access Plan, we selected service gaps and identified network development priorities that aligned with Medicaid transformation timeframes and our strategic planning in preparation for application to be a Tailored Plan. These priorities have been a major focus at all levels of our organization, and have included development of a new Care Team Model, piloting projects with Care Management Agencies, implementation of alternative payment models, network development efforts in preparation for management of medical and behavioral health care, and development of a Tailored Plan population profile that improves our understanding of the comprehensive needs of this population and prepares us for targeted network development efforts.

Additional initiatives over the past year have included continued implementation of the TBI waiver, development of crisis capacity by implementing an Enhanced Mobile Crisis Pilot and implementing a new facility-based crisis service for children, with expected opening date later this year. We have also expanded opioid treatment access and continued projects addressing social determinants of health such as housing and transportation.

In addition to the above, our most significant efforts and accomplishments have been in response to the COVID-19 pandemic. Much of our work this year has focused on maintaining or restoring access to care for members, supporting transition to telehealth for providers, developing sustainability supports for providers and taking other efforts to prevent service gaps. For example, we have implemented provider sustainability payments, raised rates, and developed new alternative service definitions that support provision of services in a more flexible and sustainable manner. This is an ongoing effort that will likely continue into FY22 as we proceed with community-wide vaccination plans and other efforts to address the impact of the pandemic.

The following summarizes progress from July 1, 2019 through June 30, 2021 for the FY2019-21 Network Access Plans:

1. Prepare for Tailored Plan implementation

- Developed Tailored Plan population profile and identified provider network design and development priorities
- Implemented new Care Team Model
- Initiated pilot projects with Care Management Agencies, including development of electronic provider portal and use testing to inform care management preparation
- Began network development efforts in preparation for management of medical and behavioral health care of tailored plan population. Implemented use of Salesforce© to track recruitment progress.

2. Implement Traumatic Brain Injury Waiver

- Continued network development, training and outreach efforts required for implementation of TBI waiver
- Opened TBI-specific group home in Durham County
- Provided cross-training with MH/SUD providers to improve capacity to serve the TBI population
- Established regular TBI Provider Collaborative meetings

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

- Continued implementation and evaluation of Wake Enhanced Mobile Crisis Pilot
- Improved timely access to aftercare appointments following inpatient, facility-based crisis or non-hospital detoxification treatment by expanding network contracts for Assertive Engagement. Implemented value-based contract with four providers to improve engagement in follow-up care, and developed Peer Bridger model with Recovery Innovations.
- Established Hospital Transition Team service to improve discharge follow-up for individuals seen at Triangle Springs hospital. We are negotiating a value-based contract with Triangle Springs to improve 7-day follow-up and will pursue this approach with other facilities as well.

4. Increase interventions and supports for individuals with complex needs

- Implemented value-based contracts with PRTFs to reduce lengths of stay and improve discharge planning
- Established two Crisis Group Homes for youth in DSS custody to divert from inpatient treatment
- Eliminated funding of Group Living High and Moderate for adults with mental illness and developed alternative programming, including a Community Recovery Transition Program (12 beds) and an Inclusive Community Living Program, a recovery-oriented program to support individuals with mental illness to live in housing of their choice.
- Developing step-down service from CST with tenancy requirements as well as DLA-20 assessment
- Developing Peer Support service focused on tenancy supports
- Developed value-based contracts for Supported Employment services
- Contracting with UNC to facilitate employment and tenancy support collaboratives
- Developing Day Treatment program for dually diagnosed children (IDD/MI) in collaboration with Wake County Public Schools
- Implemented Family Engagement Services Pilot to improve appropriate utilization of PRTF services

5. Develop an array of recovery-oriented, individualized and person-centered services that promote community inclusion

- Developing services to wrap around individuals to support living in homes of their choice
- Collaborated with IPS Supported Employment providers to implement value-based model that supports improved behavioral health integration
- Developing plans to expand benefits counseling availability

6. Improve public awareness of services

- Improved availability of information to the public about service availability and access through social media and website content
- Developed plans for improving member engagement and convened new CQI Subcommittee focusing on Member Engagement
- Implemented pilot with Healthcrowd to provide targeted health messages to members by texting
- Preparation for TP implementation, including development of marketing plan, website redesign, messaging, member handbook revision and member welcome letter

7. Improve service outcomes by addressing social determinants of health

- Implemented transportation program through ModivCare that provides up to 4 round-trip rides, include travel to pharmacies, for individuals who are discharged from hospital settings.
- Expanded therapeutic housing options to include bridge housing, which is a 3-5 month peer-led supported housing program for people who are moving to independent living settings from homelessness
- Supported numerous efforts in response to the COVID-19 pandemic, including
  - Partnership with public schools and other community-based organizations to address food insecurity by distributing food
  - Home-delivered meals for individuals with IDD and arrangement for food delivery in HUD-funded supported housing programs
  - Outreach at testing and vaccination sites to distribute information about behavioral health
  - Support for Hope for NC/FEMA grant, including neighborhood canvassing of high impact zip codes and outreach to marginalized populations
  - Supported safe sheltering initiative with 3 hotels, to assist individuals and families who are homeless but ineligible for CDC hotels
  - Implemented Health Literacy initiatives, including creation of animated videos for each disability group, development of new brochures for members, and posting of new content on the Alliance website and social media platforms.

8. Develop and enhance the continuum of care for individuals with Substance Use Disorders

- Expanded opioid treatment availability by adding OTP providers in Cumberland and Durham counties and OBOT providers in all but Johnston County
- Provided technical assistance, training and support for SUD providers to enhance quality, outcomes and accessibility of care
- Implemented new initiatives to improve initiation and engagement in MAT for individuals in the Durham County Detention Center, WakeMed Emergency Departments, and Duke inpatient medical units.
- Expanded state-funded OBOT services in Durham and Wake counties.

B. Monitoring of Medicaid Exceptions

Upon submission of the 2019 Network Adequacy and Accessibility Analysis, Alliance requested and received approval for access and choice exceptions for the following Medicaid-funded services:

- Child and Adolescent Day Treatment
- Opioid Treatment:
- (b)(3) I/DD Facility-Based Respite

We addressed gaps for Child and Adolescent Day Treatment and Opioid Treatment in 2020 by expanding contracts for both services in Cumberland County. For FY21, we have maintained an approved exception for (b)(3) I/DD Facility-Based Respite and have been able to meet respite needs through other service options.

C. Network Adequacy and Accessibility Priority Areas for FY22

As noted above, we face numerous challenges and changes in the upcoming year, and our strategic planning for improving network adequacy is subject to changes in membership and catchment area scope, approval of our application to be a Tailored Plan, and the status of the COVID-19 pandemic. Upon selection as a Tailored Plan, we will be required to submit a Network Access Plan in July, 2021 that serves as a comprehensive plan for addressing network adequacy, developing a new physical health and pharmacy network, and preparing for implementation of a Tailored Plan by July 1, 2022. Instead of developing a separate Network Access Plan for behavioral health, our intent is to incorporate the information from this report into the Network Access Plan that will guide our transition planning for Tailored Plan implementation.

For the most part, our network access plan priorities for FY22 are consistent with those from FY20 and FY21, so our FY22 priorities will maintain and expand upon current initiatives and network development efforts. Within the context of our strategic planning for Tailored Plan implementation, we will integrate the following priority areas into FY22 planning:

1. Prepare for Tailored Plan implementation
2. Continue development of Traumatic Brain Injury Waiver services
3. Expand capacity for crisis, hospital diversion and respite services for all ages/disabilities
4. Increase interventions and supports for individuals with complex needs
5. Develop an array of recovery-oriented, individualized and person-centered services that promote community inclusion
6. Improve service outcomes by addressing social determinants of health
7. Improve public awareness of services
8. Develop and enhance the continuum of care for individuals with Substance Use Disorders

D. Actions being taken to address gaps identified by members and families

For the most part, the gaps identified by members and families are consistent with previous gaps, and align with multiple ongoing initiatives. As we align the Network Access Plan with priorities for Tailored Plan implementation, we plan to address the following gaps:

- Lack of information about resources and assistance with system navigation, including education and outreach to members
- Services for individuals with dual diagnoses
- Individualized services for those with complex behavioral health and medical conditions
- Relief for primary caretakers / Respite
- Services to address transportation challenges
- Services for individuals with I/DD on Innovations waitlist
- Additional service capacity to improve timely access and provide choice (including extended hours)
- Housing/housing supports
- Services for uninsured
- Availability of qualified staff

II. Access Plan

The sections below include Alliance plans for addressing identified gaps and barriers that were identified in Sections One, Two and Three, and the following discussion is organized accordingly to correspond with each of these chapters. The plans described below are combined to form the Network Access Plan, which is included in more detail above in the section on Network Adequacy and Accessibility Priority Areas for FY22.

A. Plans for improving network availability and accessibility

As summarized in **Section One**, the Alliance service network meets geographic access and choice expectations for Outpatient, Inpatient and C-Waiver service categories. Several services within the Location-Based, Community/Mobile, Crisis and Specialized sections did not meet access/choice requirements, as described below:

Both Medicaid and Non-Medicaid Funded:

Location-Based:

- Partial Hospitalization: limited access and choice for Medicaid-funded, and no current providers for Non-Medicaid funded services

Crisis:

- Ambulatory Detox: no current contracted providers for this service
- Facility-Based Crisis-Child: no current contracted providers for this service

Medicaid-Funded:

Specialized Services:

- (b)(3) I/DD Facility-Based Respite

Non-Medicaid Funded

Location-Based:

- Psychosocial Rehabilitation: services are available in each county, but there is not a choice of two providers in all areas
- Child and Adolescent Day Treatment: limited access for Non-Medicaid-funded services in all but Wake County.
- SA Comprehensive Outpatient Treatment (Non-Medicaid): services are available in each county except for Johnston, but there is not a choice of two providers in all areas
- Opioid Treatment: there is not a choice of two providers for Non-Medicaid funded Opioid Treatment Program services in each county.

Community/Mobile:

- Peer Support: no providers currently for this service

Specialized Services:

- Psychiatric Residential Treatment Facility (PRTF): no providers for Non-Medicaid funded services
- Residential Treatment Level 2: Therapeutic Foster Care
- Residential Treatment Level 2: other than Therapeutic Foster Care

Plans for addressing gaps:

- **Service gaps for both Medicaid and Non-Medicaid funding**. We plan to request an exemption from provider access and choice standards for these services while we take steps to address the following service gaps:
    - Partial Hospitalization: there are currently not enough licensed PH programs to meet the geographic access standards for this service. We will work with hospitals and other providers to evaluation options for program expansion
    - Ambulatory Detox: we are not aware of any current ambulatory detox programs within our catchment area, but will be reaching out to behavioral health as well as medical providers during FY22 to identify potential providers of this service
    - Facility-Based Crisis-Child: we have been developing a new program in Wake County that is expected to open in Fall, 2021.
- **Medicaid-Funded Services**. We currently have only one identified service gap for Medicaid-Funded services, (b)(3) I/DD Facility-Based Respite. We are requesting a waiver for this service and do not currently see a need for this service that is not being addressed through other respite options.
- **Non-Medicaid-funded services** are limited in availability primarily due to funding limitations, so our capacity to address these gaps is contingent upon the availability of additional funding. Alliance will request an exemption from provider access and choice standards and will address identified needs on a case by case basis, depending on availability of funding. We do anticipate additional funds for opioid treatment and plan to expand access and choice of OTP and OBOT providers upon receipt of these funds.

B. Accommodation: *addressing geographic, cultural and special population needs.*

As shown in **Section Two**, Alliance catchment counties and communities vary with respect to racial and ethnic composition, health outcomes and disparities, disabled population and other demographic variables. County-level comparisons indicate that Cumberland County has higher rates of poverty, disability, health outcome disparities, youth delinquency and people who are in jails or prisons than other counties. All counties showed disparities between community race/ethnicity data and race of members served, and differences were the most significant for African-American Medicaid enrollees.

Over the past year, the COVID-19 pandemic has highlighted the disproportionate impact of racial, ethnic and economic factors on health outcomes, and the demographic disparities within Alliance counties also underscore the importance of understanding and addressing these factors. In preparation for transition to a Tailored Plan, Alliance has developed a comprehensive Diversity, Equity and Inclusion and Provider Cultural Competency Plan that will support our mission to improve the health and well-being of our members. We will incorporate the findings of this report into the implementation of this plan over the next two years.

Underserved Populations and access barriers. Alliance survey respondents identified multiple populations as being underserved, including dually diagnosed, people on the Innovations waiting list, those with Traumatic Brain Injuries, justice-involved individuals and those with limited service access due to social determinants such as housing and transportation barriers. Several ongoing or planned initiatives will address these service gaps, including:

- Implementation of the Traumatic Brain Injury waiver
- Social Determinants pilot projects addressing transportation and housing
- Implementation of the Alliance Care Team model, which emphasizes multidisciplinary team-based, whole-person, population-focused approaches to management of chronic and complex conditions
- Access improvement project focusing on ensuring timely aftercare follow-up and continuity of care for individuals being discharged from hospitals, crisis facilities, and jails

C. **Acceptability**: *improving consumer and stakeholder experience of care*

As described in **Section Three,** members, families and other stakeholders identified several gaps and barriers that align with current or planned activities for FY22. Similar to feedback noted above, members and stakeholders identified barriers associated with social determinants such as housing and transportation as significant impediments to service access. Another priority for both members and stakeholders is availability of information about services and assistance with healthcare system navigation. Additional identified priorities were services for dually diagnosed, respite services, access to care for the uninsured, and service access for individuals with IDD on the Innovations waitlist.

III. In Lieu of and Alternative Services

Although most services provided in the Alliance catchment area fall within Medicaid clinical coverage policies or State-funded service definitions, LME-MCOs have the ability to develop some services that fall outside these benefit plans. LME-MCOs are allowed to develop and request DHHS approval for Medicaid "In Lieu Of" services and Non-Medicaid "Alternative Service Definitions" to address gaps in the service array. The following is an update on the status of Medicaid In Lieu Of and Non-Medicaid Alternative Services used by Alliance providers.

Medicaid In Lieu Of Services

Family Centered Treatment (H2022 22 Z1, H2022 U3 HE, H2022 22 Z2, H2022 22 Z3,): available in all Alliance counties [contracts with four providers]
Service capacity: limited by expansion potential of each agency, but not currently restrained by funding limitations. If needed there are other licensed FCT providers in NC that might consider working in the Alliance Health catchment.
Gaps addressed: need for evidence-based family-focused approaches to in-home care for children and adolescents. Continuing pilot to utilize FCT for youth referred to PRTF, using FCT throughout their stay with the goal of quicker reunification and continuity of intensive family work, the pilot was interrupted during the pandemic.
Barriers and challenges: Multisystem lack of intervention and then reactiveness to behavioral health needs which does not support referrals earlier in the members' behavioral health treatment experience. This results in an overuse of out of home placement, further exacerbating the statewide shortage of treatment beds. 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 Alliance counties [contracts with eight providers]
Service capacity: Service is limited to nine eligible providers, but of these, only eight are providing services at this time (one agency underwent an acquisition). Service capacity is not limited, however in May 2019, Alliance removed this service from the adult benefit plan as it was not deemed cost effective for adults.
Gaps addressed: Gap between intensive services and outpatient
Barriers and challenges: 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, H0040 22): available in all Alliance counties [contracts with five providers]
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 and challenges: need to work with providers on being proactive in anticipating step-down and not only seeking step-down at the end of an existing authorization, but when member is ready for step-down

Rapid Response (S5145 22 Z3): Wake County [contract with two providers]
Service capacity: currently 5 beds, with plans to increase
Gaps addressed: children's crisis needs
Barriers and challenges: Inconsistency of NC licensing requirements with treatment needs, and availability of high quality families with consistent bed capacity. Due to a per day payment structure and the inconsistent pace of referrals, beds may get filled with longer term treatment placements, making them unavailable for crisis. Currently working with one agency in Cumberland County to develop an alternative value based payment structure to potentially improve utilization. The pandemic caused families to be much less willing to provide this level of care due to virtual school, virtual work and in some cases financial difficulties resulting in families needing to stop accepting youth. Rebuilding the pool of highly experienced, trained and willing families takes months.

Behavioral Health Urgent Care (T2016 U5): Durham and Wake counties [contracts with two providers]
Service capacity: Currently available only in Durham and Wake Counties.
Gaps addressed: availability of walk-in crisis services
Barriers and challenges: Cost of expansion to other counties.

High Fidelity Wraparound (H0032 U3; H0032 U3 Z1): available in Cumberland and Durham counties [contract with one provider]
Service capacity: highly technical model, therefore difficult and costly to disseminate. Startup was funded through a grant which led to the alternative definition. Current capacity is approximately 40-50 individuals. Only one provider eligible due to their existing infrastructure to support the model.
Gaps addressed: The need for peer involvement (family and youth) and structured model to deliver intensive case management driven by family voice and choice.
Barriers and challenges: Costly model, highly technical, requires much provider infrastructure and support. Difficulty in maintaining Family Peer position inside Alliance before Tailored Plan.

Psychosocial Rehabilitation (PSR) During Disaster (H2017 U5): available in all Alliance counties [contracts with 15 providers]
Service capacity: The service capacity mirrored capacity prior to pandemic.
Gaps addressed: Implemented during pandemic to enable flexibility in service provision, including use of telehealth options, and to promote financial sustainability of providers
Barriers and challenges: Lack of access to telehealth equipment by members, variable support by group homes to ensure access to technology

Child and Adolescent Day Treatment Provided During Disaster or Emergency (H20212 HA 22): available in all Alliance catchment counties [contracts with seven providers]
Service capacity: The service capacity mirrored capacity prior to pandemic.
Gaps addressed: Facility based Day Treatment. Mobile/Community and Home approach to safely support youth needs.
Barriers and challenges: Families not wanting others in their home for fear of possible exposure. Also, internet resources and bandwidth a challenge for some families.

Short Term Residential Stabilization (T2016 TF U5) available in Durham and Wake counties [contracts with two providers]
Service capacity: 120 annually
Gaps addressed: The need for immediate services for individuals with intellectual or developmental disabilities, non-Innovations, who are presenting in crisis to provide a safe transition and teaching environment to move individuals back home.
Barriers and challenges: Limited step down services to refer to other than ICF unless receives an Innovations slot.

Non-Medicaid Alternative Service Definitions

Assertive Engagement (YA323): Available in all Alliance catchment counties [contracts with 20 providers]
Service capacity: expanded capacity this year to improve follow-up appointment access after discharge from inpatient and crisis facilities
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 and challenges: 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): no longer available
Service capacity: discontinued
Gaps addressed: n/a
Barriers and challenges: n/a

Peer Support Hospital Discharge & Diversion (YA343): no longer available
Service capacity: discontinued
Gaps addressed: n/a
Barriers and challenges: n/a

Hospital Discharge Transition Service (YA346): Available in all Alliance catchment counties [contracts with 10 providers]
Service capacity: expanded capacity this year to include all Alliance catchment counties
Gaps addressed: need for effective transition from inpatient hospitalization to community services
Barriers and challenges: 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 [contract with one provider]
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 and challenges: limited non-Medicaid funding; alternative service definition only approved for Wake County.

Safety Supervisor (YA385): none
Service capacity: n/a
Gaps addressed: n/a
Barriers and challenges: availability of non-Medicaid funding

Outpatient DBT Group and Individual (YA386 and YA387): all Alliance counties [contracts with three providers]
Service capacity: limited to one provider in Cumberland, one provider in Johnston, two providers in Durham and three 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 and challenges: Need for ongoing training and supervisory infrastructure that supports high fidelity DBT services in an environment of frequent staff turnover.

APPENDICES

Appendix A: Performance on Access Standards for Medicaid-Funded Services

	DHHS Service Category	Setting	Standard	Performance
Psychosocial Rehabilitation	Location-Based (A)	Ambulatory	1:20,000	Met
Child and Adolescent Day Treatment	Location-Based (A)	Ambulatory	1:20,000	Met
Partial Hospitalization	Location-Based (A)	Ambulatory	1:20,000	***Not Met***
SA Intensive Outpatient Program	Location-Based (A)	Ambulatory	1:20,000	Met
SA Comprehensive Outpatient Treatment Program	Location-Based (A)	Ambulatory	1:20,000	Met
Opioid Treatment	Location-Based (A)	Ambulatory	1:20,000	Met
SA Non-Medical Community Residential Treatment	Location-Based (B)	Residential	1 per catchment	Met
SA Medically Monitored Community Residential	Location-Based (B)	Residential	1 per catchment	Met
Assertive Community Treatment Team	Community/Mobile		2 per catchment	Met
Community Support Team	Community/Mobile		2 per catchment	Met
Intensive In-Home	Community/Mobile		2 per catchment	Met
Multi-Systemic Therapy	Community/Mobile		2 per catchment	Met
(b)(3) MH Supported Employment	Community/Mobile		2 per catchment	Met
(b)(3) I/DD Supported Employment	Community/Mobile		2 per catchment	Met
(b)(3) Waiver Community Guide	Community/Mobile		2 per catchment	Met
(b)(3) Waiver Individual Support (Personal Care)	Community/Mobile		2 per catchment	Met
(b)(3) Waiver Peer Support	Community/Mobile		2 per catchment	Met
(b)(3) Waiver Respite	Community/Mobile		2 per catchment	Met
Ambulatory Detox	Crisis Services (A)	Ambulatory	1 per catchment	***Not Met***
Facility-Based Crisis - Child	Crisis Services (A)	Residential	1 per catchment	***Not Met***
Mobile Crisis Management	Crisis Services (A)		1 per catchment	Met
Facility-Based Crisis - adults	Crisis Services (B)	Residential	2 per catchment	Met
Detoxification (non-hospital)	Crisis Services (B)	Residential	2 per catchment	Met
Inpatient Hospital – Adult	Inpatient	Inpatient	1 per catchment	Met
Inpatient Hospital – Adolescent/Child	Inpatient	Inpatient	1 per catchment	Met

	DHHS Service Category	Setting	Standard	Performance
Psychiatric Residential Treatment Facility	Specialized Services	Residential	1:15,000	Met
Residential Treatment Level 2: Therapeutic Foster Care	Specialized Services	Residential	1:15,000	Met
Residential Treatment Level 2: other than Therapeutic Foster Care	Specialized Services	Residential	1:60,000	Met
Residential Treatment Level 3	Specialized Services	Residential	1:15,000	Met
Residential Treatment Level 4	Specialized Services	Residential	1 per catchment	Met
(b)(3) I/DD Out-of-home respite	Specialized Services	Residential	1:15,000	Met
(b)(3) I/DD Facility-based respite	Specialized Services	Residential	Current service gap with approved waiver	***Not Met***
(b)(3) I/DD Residential supports	Specialized Services		1:15,000	Met
Intermediate Care Facility/IDD	Specialized Services	Residential	1:15,000	Met
Community Living and Supports	C-Waiver Services (A)		1:1000	Met
Community Navigator	C-Waiver Services (A)		1:1000	Met
Community Navigator Training for Employer of Record	C-Waiver Services (A)		1:1000	Met
Community Networking	C-Waiver Services (A)		1:1000	Met
Crisis Behavioral Consultation	C-Waiver Services (A)		1:1000	Met
In Home Intensive	C-Waiver Services (A)		1:1000	Met
In Home Skill Building	C-Waiver Services (A)		1:1000	Met
Personal Care	C-Waiver Services (A)		1:1000	Met
Crisis Consultation	C-Waiver Services (A)		1:1000	Met
Crisis Intervention & Stabilization Supports	C-Waiver Services (A)		1:1000	Met
Residential Supports 1	C-Waiver Services (A)		1:1000	Met
Residential Supports 2	C-Waiver Services (A)		1:1000	Met
Residential Supports 3	C-Waiver Services (A)		1:1000	Met
Residential Supports 4	C-Waiver Services (A)		1:1000	Met
Respite Care - Community	C-Waiver Services (A)		1:1000	Met
Respite Care Nursing – LPN & RN	C-Waiver Services (A)		1:1000	Met
Supported Employment	C-Waiver Services (A)		1:1000	Met

	DHHS Service Category	Setting	Standard	Performance
Supported Employment – Long Term Follow-up	C-Waiver Services (A)		1:1000	Met
Supported Living	C-Waiver Services (A)		1:1000	Met
Day Supports	C-Waiver Services (B)		1:1000	Met
Out of Home Crisis	C-Waiver Services (B)	Residential	1:1000	Met
Respite Care - Community Facility	C-Waiver Services (B)	Residential	1:1000	Met
Financial Supports	C-Waiver Services (B)		1:1000	Met
Specialized Consultative Services (at least one provider of one of multiple services)	C-Waiver Services (B)		1:1000	Met

Appendix B: Comparison of 2019, 2020, 2021 and Tailored Plan Network Adequacy Standards

*Note: changes in standards are formatted in ***bold italics***

Medicaid Service Category	2019 Standard	2020 & 2021 Standard	TP Standard
Outpatient	Choice of 2 providers within 30 miles/minutes	Choice of 2 providers within 30 miles/minutes ***for at least 95% of members***	Choice of 2 providers within 30 miles/minutes ***for at least 95% of members***
Location-Based (A) • PSR, C&A Day Treatment, SAIOP, SACOT, Opioid Treatment	Choice of 2 providers within 30 miles/minutes	Choice of 2 providers within 30 miles/minutes ***for at least 95% of members***	Choice of 2 providers within 30 miles/minutes ***for at least 95% of members*** ***Child & Adolescent Day Treatment not subject to standard***
Location-Based (A) New to 2020: Partial Hospitalization (moved from Specialized)	Access to 1 provider within catchment area	***Choice of 2 providers within 30 miles/minutes***	***Access to 1 provider within 30 minutes or 30 miles for at least 95% of members***
Location-Based (B) [new category in 2020] ***Moved from Specialized:*** • ***SA Non-Medical CRT*** • ***SA Medically Monitored Residential Treatment***	Access to 1 provider within North Carolina	Access to 1 provider within ***catchment area***	SA Non-Medical CRT: • ***Adult: access to 1 provider within catchment area*** • ***Adolescent: contract with all CASPs within catchment area*** • ***Women & Children: contract with all CASPs within catchment area*** SA MMRT: Access to 1 provider within catchment area *****Both of these services moved to new **Residential Treatment Services** category
New for TP: Residential Treatment Services Category: • ***Residential Treatment Facility Services*** • ***SA Halfway House-Adult Male*** • ***SA Halfway House-Adult Female***			***Access to 1 provider within catchment area***

Medicaid Service Category	2019 Standard	2020 & 2021 Standard	TP Standard
• ***SA Halfway House-Adolescent*** • ***Category also includes SA Non-Medical CRT and SA Medically Monitored Residential Treatment*** • ***SU Residential Supports & MH Recovery Supports: TBD***			
Community / Mobile	Choice of 2 providers within catchment area	Choice of 2 providers within catchment area	• Choice of 2 providers within catchment area, ***AND*** • ***Each county must have access to 1 provider that is accepting new patients***
Crisis (A): new category in 2020 for: • ***Ambulatory Detox*** • ***Facility-Based Crisis-Child***	n/a	Access to 1 provider within catchment area	Access to 1 provider within **catchment area** ***Ambulatory Detox split into two services (with and w/o extended on-site monitoring)***
Crisis (A): Moved from Community/Mobile: • ***Mobile Crisis Management***	Choice of 2 providers within catchment area	***Access to 1 provider*** within catchment area	***TBD***
Crisis (B) • Facility-Based Crisis-adults • Non-hospital detoxification	Access to 1 provider within catchment area	***Choice of 2 providers*** within catchment area	• ***FBC: 1 facility within each region per 450,000 total regional population (using NC OSBM county estimates)*** • NHD: Choice of 2 providers within catchment area
Inpatient	Access to 1 provider within catchment area	Access to 1 provider within catchment area	Access to 1 provider within **catchment area**
Specialized	Access to 1 provider within North Carolina	***Choice of 2 providers*** within **catchment area**	Services moved to other categories
C-Waiver (A)	Choice of 2 providers within catchment area	Choice of 2 providers within catchment area	Choice of 2 providers within catchment area
C-Waiver (B)	Access to 1 provider within catchment area	Access to 1 provider within catchment area	Access to 1 provider within catchment area

Non-Medicaid Service	2019 Standard	2020 & 2021 Standard	TP Standard
Outpatient	Choice of 2 providers within 30 miles/minutes	Choice of 2 providers within 30 miles/minutes ***for at least 95% of members***	Choice of 2 providers within 30 miles/minutes ***for at least 95% of members***
Location-Based (A) • PSR, C&A Day Treatment, SAIOP, SACOT, Opioid Treatment	Access to 1 provider within 30 miles/minutes	***Choice of 2 providers*** within 30 miles/minutes	Choice of 2 providers within 30 miles/minutes ***for at least 95% of members*** ***Child & Adolescent Day Treatment not subject to standard***
Location-Based (A) • ***New to 2020: Partial Hospitalization (moved from Specialized)***	Access to 1 provider within catchment area	***Choice of 2 providers*** within 30 miles/minutes	***TBD***
Location-Based (B) [new category in 2020] ***Moved from Specialized:*** • ***SA Non-Medical CRT*** • ***SA Medically Monitored Residential Treatment*** • ***SA Halfway House-Female*** • ***SA Halfway House-Male*** ****New in 2020: split into M&F***	Access to 1 provider within North Carolina	Access to 1 provider within ***catchment area***	SA Non-Medical CRT: • ***Adult: access to 1 provider within catchment area*** • ***Adolescent: contract with all CASPs within catchment area*** • ***Women & Children: contract with all CASPs within catchment area*** SA MMRT: Access to 1 provider within catchment area ****Both of these services moved to new Residential Treatment Services category***
New for TP: Residential Treatment Services Category: • ***Residential Treatment Facility Services*** • ***SA Halfway House-Adult Male*** • ***SA Halfway House-Adult Female***			***Access to 1 provider within catchment area***

Non-Medicaid Service	2019 Standard	2020 & 2021 Standard	TP Standard
• ***SA Halfway House-Adolescent*** • ***Category also includes SA Non-Medical CRT and SA Medically Monitored Residential Treatment*** • ***SU Residential Supports & MH Recovery Supports: TBD***			
Community / Mobile • ***New in 2020: Peer Support & Transition Management Service***	Access to 1 provider within catchment area	***Choice of 2 providers*** within catchment area	• ***100% of eligible recipients*** must have a choice of 2 providers within catchment area***, AND*** • ***Each county must have access to 1 provider that is accepting new patients***
Crisis (A): new category in 2020 for: • ***Ambulatory Detox*** • ***Facility-Based Crisis-Child***	n/a	***Access to 1 provider within catchment area***	Access to 1 provider within catchment area ***Ambulatory Detox split into two services (with and w/o extended on-site monitoring)***
Crisis (A): Moved from Community/Mobile: • ***Mobile Crisis Management***	Choice of 2 providers within catchment area	***Access to 1 provider*** within catchment area	***TBD***
Crisis (B) • Facility-Based Crisis-adults • Non-hospital detoxification	Access to 1 provider within catchment area	***Choice of 2 providers*** within catchment area	• FBC: 1 facility within each region per 450,000 total regional population (using NC OSBM county estimates) NHD: Choice of 2 providers within catchment area
Inpatient	Access to 1 provider within catchment area	Access to 1 provider within **catchment area**	Access to 1 provider within catchment area
Specialized	Access to 1 provider within North Carolina	Access to 1 provider within **North Carolina**	***Services moved to other categories***
NEW for TP: Employment and Housing Services			***TBD***

Non-Medicaid Service	2019 Standard	2020 & 2021 Standard	TP Standard
• ***Residential Services*** • ***Respite Services*** • ***IPS-SE*** • ***Meaningful day and prevocational services*** • ***Clinically Managed Population-specific High Intensity Residential Programs*** • ***TBI long-term residential rehabilitation services: not subject to standard***			
NEW to TP: Case Management (TBD)			

Appendix C: Community Demographic and Health Data

	Goal	NC Avg	NC Best	Cumberland	Durham	Johnston	Wake
Health Outcomes (rank 1-100)	↓		1	69	12	14	1
Length of Life (rank 1-100)	↓		1	63	6	10	2
Premature death: years of potential life lost before age 75 per 100,000 population	↓	7,700	4,500	9,400	6,100	6,800	4,700
Quality of Life (rank 1-100)	↓			76	20	19	1
Poor or fair health: adults reporting fair or poor health	↓	18%	13%	19%	17%	17%	13%
Poor physical health days: physically unhealthy days reported in past 30 days	↓	3.9	3.3	4.3	3.9	3.9	3.3
Poor mental health days: mentally unhealthy days reported in past 30 days	↓	4.1	3.5	4.4	3.8	4.0	3.5
Low birthweight: live births with low birthweight (< 2500 grams)	↓	9%	6%	10%	9%	8%	8%
Health Factors (rank 1-100)	↓			73	17	42	2
Health Behaviors (rank 1-100)	↓			77	15	53	1
Adult smoking: current adult smokers	↓	17%	12%	18%	15%	18%	12%
Adult obesity: adults with BMI of 30+	↓	31%	17%	34%	25%	37%	25%
Food environment index: access to healthy food and food insecurity (index ranges from low of 0 to high of 10)	↑	6.7	8.6	6.0	6.9	8.3	8.0
Physical inactivity: adults reporting no leisure-time physical activity	↓	24%	16%	25%	19%	27%	16%
Access to exercise opportunities: adequate access to locations for physical activity	↑	74%	100%	77%	90%	70%	90%
Excessive drinking: adults reporting binge or heavy drinking	↓	17%	12%	16%	17%	18%	20%

	Goal	NC Avg	NC Best	Cumberland	Durham	Johnston	Wake
Alcohol-impaired driving deaths: driving deaths with alcohol involvement	↓	29%	0%	30%	32%	27%	32%
Sexually transmitted infections: newly diagnosed chlamydia cases per 100,000 population	↓	612.0	149.5	1096.4	877.9	424.5	566.9
Teen births: births per 1,000 females ages 15-19	↓	24	5	33	22	25	13
Clinical Care (rank 1-100)				43	7	78	3
Uninsured: population under age 65 without health insurance	↓	13%	9%	11%	13%	14%	10%
Primary care physicians: ratio of population to primary care physicians	↓	1,410:1	530:1	1,330:1	810:1	3,580:1	1,180:1
Dentists: ratio of population to dentists	↓	1,780:1	470:1	970:1	1,370:1	4,410:1	1,420:1
Mental health providers: ratio of population to mental health providers	↓	410:1	160:1	310:1	170:1	1,040:1	330:1
Preventable hospital stays: hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	↓	4,758	986	6,271	4,177	6,414	4,022
Mammography screening: female Medicare enrollees, ages 65-74, that receive mammography screening	↑	46%	61%	40%	44%	46%	47%
Flu vaccinations: % of Medicare enrollees who receive an influenza vaccination	↑	51%	61%	39%	58%	53%	59%
Social & Economic Factors (rank 1-100)			1	71	42	12	1
High school graduation: ninth-grade cohort that graduates in 4 years	↑	82%	98%	82%	82%	92%	89%
Some college: adults ages 25-44 with some post-secondary education	↑	72%	81%	72%	74%	63%	80%

	Goal	NC Avg	NC Best	Cumberland	Durham	Johnston	Wake
Unemployment: population 16+ that are unemployed but seeking work	↓	5.1%	3.0%	5.1%	3.5%	3.6%	3.4%
Children in poverty: children under age 18 living in poverty	↓	24%	9%	24%	19%	17%	10%
Income inequality: ratio of $80^{th}/20^{th}$ percentile of income	↓	4.3	3.5	4.3	4.8	4.1	4.2
Children in single-parent households: children that live in a household headed by a single parent	↓	41%	21%	41%	45%	30%	27%
Social associations: social associations per 10,000 population	↑	9.2	25.5	9.2	10.1	8.7	10.0
Violent crime: violent crime offenses per 100,000 population	↓	351	33	548	666	185	115
Injury deaths: deaths due to injury per 100,000 population	↓	75	44	77	59	64	44

	Goal	NC Avg	NC Best	Cumberland	Durham	Johnston	Wake
Physical Environment (rank 1-100)			1	76	38	80	77
Air pollution: average daily density ($\mu g/m^3$) of fine particulate matter (2.5)	↓	9.8	7.8	10.6	10.6	10.4	11.0
Drinking water violations: population potentially exposed to water exceeding violation limit during past year	No	n/a	No	Yes	No	Yes	Yes
Severe housing problems: households with ≥ 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen or plumbing facilities	↓	16%	9%	16%	17%	13%	14%
Driving alone to work: workforce that drives alone to work	↓	81%	67%	80%	77%	83%	79%
Long commute - driving alone: among workers who commute in their car alone, those that commute more than 30 minutes	↓	33%	18%	23%	26%	48%	36%

Additional Data

	Goal	NC Avg	NC Best	Cumberland	Durham	Johnston	Wake
Length of Life							
Life Expectancy		78	82.1	76	80	78	82
Premature age-adjusted mortality: deaths among residents < 75, per 100,000 population	↓	370	230	460	300	360	240
Child mortality: deaths among children < 18, per 100,000 population	↓	60	30	80	60	50	40
Infant mortality: infant deaths (within 1 year), per 100,000 live births	↓	7	4	9	7	6	6

	Goal	NC Avg	NC Best	Cumberland	Durham	Johnston	Wake
Quality of Life							
Frequent physical distress: adults reporting 14 or more days of poor physical health per month	↓	13%	10%	14%	12%	12%	10%
Frequent mental distress: adults reporting 14 or more days of poor mental health per month	↓	13%	11%	14%	12%	13%	11%
Diabetes prevalence: adults with diagnosed diabetes	↓	11%	6%	12%	7%	10%	9%
Health Behaviors							
Food insecurity: people who lack adequate access to food	↓	15%	10%	19%	17%	12%	12%
Limited access to healthy foods: people who are low income and do not live close to a grocery store	↓	7%	0%	13%	7%	2%	5%
Drug overdose deaths: drug poisoning deaths per 100,000 population	↓	22	8	26	14	15	13
Motor vehicle crash deaths: motor vehicle crash deaths per 100,000 population	↓	14	7	16	9	16	7
Insufficient sleep: adults who report fewer than 7 hours of sleep on average	↓	34%	29%	38%	34%	34%	32%
Clinical Care							
Uninsured adults: adults under 65 without health insurance	↓	16%	11%	14%	15%	16%	11%
Uninsured children: children under age 19 without health insurance	↓	5%	3%	4%	5%	5%	4%
Health care costs: Medicare reimbursements per enrollee	↓	$9,285	$7,214	$9,455	$8,572	$10,647	$8,986
Other primary care providers: ratio of population to primary care providers other than physicians	↓	801:1	407:1	530:1	417:1	1,417:1	884:1
Social & Economic Factors							
Disconnected youth: teens and young adults ages 16-24 who are neither working nor in school	↓	7%	3%	9%	5%	9%	4%

	Goal	NC Avg	NC Best	Cumberland	Durham	Johnston	Wake
Median household income	↑	$53,900	$80,400	$46,800	$59,300	$60,300	$80,200
Children eligible for free or reduced price lunch	↓	56%	26%	72%	53%	41%	32%
Residential segregation - black/white: index of dissimilarity; higher values indicate greater residential segregation (index ranges from 0-100)	↓	50	4	30	41	24	43
Residential segregation - non-white/white index of dissimilarity; higher values indicate greater residential segregation (index ranges from 0-100)	↓	45	7	27	37	23	36
Homicides: deaths due to homicide per 100,000 population	↓	6	3	11	11	3	3
Suicides: deaths due to suicide per 100,000 population	↓	13	7	15	8	13	9
Firearm fatalities: deaths due to firearms per 100,000 population	↓	13	6	18	14	11	6
Juvenile arrests: rate of delinquency cases per 1,000 juveniles	↓	16	5	29	10	8	8
Physical Environment							
Homeownership: % of occupied housing units that are owned	↑	65%	84%	51%	54%	72%	64%
Severe housing cost burden: % of households that spend 50% or more of their household income on housing	↓	13%	6%	17%	15%	11%	11%

Source: Robert Wood Johnson Foundation, County Health Rankings and Roadmaps, www.countyhealthrankings.org

Appendix D: 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 Three. The tables below provide summaries of survey data, focus group and stakeholder feedback data.

Survey Responses:

The survey was conducted during November and December of 2020 and yielded a total of 674 responses. The following provides a breakdown of submissions by respondent group and county:

Members and Family 158
Provider.....278
Stakeholder 106
Staff.....132
TOTAL 674

County	Members & Families	Providers	Stakeholders	County Total
Cumberland	63	97	27	91
Durham	20	126	30	108
Johnston	6	84	20	96
Wake	63	146	28	194
Other	6	16	1	12
TOTAL	158	278	106	

Feedback from Consumer, Stakeholder, Provider and Staff Groups:

Numerous community groups were invited to provide input through collective responses, completion of on-line surveys, or both. The following groups provided feedback through targeted electronic surveys: (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
- Alliance Human Rights Committee
- Cumberland, Durham, Johnston and Wake County Community Collaboratives for Children & Families (CCC&Fs)
- Alliance Hospital Partners Collaborative (Hospital Partners)
- Cumberland, Durham and Wake Crisis Collaboratives (Crisis Collabs)
- Cumberland, Durham and Wake Juvenile Justice SA/MH Partnerships (JJSAMHP)
- Cumberland, Durham, Johnston and Wake CIT Collaboratives (CIT)
- Cumberland, Durham, Johnston and Wake IDD Stakeholders (IDD SH)
- Alliance Traumatic Brain Injury (TBI) Provider Collaborative and TBI Stakeholder Committee
- Provider Collaboratives for Substance Use Disorders (SUD), Intensive In-Home (IIH), Assertive Community Treatment Team (ACTT) and Therapeutic Foster Care (TFC)
- Cumberland, Durham, Johnston and Wake School Health Advisory Committees (SHAC)
- Cumberland, Durham, Johnston and Wake School affiliates of the National Alliance on Mental Illness (NAMI)
- Wake County Juvenile Crime Prevention Council (JCPC)

In addition to the above, 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)
- Child Protection/Fatality Team (Cumberland)
- SOAR Team members (Cumberland)
- Early Childhood Collaborative (Wake)
- Youth Thrive Action Teams
- Alliance network providers
- Durham Parks and Recreation
- Durham Public Schools Student Services
- Durham TRY
- Durham Partnership for Seniors
- Stepping Up (Durham)
- Durham Family Partners
- Partnership for a Healthy Durham
- Made in Durham Advisory Board
- Early Childhood Mental Health Taskforce
- Wake Directors Group
- Durham Directors Group
- Wake County Schools
- Autism Society of Cumberland County
- Stepping Up Initiative (Durham)
- Parent groups (Cumberland, Durham)
- Johnston County Public Health

Stakeholder Survey Feedback on Populations Identified as Underserved

	Community Survey	CFAC	APAC	Human Rights Cmtee	Crisis Collaboratives	CIT Collaboratives	CCC&Fs	JJSAMHPs	SHAC	Providers	Stakeholders	Alliance Staff	Cumberland	Durham	Johnston	Wake	NAMI	TBI
Number of responses	355	29	18	7	42	22	59	42	18	288	78	132	124	156	104	174	28	13
People who are Dually Diagnosed (IDD/MI, SUD/MI or SUD/IDD)	1	2	1	3	1	1	1	1	1	1	1	2	1	1	1	1	1	3
People with IDD who are not on Innovations waiver	2	3	2	1	3	2	2	2	5	2	3	1	2	2	2	2	2	2
People with traumatic brain injuries	3	4	5	2	5	3	3	5	2	4	6	3	4	3	3	5	4	1
People who are court-involved or in jails/prisons	4	1	3	4	2	5	5	3	4	3	4	4	3	5	5	3	3	8
People with complex/chronic medical problems	5	8	4	7	4	4	4	4	7	5	5	5	5	4	4	4	6	4
Youth in the juvenile justice system	6	7	7	5	8	6	6	6	9	8	2	9	6	8	8	8	8	12
People with physical disabilities	7	9	10	9	9	12	7	8	6	6	7	10	7	6	6	7	12	6
Pregnant women with substance use disorders	8	5	11	10	6	8	9	11	8	7	9	8	8	7	7	6	7	11
Veterans, military members & families	9	11	6	8	11	7	11	9	10	9	10	7	9	10	10	9	11	9
People who are deaf or hard of hearing	10	6	12	6	10	9	8	7	3	10	11	6	11	11	9	11	10	5
People who are LGBTQ	11	10	9	11	7	10	10	10	12	11	8	12	10	9	11	10	5	7
People with visual impairments	12	12	8	12	12	11	12	12	11	12	12	11	12	12	12	12	9	10

Blue = Highest ranked

Green = 2nd highest

Yellow = 3rd highest

Stakeholder Survey Feedback on Barriers

	Community Survey	CFAC	APAC	Human Rights	Crisis Collabs	CIT Collaboratives	Child SOC Collabs	JJSAMHPs	SHAC	Members & Family	Providers	Stakeholders	Alliance Staff	Cumberland	Durham	Johnston	Wake	NAMI	TBI
Number of responses	360	29	18	7	42	22	59	42	18	108	288	78	132	124	156	104	174	28	13
Lack of reliable transportation to appointments	1	3	1	2	3	1	2	3	4	1	1	1	3	1	3	1	1	2	4
Homeless/housing issues	2	2	2	3	1	2	3	2	5	11	3	2	1	3	2	3	2	1	1
Lack of insurance	3	1	3	1	2	4	4	1	2	10	2	3	2	2	1	4	3	4	8
Services not available nearby	4	4	15	15	5	8	5	6	1	3	4	5	4	4	5	2	4	7	2
Limited information about how to obtain services	5	5	6	5	7	3	1	4	6	6	5	4	5	5	4	5	5	3	5
No access to phone, internet or e-mail	6	6	5	9	6	5	6	12	11	9	6	11	7	8	6	7	7	8	6
Availability of qualified staff	7	7	12	4	8	6	8	11	13	12	8	9	6	13	8	8	8	5	3
Wait too long for appointments	8	9	9	7	4	7	9	8	14	2	7	8	9	6	7	6	6	6	7
Cost of medication	9	11	4	8	11	12	12	9	7	7	9	10	11	7	9	9	9	11	13
Language barrier	10	14	13	13	13	15	11	5	8	14	11	7	10	12	13	10	10	14	15
Services not available during convenient days or times	11	10	7	10	9	10	13	10	12	4	13	6	13	9	14	11	11	9	10
Not satisfied with quality or choice of providers	12	15	14	14	15	13	14	15	9	8	14	15	8	14	11	14	12	12	12
Medical problems or physical disability	13	12	11	12	10	9	10	7	15	5	12	12	12	10	10	12	13	15	11
Lack of childcare	14	8	8	6	12	14	7	13	3	13	10	13	14	11	12	13	14	10	9
Lack of physical access or assistive devices	15	13	10	11	14	11	15	14	10	15	15	14	15	15	15	15	15	13	14

Blue = Highest ranked

Green = 2nd highest

Yellow = 3rd highest

Stakeholder Survey Feedback on Social Determinants of Health

	Community Survey	CFAC	APAC	Human Rights Cmtee	Crisis Collaboratives	CIT Collaboratives	Child SOC Collabs	JJSAMHPs	SHAC	Providers	Stakeholders	Alliance Staff	Cumberland	Durham	Johnston	Wake	NAMI	TBI
	360	29	18	7	42	22	59	42	18	288	78	132	124	156	104	174	28	13
Employment																		
% Inadequate	15%	29%	14%	0%	10%	11%	17%	3%	20%	14%	19%	17%	17%	16%	17%	17%	29%	0%
% Inad./Limited	69%	88%	93%	100%	67%	67%	74%	58%	80%	65%	72%	74%	64%	66%	74%	71%	82%	77%
% Good/V. Good	7%	12%	7%	0%	13%	11%	7%	21%	10%	7%	11%	4%	8%	12%	10%	8%	12%	0%
Food Insecurity																		
% Inadequate	11%	24%	7%	0%	7%	11%	12%	9%	20%	9%	13%	14%	12%	10%	11%	9%	12%	0%
% Inad./Limited	60%	65%	79%	80%	67%	67%	60%	55%	50%	60%	49%	66%	60%	57%	60%	61%	71%	77%
% Good/V. Good	13%	12%	0%	0%	17%	6%	12%	15%	20%	13%	23%	8%	10%	19%	14%	13%	6%	15%
Housing																		
% Inadequate	45%	53%	57%	80%	60%	61%	55%	48%	40%	47%	49%	40%	41%	54%	52%	56%	53%	69%
% Inad./Limited	87%	94%	86%	100%	97%	89%	93%	91%	90%	85%	94%	86%	82%	89%	90%	88%	82%	100%
% Good/V. Good	2%	0%	0%	0%	0%	0%	2%	3%	10%	1%	4%	3%	1%	4%	6%	4%	0%	0%
Transportation																		
% Inadequate	22%	12%	14%	20%	20%	26%	24%	3%	40%	22%	23%	21%	23%	14%	21%	21%	24%	31%
% Inad./Limited	74%	76%	100%	100%	73%	79%	71%	67%	70%	75%	71%	73%	82%	63%	82%	78%	82%	92%
% Good/V. Good	7%	6%	0%	0%	17%	5%	10%	15%	0%	8%	6%	7%	5%	11%	7%	7%	12%	8%

Appendix E: Crisis Continuum

The following tables identify the services within the Alliance Health crisis continuum for each of the four counties in the Alliance catchment area. The chart is grouped based upon the State defined crisis continuum. The level of service varies by county and in some cases, a service may not be available in a particular county.

Early Intervention				
Continuum	**Cumberland**	**Durham**	**Johnston**	**Wake**
First Responder	Larger provider is Carolina Outreach. All Alliance contracts require any enhanced service provider to be a First Responder	Available but there is a wait list for ACTT and CST for IPRS funded consumers. All Alliance contracts require any enhanced service provider to be a First Responder	Available; ACTT only serves part of the county; need greater services. All Alliance contracts require any enhanced service provider to be a First Responder	All Alliance contracts require any enhanced service provider to be a First Responder
NC START	Eastern region – not managed by Alliance	Managed by Alliance; respite beds available	Eastern region - not managed by Alliance	Managed by Alliance; respite beds available
Outpatient Provider	Available, but more providers are needed; especially those with Spanish language capacity	Multiple providers	Basic and enhanced services are provided Public health department provides mostly med management with some therapy	Multiple providers
Same Day Access Providers	Limited walk-in capacity at the Cape Fear Valley Health Outpatient Mental Health Center	Limited availability – however, there are several providers offering same day access. Behavioral Health Urgent Care is also available to meet this need.	Not available	Several providers offer same day access, with one provider offering extended hours. Behavioral Health Urgent Care is also available to meet this need.

Early Intervention				
Continuum	**Cumberland**	**Durham**	**Johnston**	**Wake**
Family & Community Support	Homeless shelters available; limited providers under Shelter Plus Care (PATH) contracts	Shelters include Urban Ministry (offers specific programs like vets & families) and Rescue Mission (difficult to place due to restriction on 7 day wait time; faith-based) Care coordination, treatment team meetings and homeless care reviews are happening in shelters. TROSA – 2 year residential substance abuse program; viewed as alternative to jail. Halfway house and Oxford House		Healing Place Raleigh Rescue Mission Helen Wright Center Oxford House
School-based	Carolina Outreach and Upward Change are new selected providers in Cumberland County Schools-RFP coordinated with Alliance.	One care coordinator at CC Spalding (elementary school);	Easter Seals UCP and Hope Services, selected through RFP coordinated with Alliance.	School-based team (includes Family Partner on team) School-based crisis intervention team
Crisis Telephone Line	Alliance; Hopeline of NC; 211 United Way of NC; National Suicide Prevention Lifeline; county resources	Alliance; Hopeline of NC; 211 United Way of NC; National Suicide Prevention Lifeline; county resources	Alliance; Hopeline of NC; 211 United Way of NC; National Suicide Prevention Lifeline; county resources	Alliance; Hopeline of NC; 211 United Way of NC; National Suicide Prevention Lifeline; county resources
MCO Access Center	Alliance	Alliance	Alliance	Alliance

Response				
Continuum	**Cumberland**	**Durham**	**Johnston**	**Wake**
Peer Support living room	Part of the model at the Cumberland Recovery Response Center operated by RI International, once licensed in this year.	Part of the model at the Durham Recovery Response Center operated by Recovery Innovations	Not available	Not available
Rapid Response (youth)	Pinnacle Family Services Pathways Methodist Home	Pinnacle Family Services Pathways Methodist Home	Pinnacle Family Services Pathways Methodist Home	Pinnacle Family Services Pathways Methodist Home
Mobile Crisis Team	Therapeutic Alternatives	Freedom House Recovery Center	Therapeutic Alternatives	Therapeutic Alternatives Enhanced Mobile Crisis Pilot with Wake EMS APPs
CIT Partnership	Active CIT program with numerous officers trained.	Active CIT program with numerous officers trained.	Active CIT with increasing numbers of officers being trained	Active CIT program with numerous officers trained.
EMS Partnership	Paramedics and 911 operators are CIT trained but no advanced paramedics	Community Paramedicine Program fully launched in 2018operators are CIT trained	Paramedics and 911 operators are CIT trained but no advanced paramedics; some community paramedics focused on top utilizers (physical health also)	Advanced Practice paramedics; also Paramedics and 911 operators are CIT trained. Enhanced Mobile Crisis Pilot with Wake EMS APPs
24/7 Crisis Walk-in Clinic	Cumberland Recovery Response Center operated by RI International	Durham Recovery Response Center operated by RI International	Johnston Public Health - available Monday to Friday (8 to 5)	Wakebrook Crisis and Assessment Services
Hospital Emergency Department	Cape Fear Hospital	Duke; Duke Regional and UNC-Chapel Hill (in Orange County)	Johnston Health System	UNC Rex, Duke Raleigh, WakeMed

Stabilization				
Continuum	**Cumberland**	**Durham**	**Johnston**	**Wake**
Crisis Respite Housing	Not available	Not available; some respite for children available with special authorization (provide by Alpha Management MH) 2 beds available for NC START (2 each for crisis and planned)	Not available	2 beds available for NC START (2 each for crisis and planned)
Crisis for Kids	Freedom House & Cape Fear plan to implement	Not available	Not available	Provider has been selected to implement this service, and facility development is in process
Tier IV Behavioral Health Urgent Care	Cumberland Recovery Response Center available for walk-ins and voluntary law enforcement drop offs;	Durham Recovery Response Center operated by Recovery Innovations	Crisis Stabilization Unit at UNC Johnston Health Hospital - 7 beds in the ED that operate like CEO and FBC	UNC WakeBrook Crisis & Assessment Services – *12 chair/beds for children and adults*
Facility Based Crisis	RI International; 16 beds shared with FBC and detox; when crisis is on diversion, sent to ED to access detox beds. Facility in process-renovations close to complete, and will reopen once licensed.	Durham Recovery Response Center operated by Recovery Innovations - 16 FBC /non-medical detox	Not available	UNC WakeBrook FBC – 16 beds
Non-hospital detox	RI International is; 16 beds shared with FBC and detox; Facility in process-renovations close to complete, and will reopen once licensed.	Durham Recovery Response Center operated by Recovery Innovations - 16 FBC /non-medical detox	Not available	UNC WakeBrook Alcohol and Drug Detox Unit (ADU) – 16 beds
Community Hospital Incl 3 way	Three-way beds Inpatient Psych Unit	Three-way beds Inpatient Psych Unit	Three-way beds Inpatient Psych Unit	Three-way beds Inpatient Psych Unit

bed	Cape Fear Valley Health	Duke University Hospital Duke Regional Hospital	UNC Johnston Health System	WakeBrook Holly Hill –County sponsored beds for uninsured
State Psych & ADATC	Central Regional Hospital, Broughton, Cherry Hill, RJ Blakely	Central Regional Hospital, Broughton, Cherry, RJ Blakely	Central Regional Hospital, Broughton, Cherry, WB Jones	Central Regional Hospital, Broughton, RJ Blackley

Transition Supports				
Continuum	**Cumberland**	**Durham**	**Johnston**	**Wake**
Peer Crisis Navigators	None	None	None	None
LME/MCO Care Coordination	Provided by Alliance; includes jail liaison	Provided by Alliance; includes jail liaison & social workers contracted at CJRC; Alliance funds Duke ED embedded care coordinator	Provided by Alliance includes jail liaison	Provided by Alliance; includes jail liaison
Care Review Teams	Alliance	Alliance. Adult, youth, transitional aged-youth, homeless, Spanish-speaking, etc.	Alliance	Alliance
Hospital Transition Team	Not available	Not available	Not available	Available

Prevention				
Continuum	**Cumberland**	**Durham**	**Johnston**	**Wake**
WRAP	Need to determine how widely used	Need to determine how widely used	Need to determine how widely used	Need to determine how widely used
Crisis Planning	Training & expectations provided to provider network	Training & expectations provided to provider network	Training & expectations provided to provider network	Training & expectations provided to provider network
Integration/re-integration into treatment and support system	Training & expectations provided to provider network	Training & expectations provided to provider network	Training & expectations provided to provider network	Training & expectations provided to provider network
Advanced directive	Available but needs to be promoted	Available but needs to be promoted	Available but needs to be promoted	Available but needs to be promoted
MH First Aid	Available & utilized	Available & utilized	Available & utilized	Available & utilized
Transitional Living	Myrover Reese	Freedom House; Durham Recovery; Dove House and TROSA Recovery Center of Durham	Not available	Southlight NC Recovery
Drop-in Center	Not available	Wellness City (Recovery Innovations)	Southeastern Healthcare (PSR provider)	Fellowship Health Resources

Appendix F: State Survey Data Summary

QI5: Member Experience Report FY2021

Completed 2/12/2021 by Ginger Yarbrough, NCQA Accreditation Manager

Contents

Section 1: Grievances and Appeals Data Findings

Alliance collects data regarding grievances and appeals throughout the year. Appeals are inclusive of both UM appeals and grievance appeals. This information is aggregated and reported below. Alliance has established a goal of no more that 10 grievances per 1,000 members and no more than 10 appeals per 1,000 members for each category listed.

Grievances

The following table shows the aggregate Grievance total and rate per 1,000 members for the past two years:

Grievance Category	FY2019	FY2020	Change per 1,000	Goal Grievances/1,000 Members	Met
Quality of Care	202/9.18	142/6.45	↓ 30%	10/1,000	Met
Access	105/4.77	88/4	↓ 16%	10/1,000	Met
Attitude/Service	10/0.5	20/0.91	↑ 82%	10/1,000	Met
Billing/Financial	41/1.86	51/2.32	↑ 25%	10/1,000	Met
Quality of Practitioner Office Site	0/0	0/0	No Change	10/1,000	Met

Appeals

The following Table shows the aggregate appeals data total and rate per 1,000 members for the past two years:

Appeal Category	FY2019	FY2020	Change per 1,000	Goal Grievances/1,000 Members	Met
Quality of Care	0/0	0/0	No change	10/1,000	Met
Access	168/7.64	139/6.32	↓ 17%	10/1,000	Met
Attitude/Service	0/0	0/0	No change	10/1,000	Met
Billing/Financial	0/0	0/0	No change	10/1,000	Met
Quality of Practitioner Office Site	0/0	0/0	No change	10/1,000	Met

Quantitative Analysis:

- Grievance and appeals data include all instances of each category. Services for IDD and MH are roughly even, with the highest number of grievances and appeals coming from members needing services across more than one area.
- About 70% of grievances are from/on behalf of adults which is consistent with census data related to population in Alliance's catchment area.[1]
- "Quality of Care" grievances include many different types of concerns, including lack of follow-through on planned interventions; difficulty with housing requests; injuries while in care; inconsistencies between claims and services rendered; and other quality issues. Quality of Care saw the biggest decrease at 30% drop from FY19 to FY20.

[1] (Carlyle Johnson 2019)

- In the “Access” category, grievances and appeals include issues getting medication refills; denials for higher levels of care; difficulty reaching providers; and members being discharged from providers.
- For the most part, “Attitude/Service” grievances are more serious and include things such as failure of providers to meet the member’s needs and going without services for significant amounts of time. While the raw data indicates an 82% increase in reports related to attitude/service, it is important to note that there is still a low report rate in this category overall at just 0.91 instance per 1,000 members indicating limited opportunity for improvement in this category.
- Each appeal form UM and Grievances were regarding access to services in both 2019 and 2020. There were no appeals related to any other category per our analysis.
- Each category met or exceeded the performance goal of less than 10 grievances per 1,000 members.

Qualitative Analysis

Findings were presented in the Member Experience Committee, a subcommittee of CQI Committee. Attendees include: Suzanne Davis-Marens, Committee Chair and Senior Director of Access; Todd Parker, QM Incident and Grievances Manager; Doug Wright, Director of Community and Member Engagement; Carlyle Johnson, Director of Provider Network Strategy and Innovations; Wes Knepper, Senior Director of Quality Management. Discussions included review of analytical findings, barriers, opportunities, and interventions to increase overall Member Experience.

- Financial grievances include billing that is inconsistent with coverage as well as individual budget allotments for IDD/Innovations services.
- Of the grievances filed in 2020, 137 were resolved by educating the member/guardian. This is consistent with the identified themes noted in the ECHO® survey results of families desiring information related to the member’s treatment and conditions. Of the remaining grievances and appeals, 78 resulted in the provider contributing to the resolution and 7 were referred to DHSR to address as they were concerns related to licensure.
- Across the various categories, there was one provider agency that accounted for approximately 12% of all grievances and appeals. In further discussions, it was noted that this provider agency serves a large portion of the population and tends to service members receiving enhanced mental health services – often resulting in higher grievances and appeals. There were no specific concerns or trends identified by the QM Grievances and Appeals team that would lead to further intervention with this provider. However, the ME Committee did consider that more investigation into the agency’s grievance and appeal procedures may be necessary to determine if there is opportunity for the provider to resolve conflicts more effectively internally before escalating to Alliance for resolution.
- It is important to note that the last four months of FY20 were impacted by COVID-19. Starting in March of 2020, North Carolina Governor Cooper issued a State of Emergency in response to COVID-19. Other COVID-19 impacts include policy flexibilities regarding prior authorization requirements and requirements related to continued authorizations for many mental health services authorized by Alliance Health. This resulted in a decrease in Utilization Reviews and therefor a reduction in denials. Because there were fewer denials, the rates of appeals also

decreased significantly. This could account for some of the reduced rates reported in the categories above.[2]

Next Steps:

- *Grievances remain below the established goal of fewer than 10 grievances per 1,000 members per category.*
- *Appeal rates remain below established goal of 10 grievances per 1,000 members per category.*
- *Alliance will continue to monitor for trends and changes in FY2021.*

Section 2: Member Experience Survey Findings

The North Carolina Department of Health and Human Services uses the Experience of Care & Health Outcomes (ECHO) surveys to evaluate the experiences of children and adults receiving behavioral health services through Alliance Health. To encourage survey responses for both the adult and child surveys, a three-wave protocol was followed consisting of an initial survey mailing and reminder postcard to all respondents, a second survey mailing to non-respondents, and a final telephonic follow-up to non-respondents. Alliance's target is to perform at or above state average for each applicable question listed below.

ECHO® Adult Survey

The ECHO® Adult Survey was distributed by mail and telephone to adult Medicaid enrollees over the age of 18 who received mental health, substance use, or intellectual/developmental disability services through Alliance Health during the last year. For Alliance Health, 65 enrollees responded yielding a usable response rate of 11.5%. A summary of findings is included below. For full report including population, sample size, sampling technique, administration, and response rates, please see Appendix A.

Alliance's target is to perform at or above State Achievement Score for each applicable question listed below.

Services

Question	Alliance Achievement Score	State Achievement Score	Met
In the last 12 months, were you given information about different kinds of counseling or treatment that are available?	59.57%	58.73%	Met
In the last 12 months, how much were you helped by the counseling or treatment you got?	83.87%	80.73%	Met

Access

Question	Alliance Achievement Score	State Achievement Score	Met
In the last 12 months, how much of a problem, if any, were delays in counseling or treatment while you waited for approval?	47.37%	44.0%	Met
In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called your health plan's customer service?	43.55%	33.3%	Met

Availability

[2] (NCDHHS 2020)

Question	Alliance Achievement Score	State Achievement Score	Met
In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted?	77.27%	65.07%	Met
In the last 12 months, how often were you seen within 15 minutes of your appointment?	66.67%	68.64%	**NOT MET**

Acceptability

Question	Alliance Achievement Score	State Achievement Score	Met
Does your language, race, religion, ethnic background, or culture make any difference in the kind of counseling or treatment you need?	11.4%	9.3%	NA
In the last 12 months, was the care you received responsive to those needs?	100%	60.71%	Met
In the last 12 months, how often did you feel safe when you were with the people you went to for counseling or treatment?	93.75%	91.34%	Met

ECHO® Child Survey

The ECHO Child Survey was distributed by mail and telephone to the guardians of a child Medicaid enrollees ages 12 – 17 years who receive mental health, substance use, or intellectual/developmental disability services during the last year. For Alliance Health, complete responses were obtained from 77 legally responsible parties yielding a usable response rate of 13.5%. A summary of findings is included below. For full report including population, sample size, sampling technique, administration, and response rates, please see Appendix B.

Alliance's target is to perform at or above State Achievement Score for each applicable question listed below.

Services

Question	Alliance Achievement Score	State Achievement Score	Met
In the last 12 months, were you given information about different kinds of counseling or treatment that are available for your child?	65%	70.2%	**NOT MET**
In the last 12 months, how much was your child helped by the counseling or treatment you got?	77.03%	76.64%	Met

Access

Question	Alliance Achievement Score	State Achievement Score	Met
In the last 12 months, how much of a problem, if any, were delays in counseling or treatment while you waited for approval?	59.09%	46.10%	Met
In the last 12 months, how much of a	77.78%	47.22%	Met

problem, if any, was it to get the help you needed when you called your health plan's customer service?			

Availability

Question	Alliance Achievement Score	State Achievement Score	Met
In the last 12 months, when your child needed counseling or treatment right away, how often did he or she see someone as soon as you wanted?	61.76%	66.34	**NOT MET**
In the last 12 months, how often was your child seen within 15 minutes of his or her appointment?	62.07%	73.73%	**NOT MET**

Acceptability

Question	Alliance Achievement Score	State Achievement Score	Met
Does your child's language, race, religion, ethnic background, or culture make any difference in the kind of counseling or treatment he or she needs?	88.3%	95.7%	N/A
In the last 12 months, was the care your child received responsive to those needs?	66.67	73.33	**NOT MET**

Quantitative Analysis

- Only 60% of approved services are being utilized. This may be partially due to a 43.8% turnover rate for direct support professionals.
- Currently 13,000 individuals on the wait list for Innovations Waiver
- There has been an 86% percent increase in individuals who need direct support providers.

Qualitative Analysis

Findings were presented in the Member Experience Committee, a subcommittee of CQI Committee. This committee consists of the following people: Suzanne Davis-Marens, Committee Chair and Senior Director of Access; Todd Parker, QM Incident and Grievances Manager; Doug Wright, Director of Community and Member Engagement; Victoria Boviall, Integrated Care Nurse; Carlyle Johnson, Director of Provider Network Strategy and Innovations; Michael Bollini, COO. Discussions included review of analytical findings, barriers, opportunities, and interventions to increase overall Member Experience.

Literature reviewed:

Alliance Health CAHPS 3.0 Adult Medicaid ECHO® Report, December 2019

Alliance Health CAHPS 3.0 Child Medicaid ECHO® Report, December 2019

Alliance Consumer and Family Advisory Committee (CFAC) feedback, July 2020

Causal Analysis

- Members and families are not familiar with the services available to them and their loved ones. This was consistent between children and adult members. Adults also report desire to be more involved in their treatment and decision-making.

Educational Materials are lacking

- The ECHO® survey combined with a review of grievances indicate several opportunities for improvement. Of note, a significant number of grievances were resolved by providing education to

the complainant. Combined with member and caregiver reports of wanting more information about effective treatment and services available, many of the interventions target educational opportunities with members and providers.

- Alliance has noted that there is no systematic, targeted, direct communication efforts at this time. Alliance also has several communication tools including a provider handbook, materials on our website, and information sent via Healthcrowd. Even with these communication tools, members appear to need additional education indicating that our educational tools are not sufficiently accessible.
- Many members face cognitive processing issues, so materials need to be provided in a variety of modes to increase likelihood of understanding. Modes include social media, written, visual, and using person-centered language. Another opportunity is increasing provider exposure to materials so they are able to support member understanding.

Network Providers lack understanding of treatment and services

- Providers and practitioners may not have an awareness or understanding for treatments they do not actively provide. Providers may also not have a clear understanding of HEDIS Measures available to support treatment.
- Alliance provides some training resources through Recovery University and targeted trainings, but providers may not be aware of these training resources.
- Alliance Provider Network will promote these training opportunities as well as explore additional training opportunities with provider network once gaps are assessed.

Customer Service

- *Alliance must manage resources effectively and efficiently. To do this, Alliance has set metrics for the Access Center including the amount of time that a call should take dependent on staff. This can result in calls that may feel rushed or depersonalized.*
- *This may also contribute to the ECHO® results related to members not feeling that they were able to receive adequate support or help when calling customer services.*
- *Alliance can remove time-limit expectations which may allow for better customer services. This will also allow for adherence to the new "One-Call Resolution" Policy that was enacted to have members' needs met with one contact instead of members having to call back repeatedly for the same issue.*

Next Steps

- Improve educational materials and communication tools for use with members and providers. Increase frequency and readability of materials shared.
- Support providers in clinical guidelines, clinical coverage policies, best practices, and treatment options. Provide targeted trainings based on gaps analysis. Promote trainings through communication efforts.
- Support providers and clinicians in understanding and promotion of HEDIS Measures.
- Members and caregivers would like better customer service.
- Improve the member experience when contacting the Alliance Access Center.

Section 3: Out-of-Network Requests & Utilization

For calendar year 2020, Alliance has received 619 unique requests for Out-of-Network (OON) Services while serving approximately 22,000 members during the same period of time. These requests were submitted on behalf of 181 members. This results in approximately 28 requests for every 1,000 members receiving behavioral health services. However, only eight members out of every 1,000 members has requested OON Services. Below is a table illustrating OON requests by expedited vs routine requests and

approval vs denial.

OON Service Request Type	Approved/per 1,000 members	Denied or Unable to Process/per 1,000 members	TOTAL/per 1,000 members
Expedited	24/0.92	5/0.23	**29/1.32**
Routine	513/23.32	77/3.5	**590/26.82**
TOTALS	**537/24.41**	**82/3.73**	**619/28.14**

Quantitative Analysis

- Throughout calendar year 2020, Alliance Health's UM department processed 45,221 total Medicaid Service Authorization Requests (SAR). OON Requests accounted for just at 1% of all SARs processed over the year. It is also important to note that fewer than 1% of members actively participating in behavioral health services requested OON services.
- There were 78 unique providers who submitted OON requests throughout the review period. Of the eight providers serving more than five members requesting OON services, five are hospital systems operating outside of Alliance's geographic counties. The most requested services are various levels of residential services at 98 requests (16% of OON SARs) and institutional/hospital-based services at 81 requests (13% of OON SARs).

Qualitative Analysis

- When exploring findings for health disparities related to age, gender, and race, there are no obvious disparities noted.
- Because OON requests account for only 1% of all SARs processed and impact less than 1% of the member population, there is little room for improvement that can be identified using OON data alone.
- As a very small percentage of the population was requesting out of network providers, this is not a major area of concern for the organization.

Next Steps

- Alliance will continue to monitor OON SARs for changes and trends in FY2021.

Improvement Activities

The following interventions were identified and chosen due to impact ability and feasibility. Many interventions overlap with opportunities and interventions identified in QIPs addressing HEDIS Measures. These interventions were chosen to align and support overall efforts while improvement member experience.

Barrier	Opportunity	Intervention	Expected Completion Date
Alliance's educational tools for members and caregivers are not sufficiently accessible to communicate treatment options, benefits, and care.	Improve educational materials and communication tools for use with members and providers.	Health Literacy materials will be shared frequently with members and community via social media, website, and newsletters.	*October 2020 – current On-going via Facebook and LinkedIn.*

		Promote health literacy materials through provider newsletters for increased exposure to members.	*February 26, 2020 Tools were posted to Alliance's Provider Resources section of website along with training videos.* *February - March 2020 Presentation to CST & ACTT Collaboratives* *12/11/2020 Posted to Provider News Feed.* *Physically printed materials will be delivered once Public Health Emergency is over.*
		Health literacy to review readability and understandability information provided and update annually.	*Each document is reviewed annually on a monthly rotating scheduled.*
		Maximize the HealthCrowd texting campaign to provide health education regarding benefits, treatment, and opportunities for our members.	*TBD pending the results of Legal and Compliance review.*
Network Providers lack understanding of best practices, clinical guidelines, and treatment options.	Support providers in clinical guidelines, clinical coverage policies, best practices, and treatment options. Support providers and clinicians in understanding and promotion of HEDIS Measures.	Develop trainings to address provider gaps through Recovery University.	*Targeted trainings - Next Scheduled 2/25/2021 Lunch and Learn*
		Increase availability of motivational interviewing resources through Recovery University.	*TBD – MI is best trained in person and COVID-19 prevents this at this time.*
		Offer the "Changing Hearts and Minds" trainings to Alliance staff and providers.	*To be initiated May 2021 at all provider meetings*

		Continue work with The Barthwell Group on the Alliance Diversity, Equity, and Inclusion Plan to include Alliance and provider staff	*10/1/2020 - current*
		Promote trainings in Provider Newsletter and meetings to encourage attendance and participation.	*Ongoing via Provider Newsfeed.*
		Provide educational information to providers and practitioners regarding HEDIS Measures	*Posted to website 11/9/2020*
Alliance Access Center Staff face high call volumes and face call resolution metrics including time spent on calls.	Members and caregivers would like better customer service. Improve the member experience when contacting the Alliance Access Center.	Remove the call time expectation (previously 7 – 11 minutes, depending on staff role) from the Access Center performance management matrix. This will allow staff to focus on providing excellent customer service rather than shortening the call length.	*2/19/2020 Weekly Update to Access Staff*
		Add one-call resolution expectations to the Alliance Access Center performance management matrix, encouraging staff to take responsibility for the ultimate resolution of each matter presented.	*Implemented 7/1/2020*

Section 3: Actions Taken to Improve Member Experience

Interventions *List chronologically the interventions that have been implemented with the goal of improving the measure. Describe only the interventions and provide quantitative details whenever possible. For each intervention identified, list the barriers that each intervention is designed to address.*			
Description of Intervention	**Identified Barrier**	**Start Date**	**Status**
Shared Decision-Making Tools were posted to Alliance's Provider Resources section of website along with training videos. *Physically printed materials will be delivered once Public Health Emergency is over.*	Alliance's educational tools for members and caregivers are not sufficiently accessible to communicate treatment options, benefits, and care.	*2/26/2020* *12/11/2020 Re-posted to Provider News Feed* .	Complete
Health Literacy materials will be shared frequently with members and community via social media, website, and newsletters.	Alliance's educational tools for members and caregivers are not sufficiently accessible to communicate treatment options, benefits, and care.	March 2020	Ongoing
Health literacy to review readability and understandability information provided and update annually.	Alliance's educational tools for members and caregivers are not sufficiently accessible to communicate treatment options, benefits, and care.	August 2020	Ongoing
HEDIS Education posted to Alliance Website for Providers	Network Providers lack understanding of best practices, clinical guidelines, and treatment options.	11/9/2020	Complete
CST Collaborative Presentation of Shared Decision-Making Tools	Network Providers lack understanding of best practices, clinical guidelines, and treatment options.	4/14/2020	Complete
ACTT Collaborative Presentation of Shared Decision-Making Tools	Network Providers lack understanding of best practices, clinical guidelines, and treatment options.	4/15/2020	Complete
Training 1 of 6: Improving Outcomes in Psychotic Disorders: Clozapine, LAIAs, VMAT2 Inhibitors for TD 57 attendees	Network Providers lack understanding of best practices, clinical guidelines, and treatment options.	1/28/2021	Complete
Provider DEI Assessment Survey by The Barthwell Group (consultant)	Network Providers lack understanding of best practices, clinical guidelines, and treatment options.	2/17/2021	Ongoing
Training 2 of 6:	Network Providers lack	2/25/2021	Complete

Improving Outcomes in Psychotic Disorders: Clozapine, LAIAs, VMAT2 Inhibitors for TD 38 attendees	understanding of best practices, clinical guidelines, and treatment options.		
Implemented Procedure #4019 One-Call Resolution.	Alliance Access Center Staff face high call volumes and face call resolution metrics including time spent on calls.	8/14/2021	Complete

Appendix G: Community Survey

Alliance Health

Alliance Health 2020 Community Needs Survey (Member & Family Printout Version)

Community Needs Assessment Survey 2020

Alliance Health is committed to the continuous improvement of the services offered to our members with mental illness, intellectual and developmental disabilities, substance use disorders and traumatic brain injuries. We are conducting a needs assessment to evaluate the service needs and gaps within Alliance communities.

Please take a few minutes to complete this brief survey. Your responses are very important to help us understand the service needs in our community. The information that we receive through this process will inform our service planning and development efforts for the next year and will help us better serve adults, children and families in our communities.

Completed surveys may be returned:
1) By mail to Alliance Health at 5200 W. Paramount Parkway, Morrisville NC 27560, or

2) By scanning and e-mailing to cjohnson@alliancehealthplan.org

All responses are anonymous, and we do not collect any identifying information about respondents.

Please complete the survey by Friday, December 11, 2020.

1. Please tell us which of the following describes you best:

- ◯ Person receiving services for mental illness, substance use, intellectual / developmental disabilities or traumatic brain injury
- ◯ Family member, guardian, or friend of individual who receives services

2. Which of the following best describes your gender?

- ◯ Female
- ◯ Male
- ◯ Prefer not to respond
- ◯ Prefer to self-describe:

1

3. Which race/ethnicity best describes you? (Please choose only one.)

- ○ Asian or Pacific Islander
- ○ Black or African American
- ○ Hispanic or Latinx
- ○ Native American or Alaskan Native
- ○ White or Caucasian
- ○ Prefer not to respond
- ○ Multiple ethnicity / Other (please specify)

Parents, family and guardians: for the the following questions, please respond on behalf of the member who receives services.

4. What type of services do you receive? (select all that apply):

- ☐ Child/Adolescent Mental Health
- ☐ Child/Adolescent Developmental Disabilities
- ☐ Child/Adolescent Substance Abuse
- ☐ Child Traumatic Brain Injury
- ☐ Adult Mental Health
- ☐ Adult Developmental Disabilities
- ☐ Adult Substance Abuse
- ☐ Adult Traumatic Brain Injury
- ☐ Other (please specify)

5. In which county do you live?

- ○ Cumberland
- ○ Durham
- ○ Johnston
- ○ Wake
- ○ Other (please specify)

2

6. Are you receiving the mental health, substance use, intellectual/developmental disability or traumatic brain injury services that you need?

- Yes
- No

If not, which services are you needing but not able to receive?

7. In the past year, have you had to travel outside of the county where you live to receive mental health, intellectual/developmental disability, substance use disorder or traumatic brain injury services because the service was not available in your county?

- Yes
- No

If you answered "Yes," which services were not available in your county?

3

8. From the list below, identify up to five (5) barriers that you have experienced when accessing care, and rank them in order from most concerning (1) to least concerning (5).

	1st (Most concerning)	2nd	3rd	4th	5th
Lack of reliable transportation to appointments	○	○	○	○	○
Services not available nearby	○	○	○	○	○
Services not available during times of day or days of week that are convenient	○	○	○	○	○
Limited information about how to obtain services	○	○	○	○	○
Lack of childcare	○	○	○	○	○
Language barrier	○	○	○	○	○
Medical problems or physical disability	○	○	○	○	○
Lack of physical access or assistive devices (e.g., wheelchair ramp, bathroom rails, etc.)	○	○	○	○	○
Wait too long for appointments	○	○	○	○	○
Lack of insurance	○	○	○	○	○
Cost of medication	○	○	○	○	○
Not satisfied with quality or choice of providers	○	○	○	○	○
Homeless/housing issues	○	○	○	○	○
Availability of qualified staff	○	○	○	○	○
No access to phone, internet or e-mail	○	○	○	○	○

4

9. In the past 12 months, have you been seen as quickly as you wanted for the following appointments?

	No	Sometimes but not always	Yes	Did not need this service
Intake appointment for new services	○	○	○	○
Initial appointment for counseling/therapy	○	○	○	○
Initial appointment with psychiatrist or prescriber	○	○	○	○
Follow-up appointments for counseling/therapy	○	○	○	○
Follow-up appointments with psychiatrist or prescriber	○	○	○	○

10. If you have experienced a behavioral health crisis during the past year and needed to access services quickly, were you able to get services when you wanted them?

- ○ Yes
- ○ No
- ○ I have not needed urgent access to services in the past year

11. In the past year, have you been able to obtain information about services that are available and how to access them?

- ○ Yes
- ○ No

12. If you answered 'No' to Question 10, what information were you trying to get but unable to find?

13. When you want to go somewhere in the community, do you have a way to get there?

- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Usually
- ○ Always

14. Please let us know if you have experienced any of the following in the past 12 months:

	No	Yes
Had to eat less than you felt you should because you did not have enough food	○	○
Utility company shut off your service because you could not pay your utility bill	○	○
You were worried about not having stable housing	○	○
You needed to see a doctor but could not do so because of cost	○	○
You had to go without healthcare because you did not have a way to get to your appointment	○	○

15. Does language, race, ethnic background or culture make any difference in the kind of counseling or treatment you need?

- ○ Yes
- ○ No

16. In the last 12 months, was the care you received responsive to these needs?

- ○ Yes
- ○ No

If you answered 'No,' please provide more details about cultural, racial, ethnic, or language needs that were not met.

6

17. In the past 12 months, have you requested any special accommodations from your provider to get the care that you needed? Some examples include wheelchairs, accessible service locations, sign language interpreters, foreign language translators and other supports necessary to receive services.

- ◯ No, I did not need any accommodation
- ◯ Yes, I asked for accommodations and received them (please describe the accommodations received)
- ◯ I asked for accommodations but did NOT receive them (please describe the accommodations requested)

Please describe the accommodations that you requested

18. Do you have any other comments regarding service needs or gaps that you would like us to consider?

Thanks for completing the survey! Please select 'DONE' to submit your responses.

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Supplementary Documentation

See separate Geographic Access Maps Supplement, which includes maps for 2020 and 2021 and a list of Office-Based Opioid Treatment (OBOT) providers.

Network Adequacy and Accessibility Analysis

Geographic Maps Supplement

Combined Maps for 2020 and 2021

July 1, 2021

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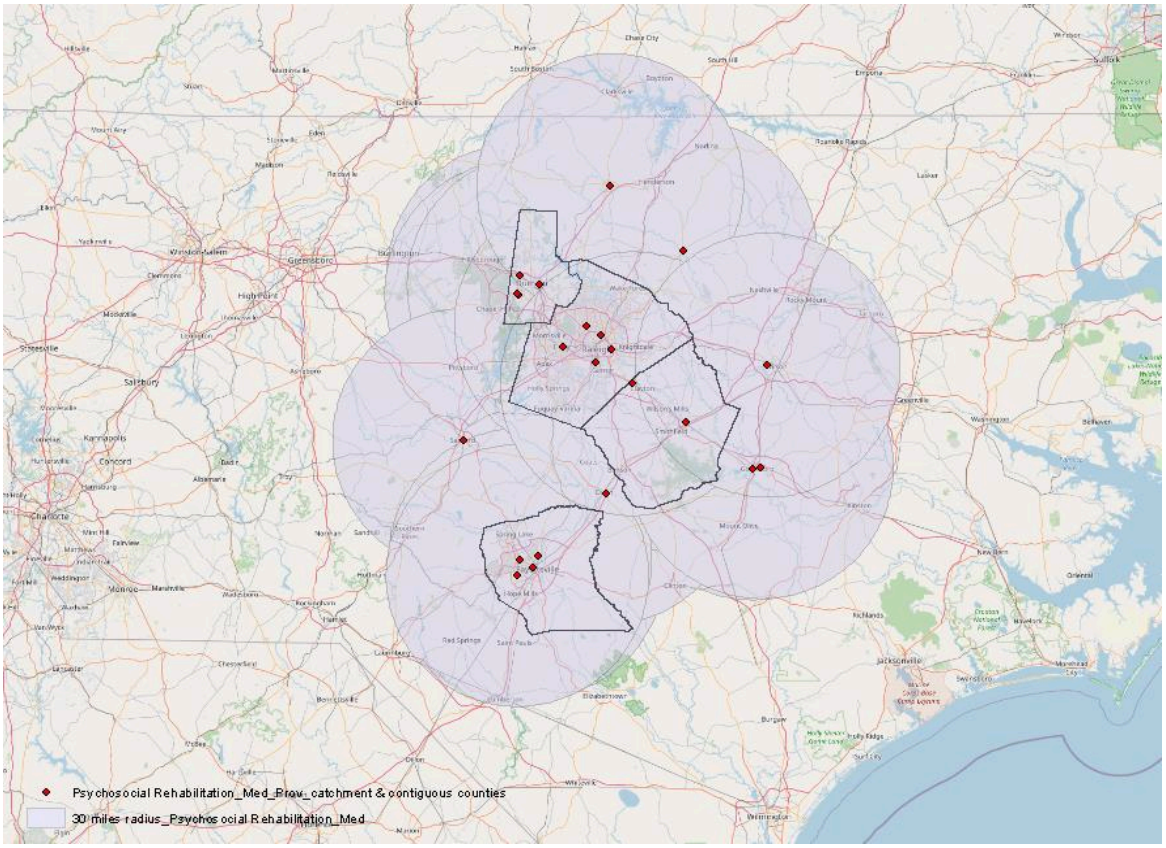
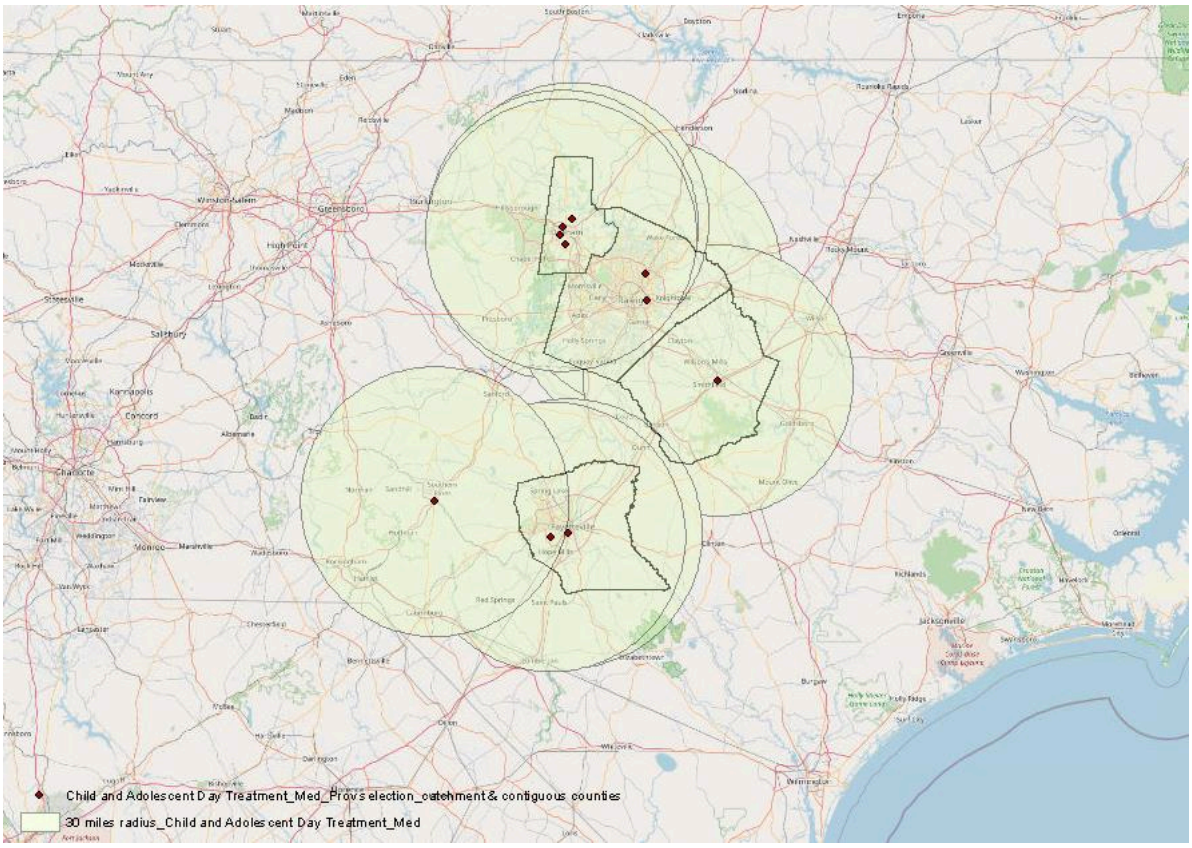
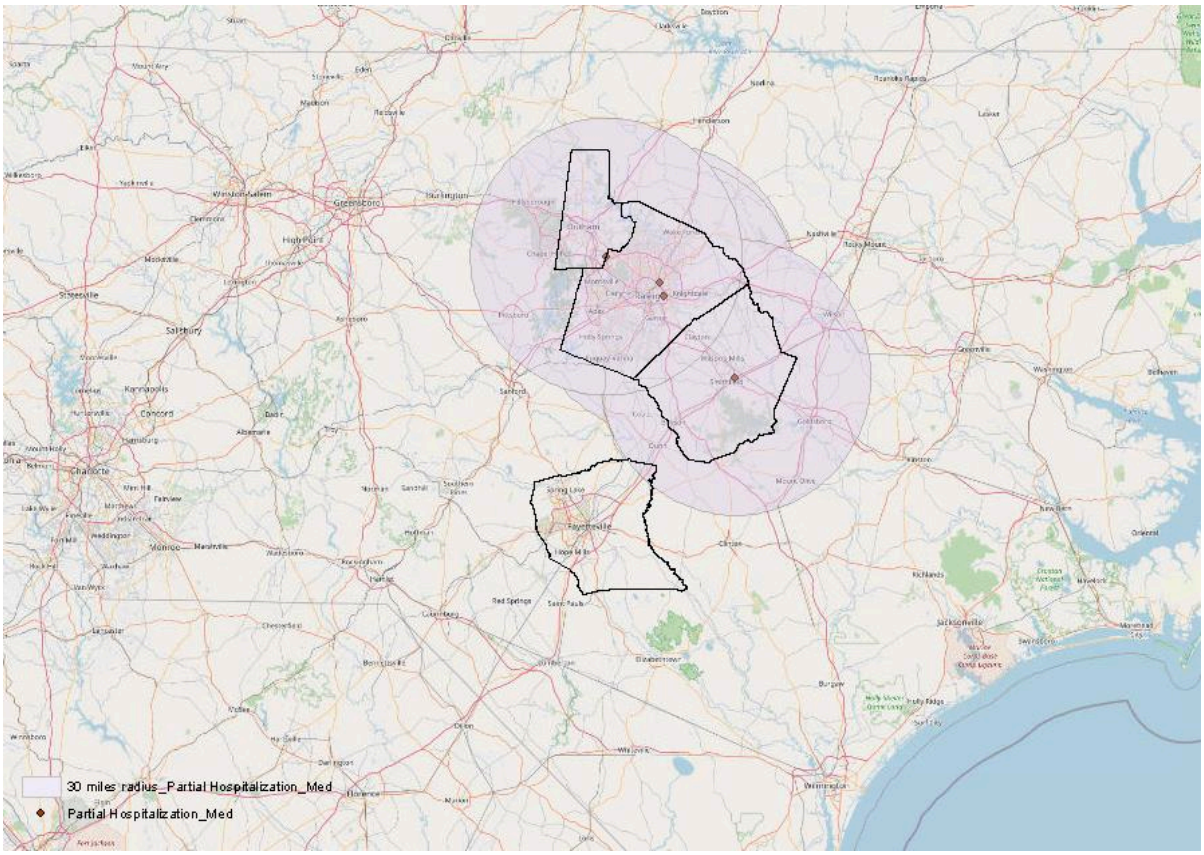
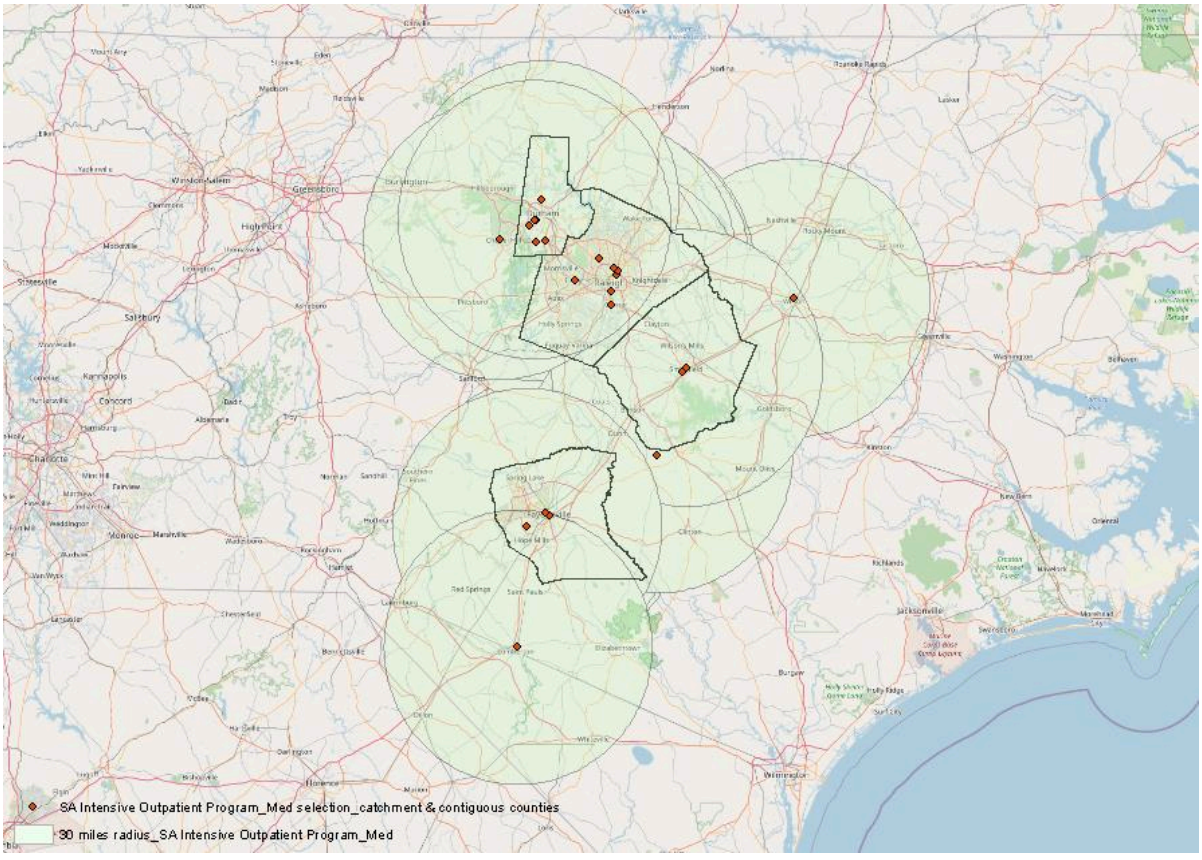
2020 Maps

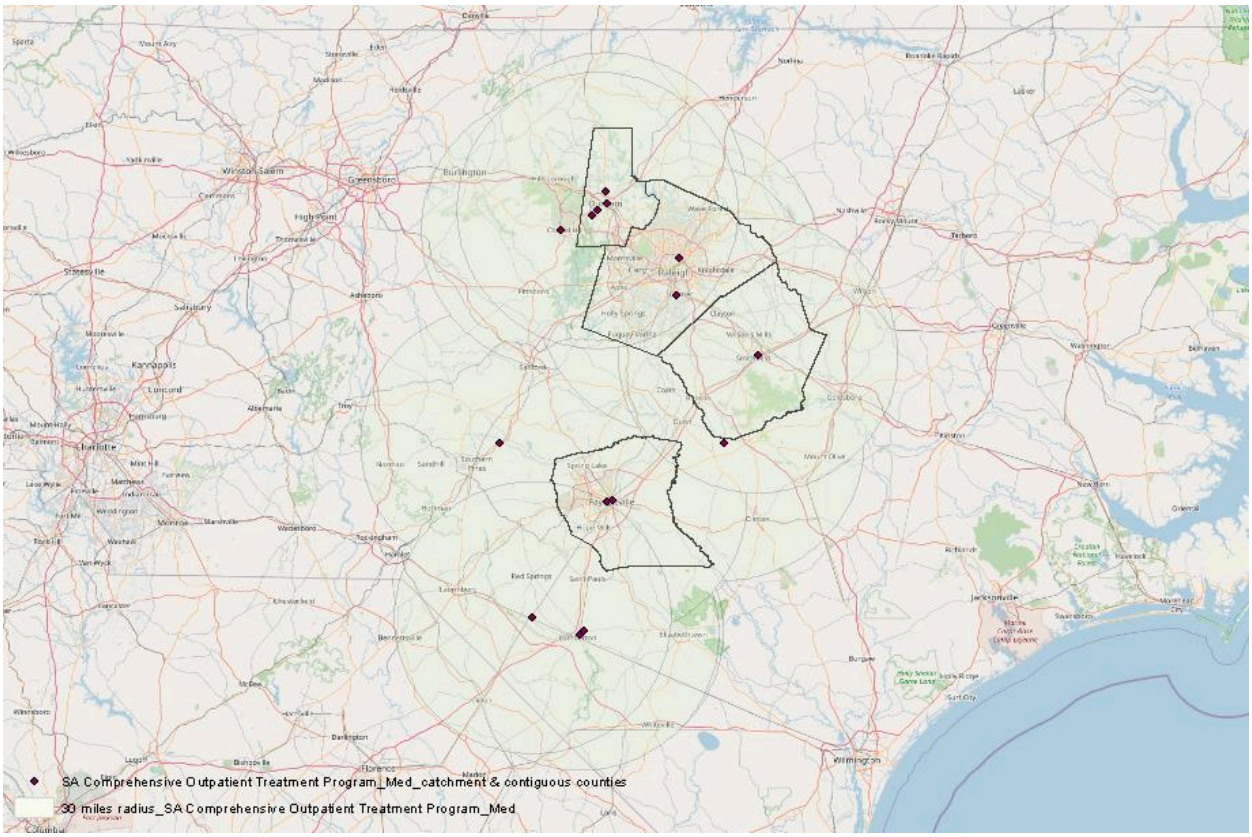
Medicaid-Funded

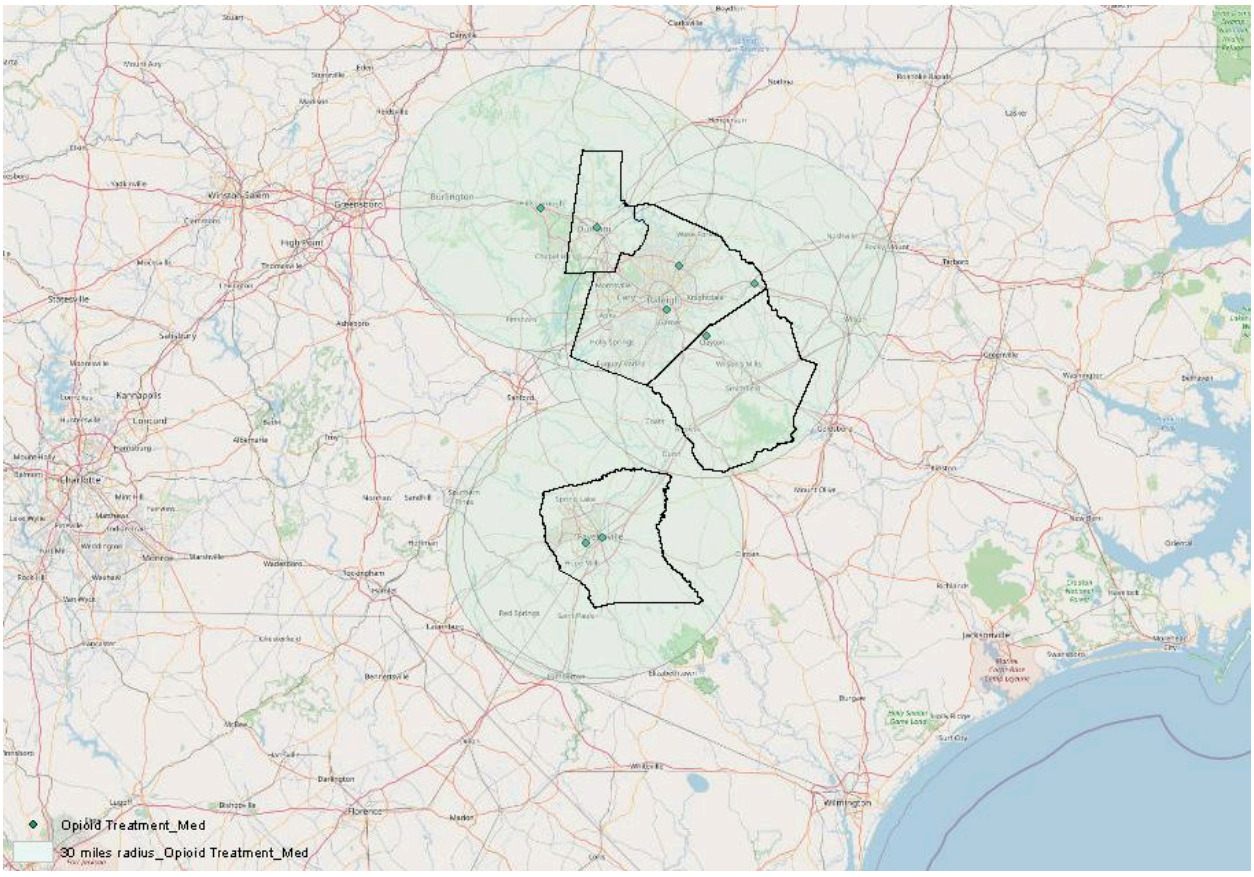

Psychosocial Rehabilitation_Med_Prov_catchment & contiguous counties
30 miles radius_Psychosocial Rehabilitation_Med

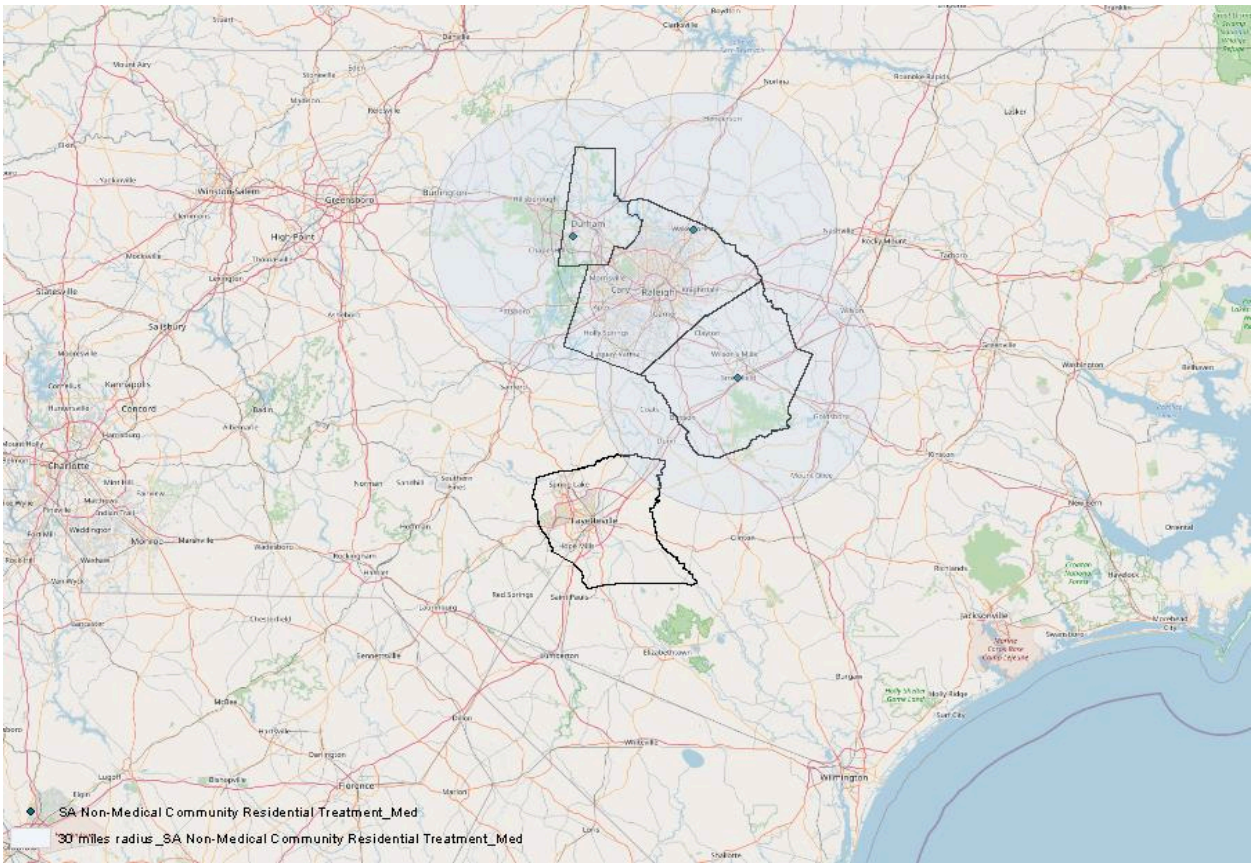

Child and Adolescent Day Treatment_Med_Provs election_catchment & contiguous counties
30 miles radius_Child and Adolescent Day Treatment_Med

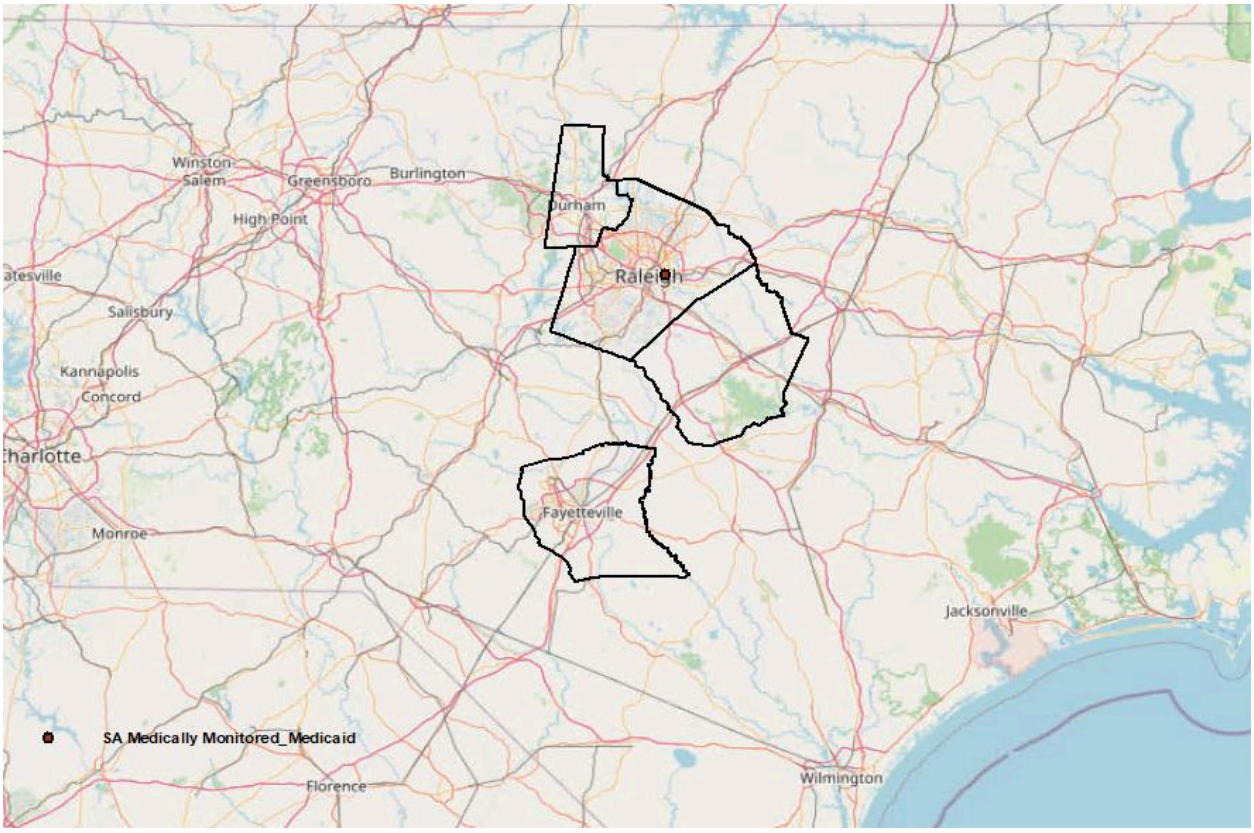

30 miles radius_Partial Hospitalization_Med
Partial Hospitalization_Med


SA Intensive Outpatient Program_Med selection_catchment & contiguous counties
30 miles radius_SA Intensive Outpatient Program_Med


SA Comprehensive Outpatient Treatment Program_Med_catchment & contiguous counties
30 miles radius_SA Comprehensive Outpatient Treatment Program_Med


Opioid Treatment_Med
30 miles radius_Opioid Treatment_Med


SA Non-Medical Community Residential Treatment_Med
30 miles radius_SA Non-Medical Community Residential Treatment_Med


Winston-Salem
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Burlington
High Point
Durham
Raleigh
Salisbury
Kannapolis
Concord
Monroe
Fayetteville
Jacksonville
Wilmington
Florence
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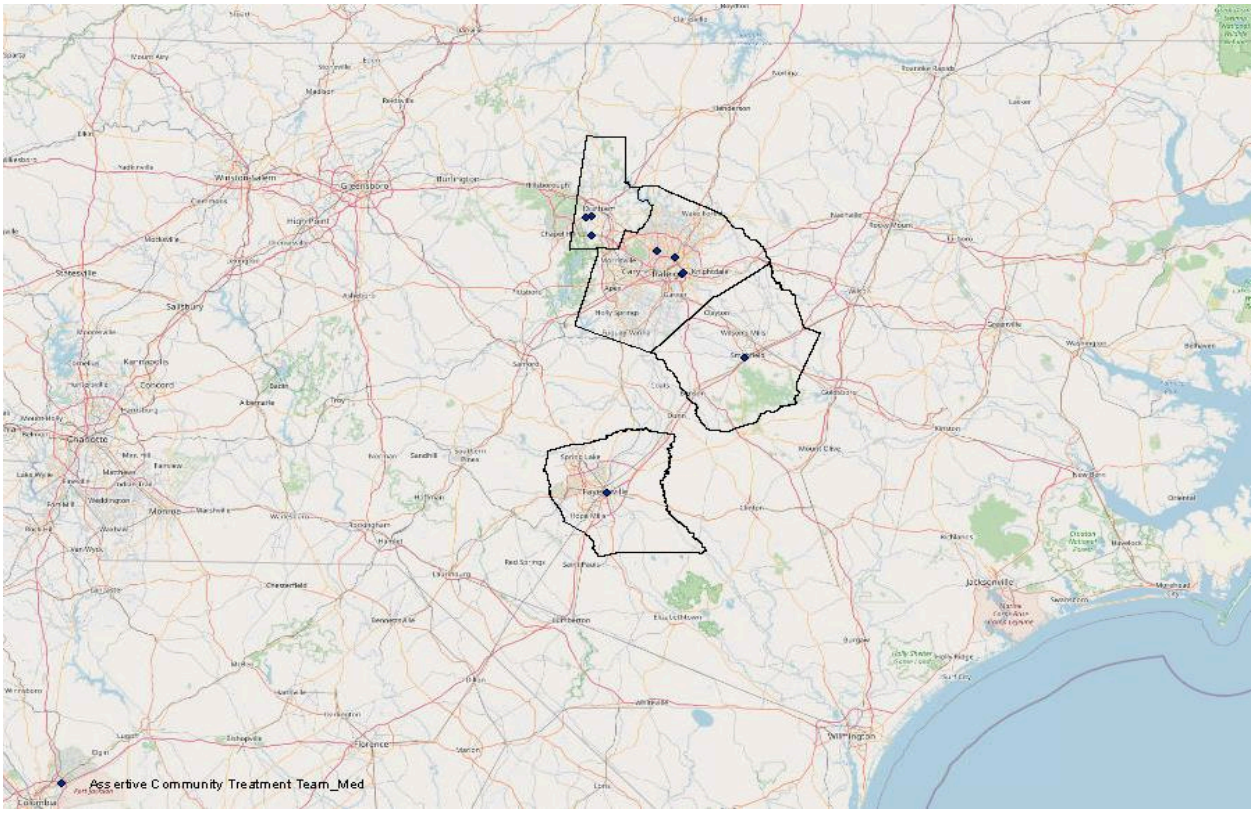
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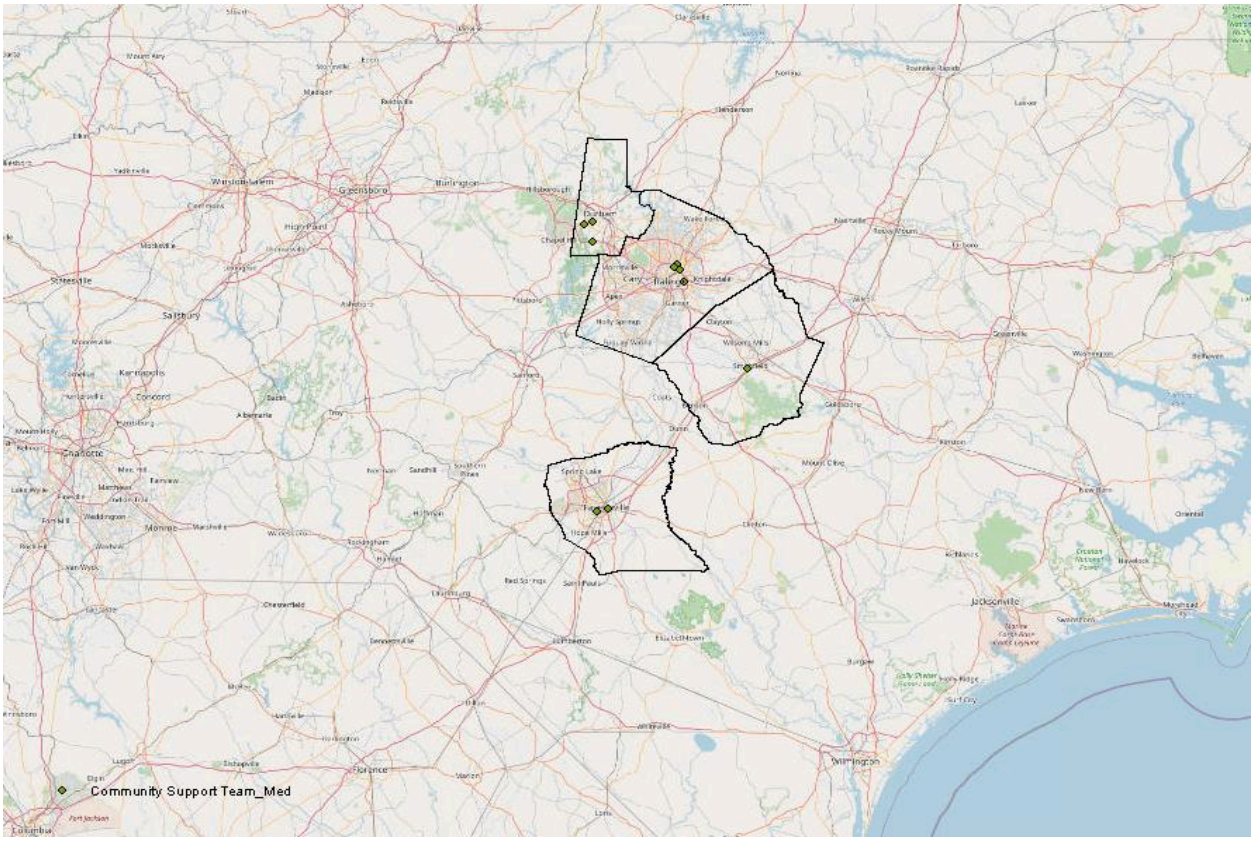
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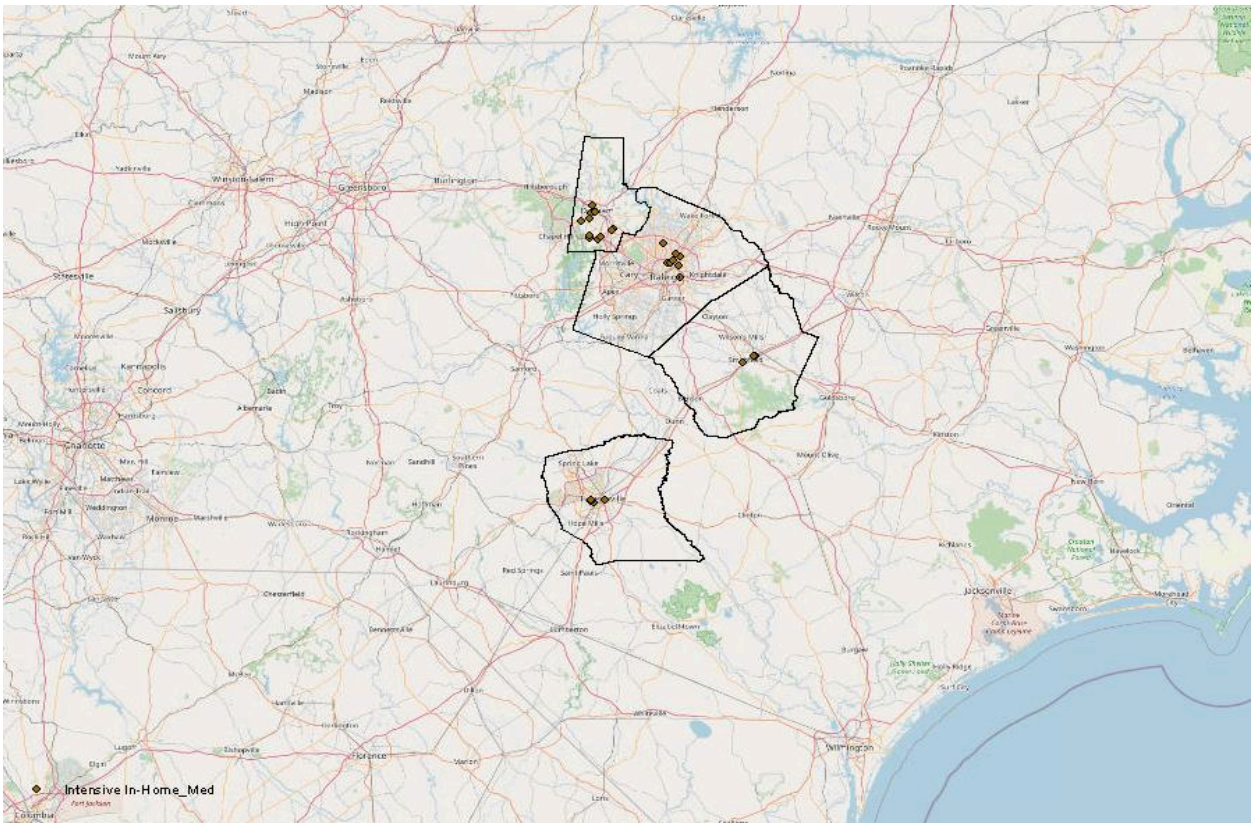
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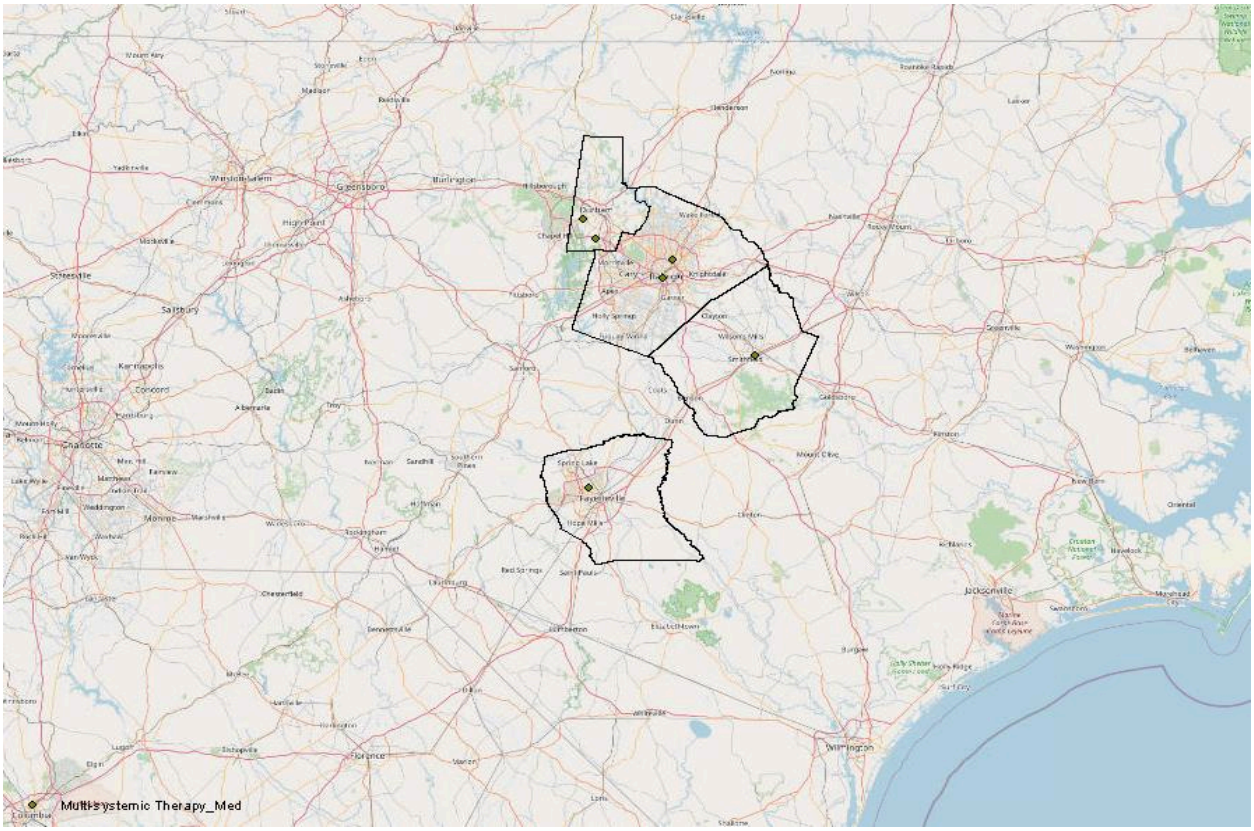
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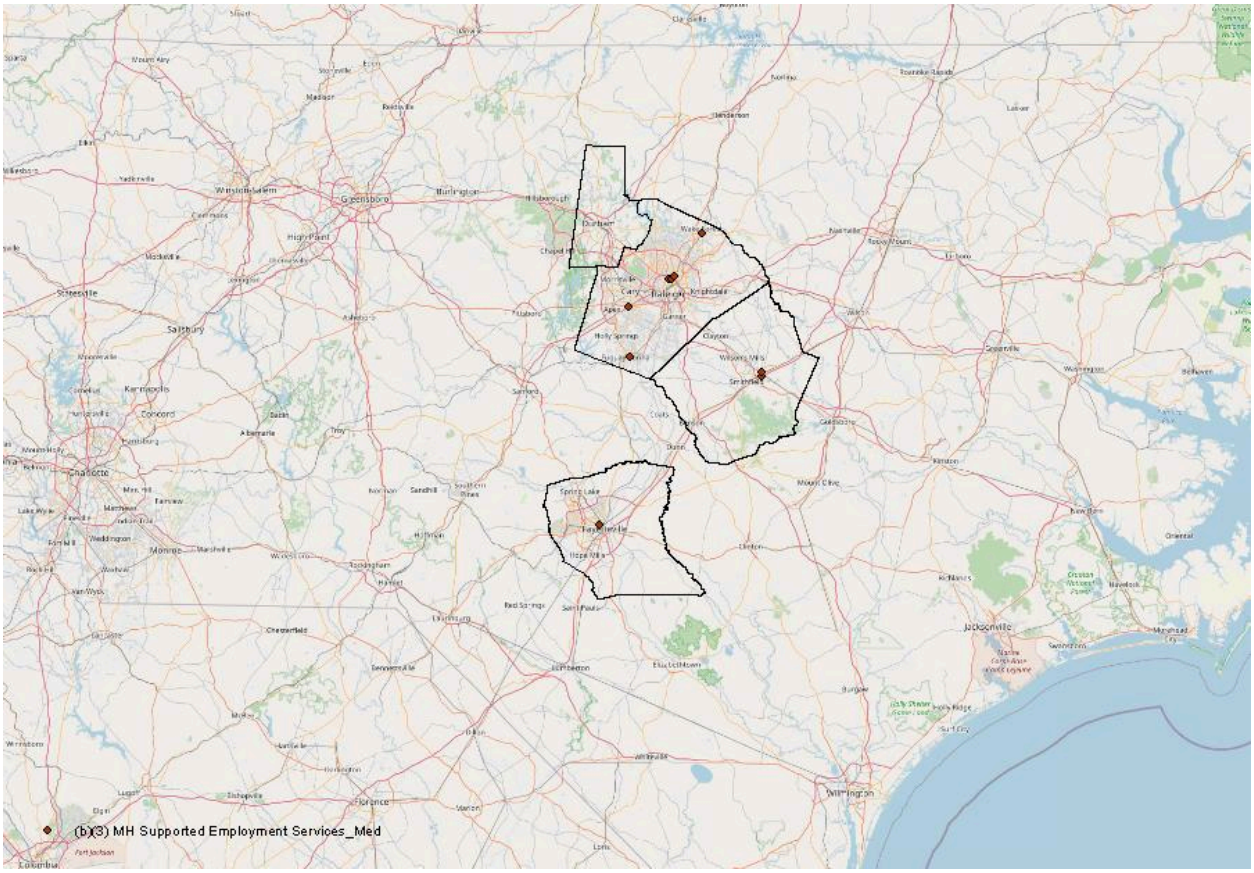
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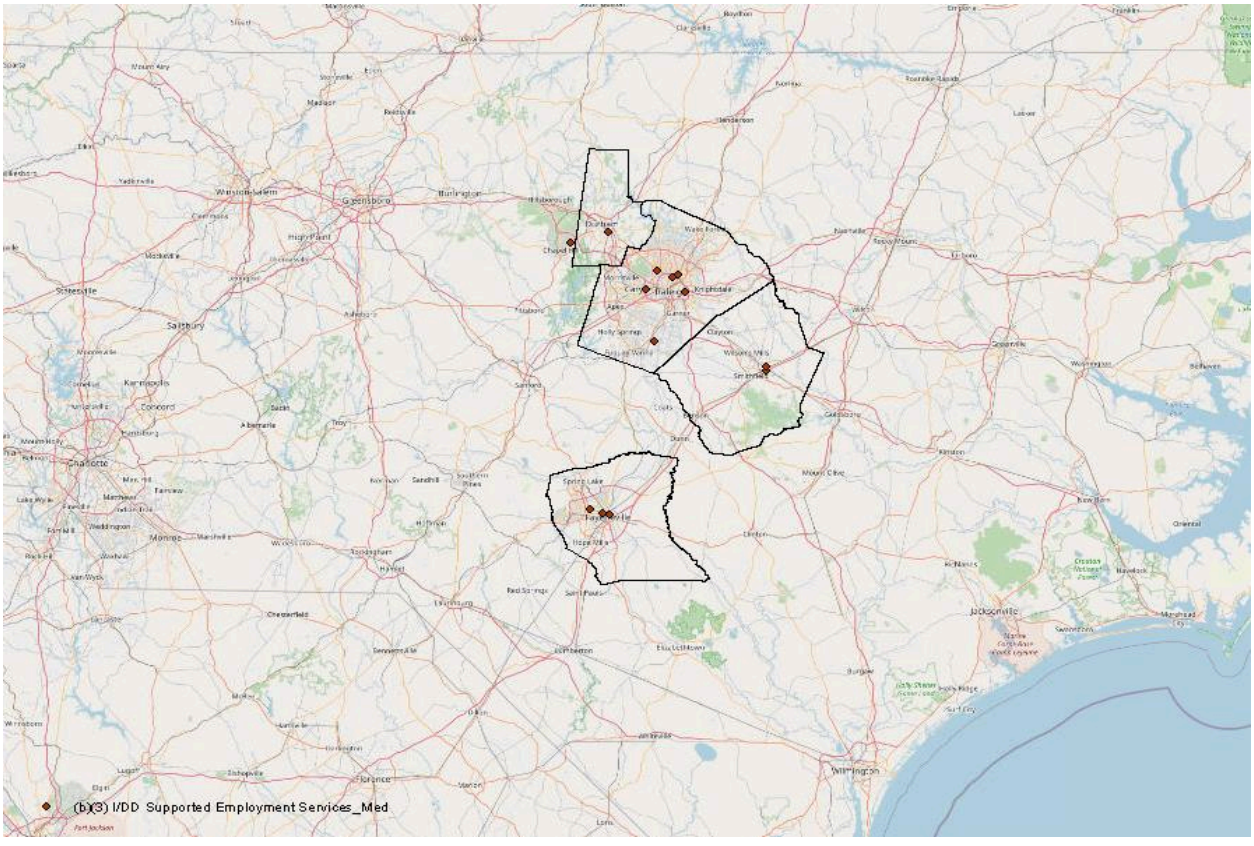
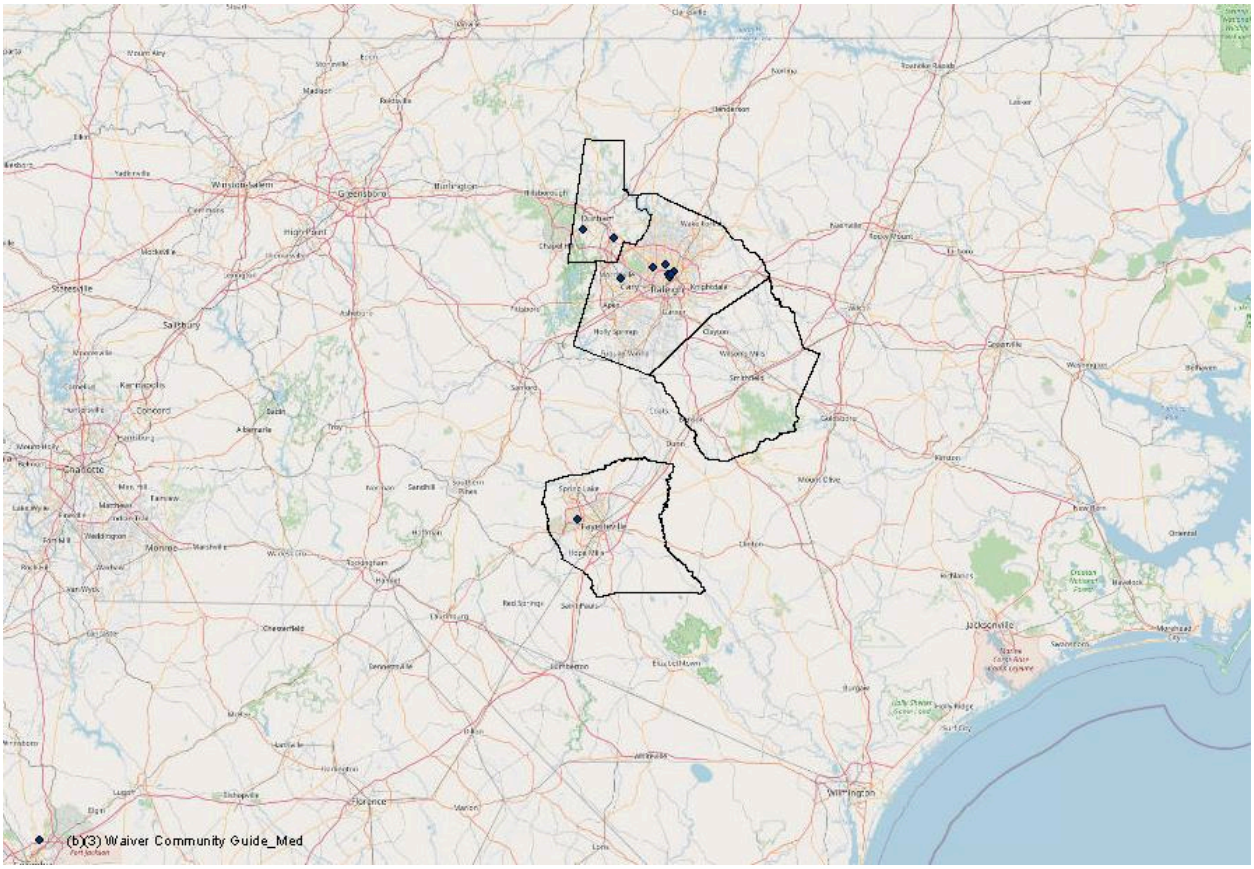

(b)(3) I/DD Supported Employment Services_Med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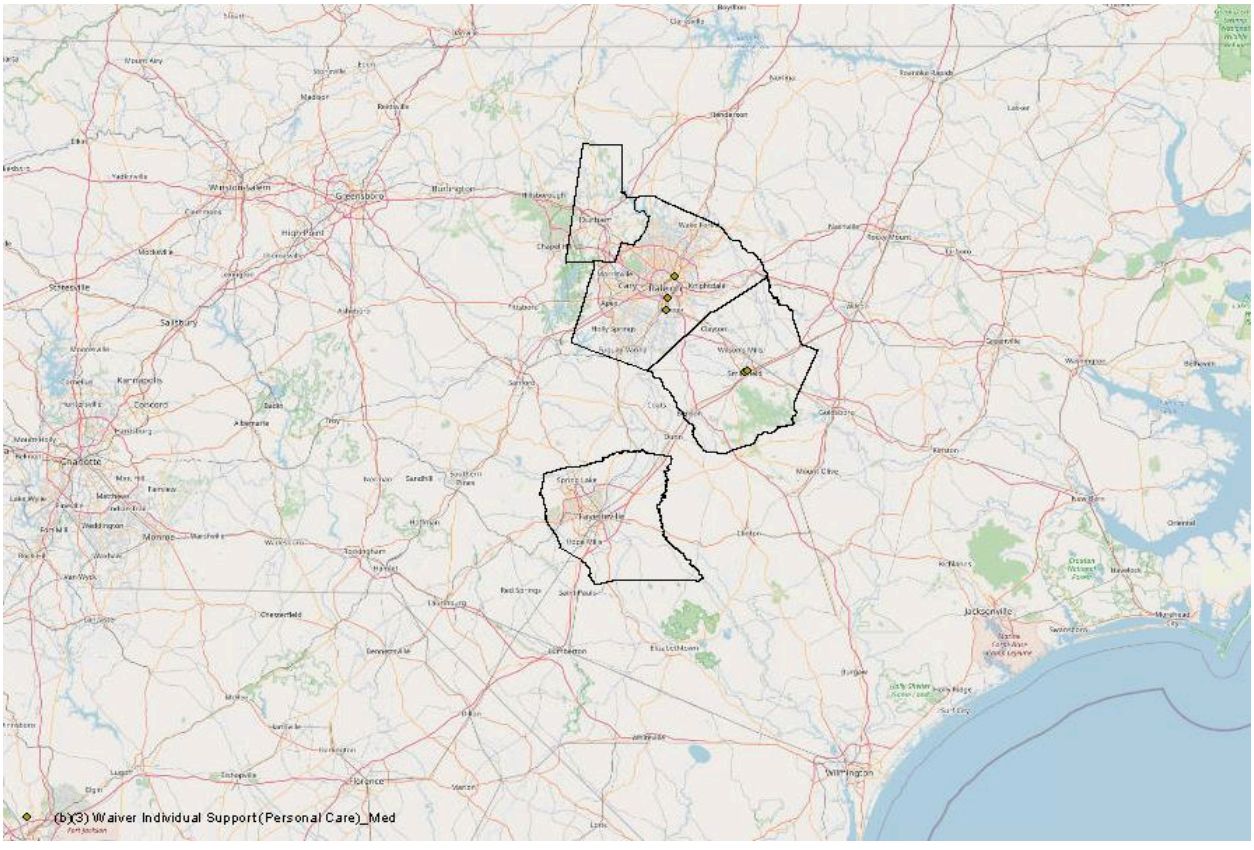
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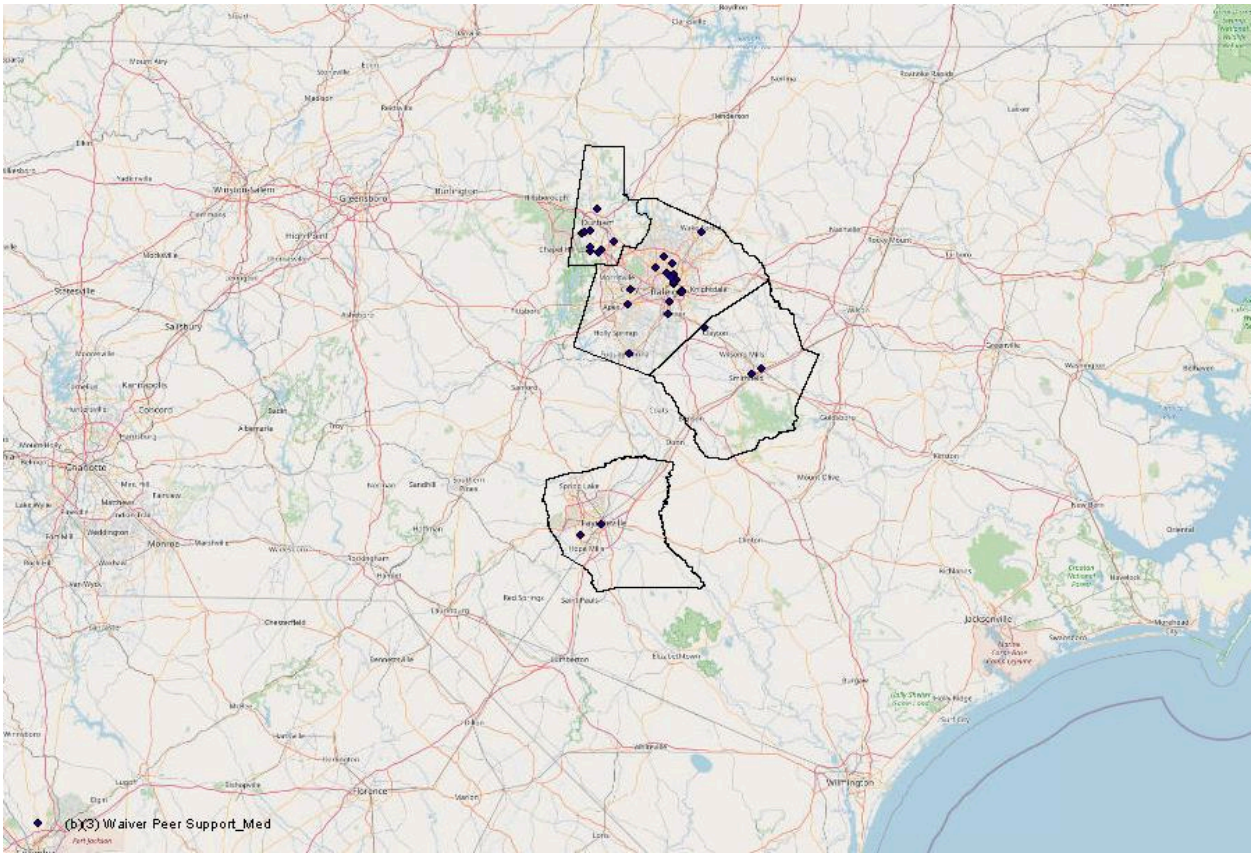
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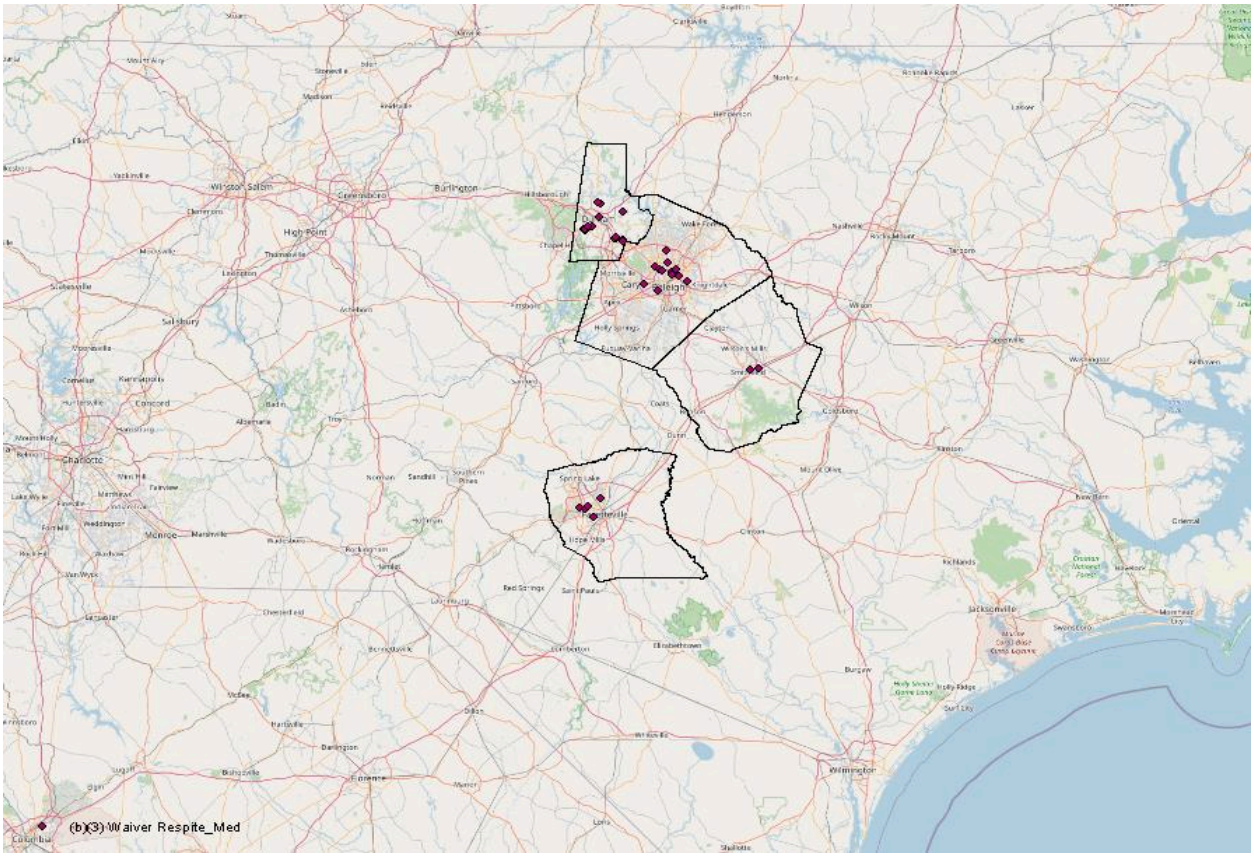
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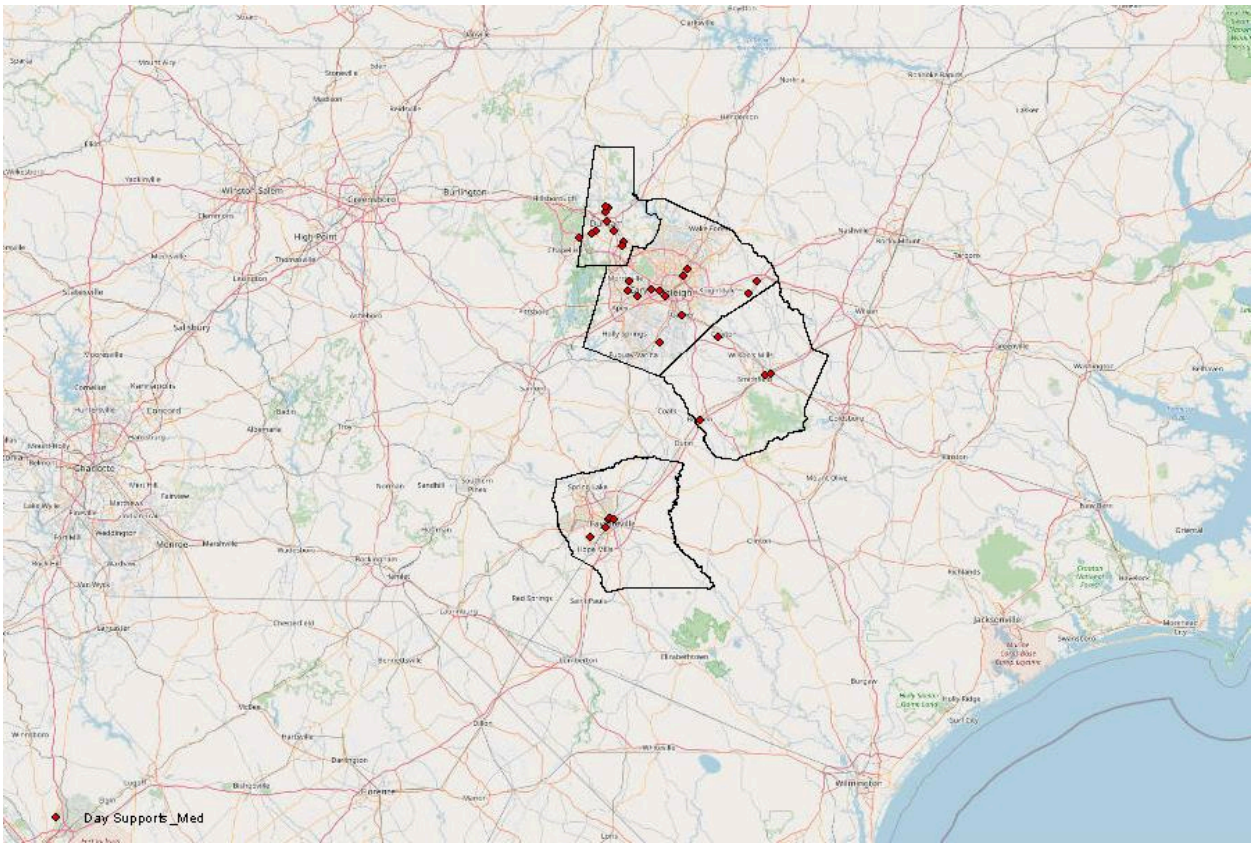
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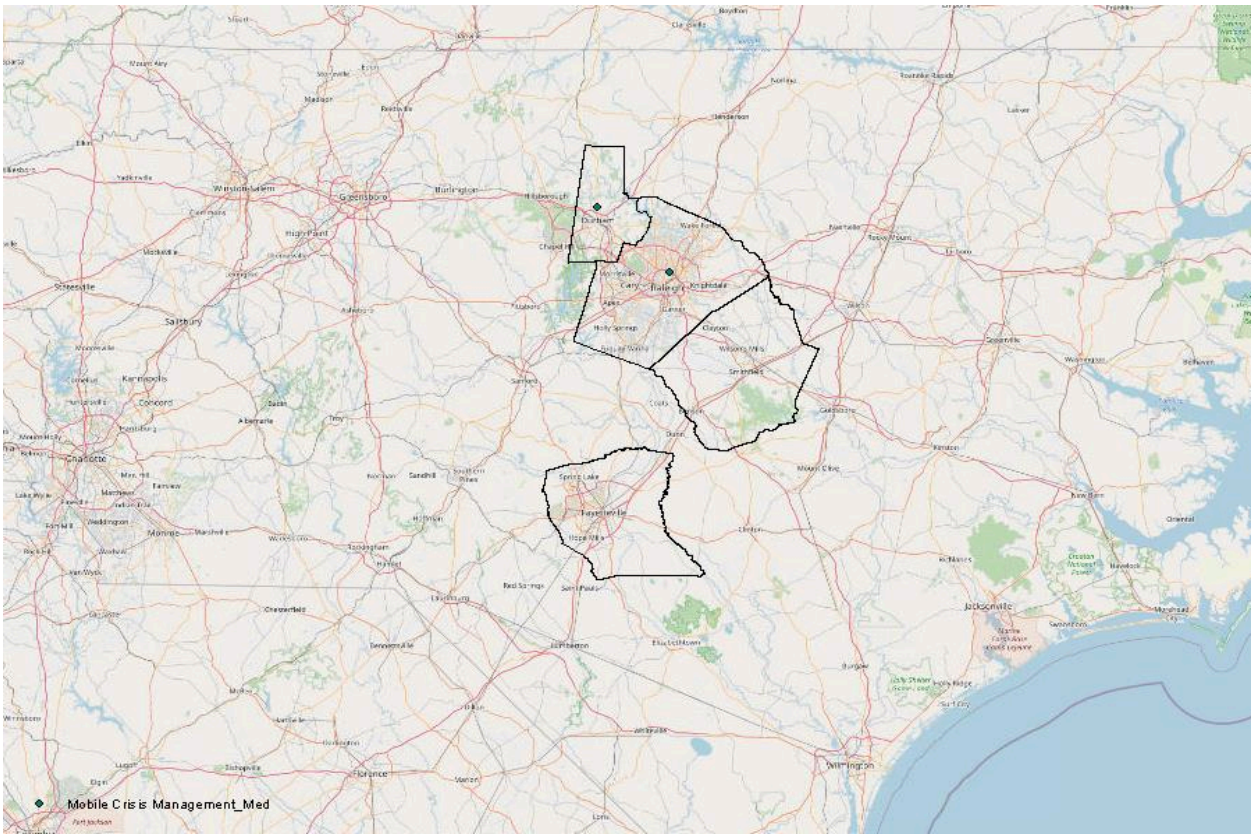
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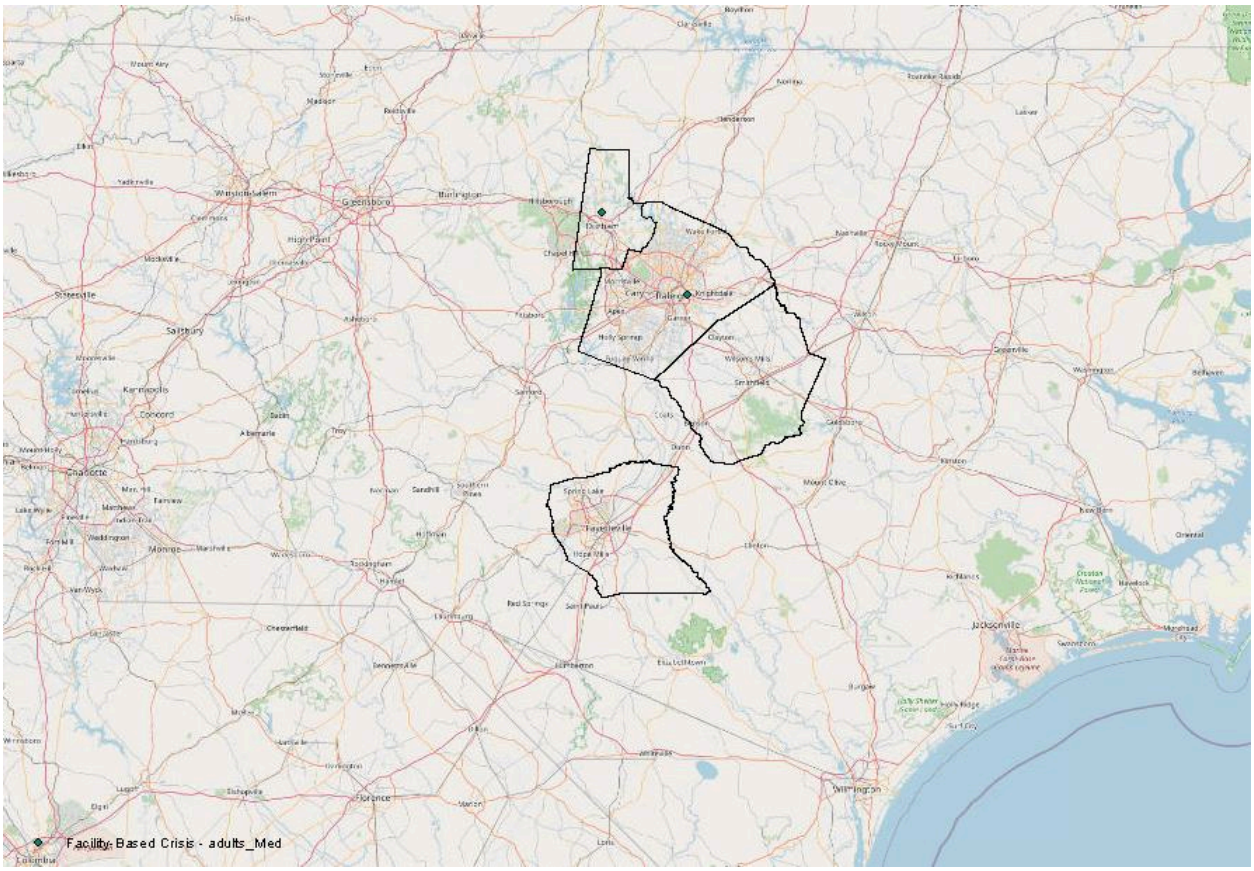
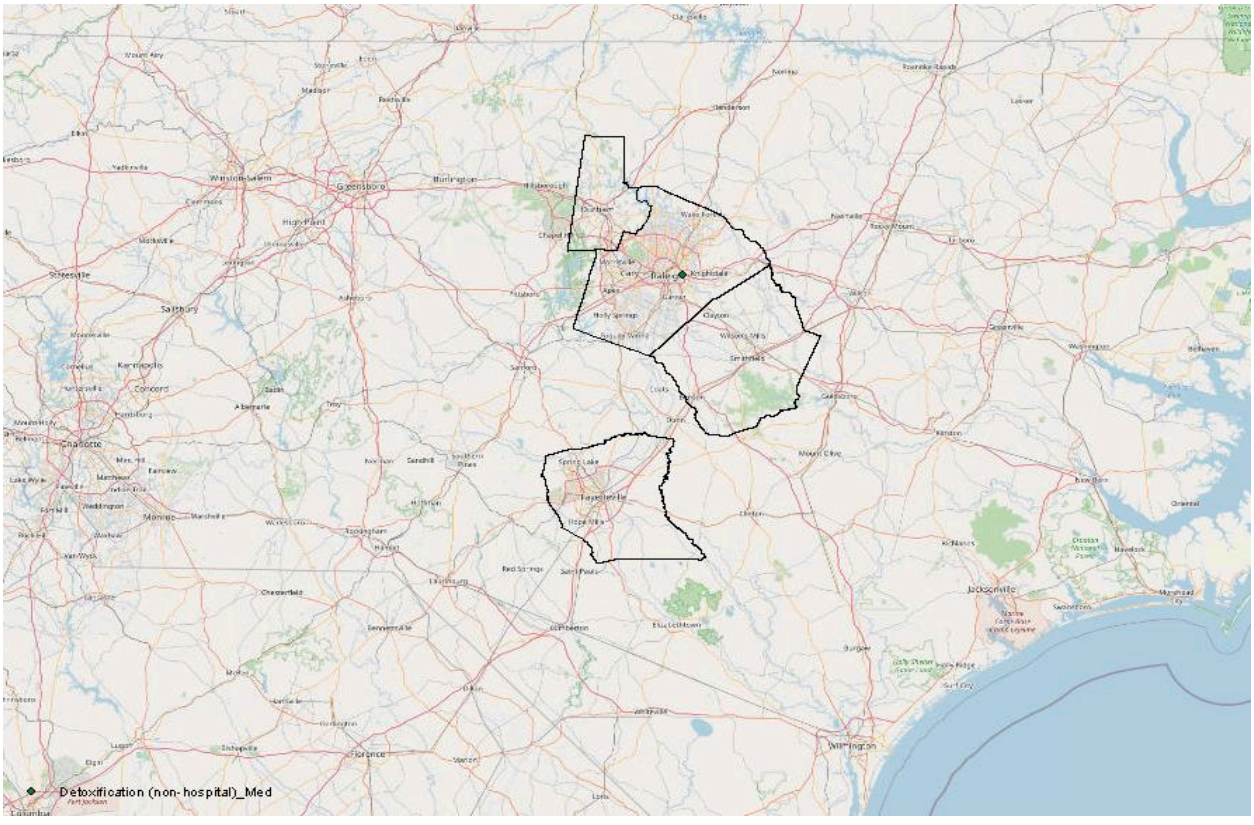
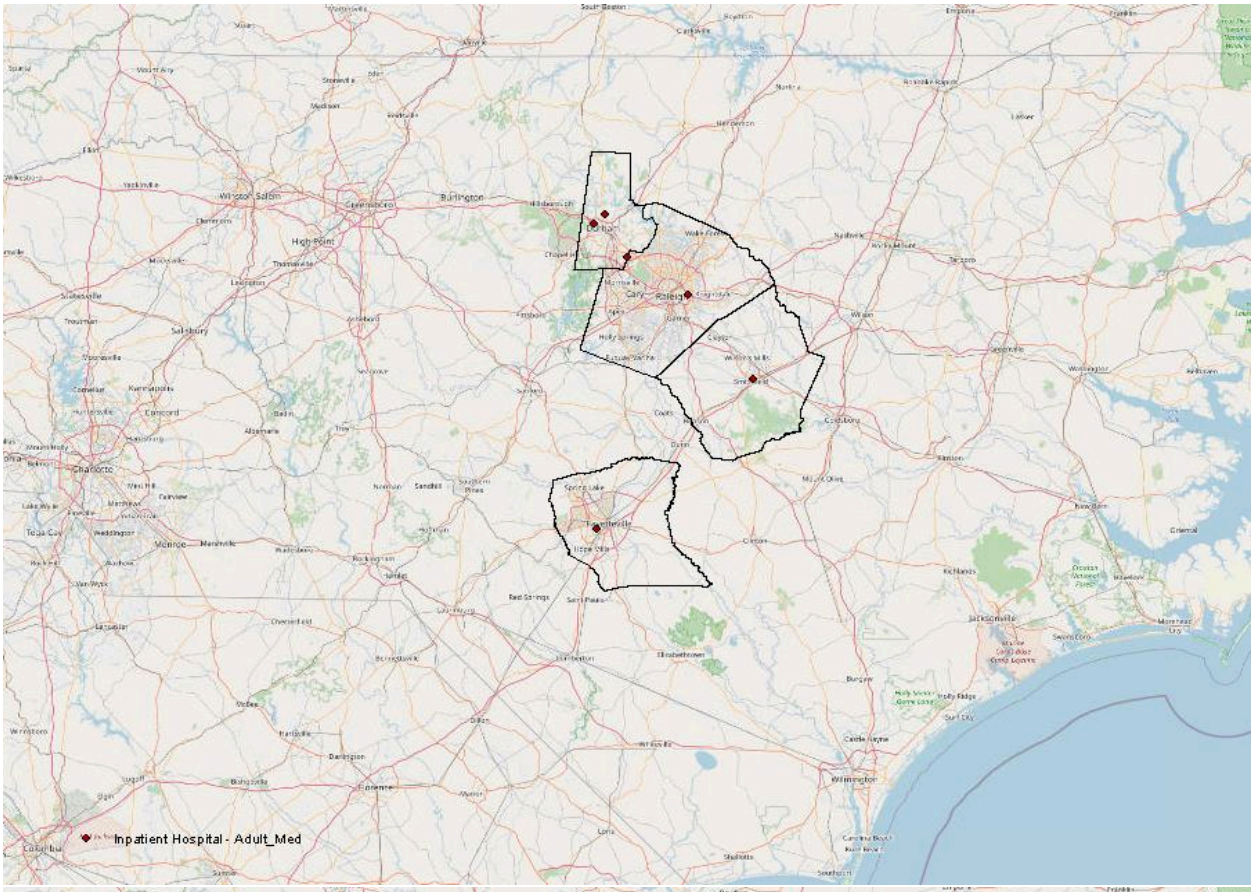

Facility-Based Crisis - adults_Med


Detoxification (non-hospital)_Med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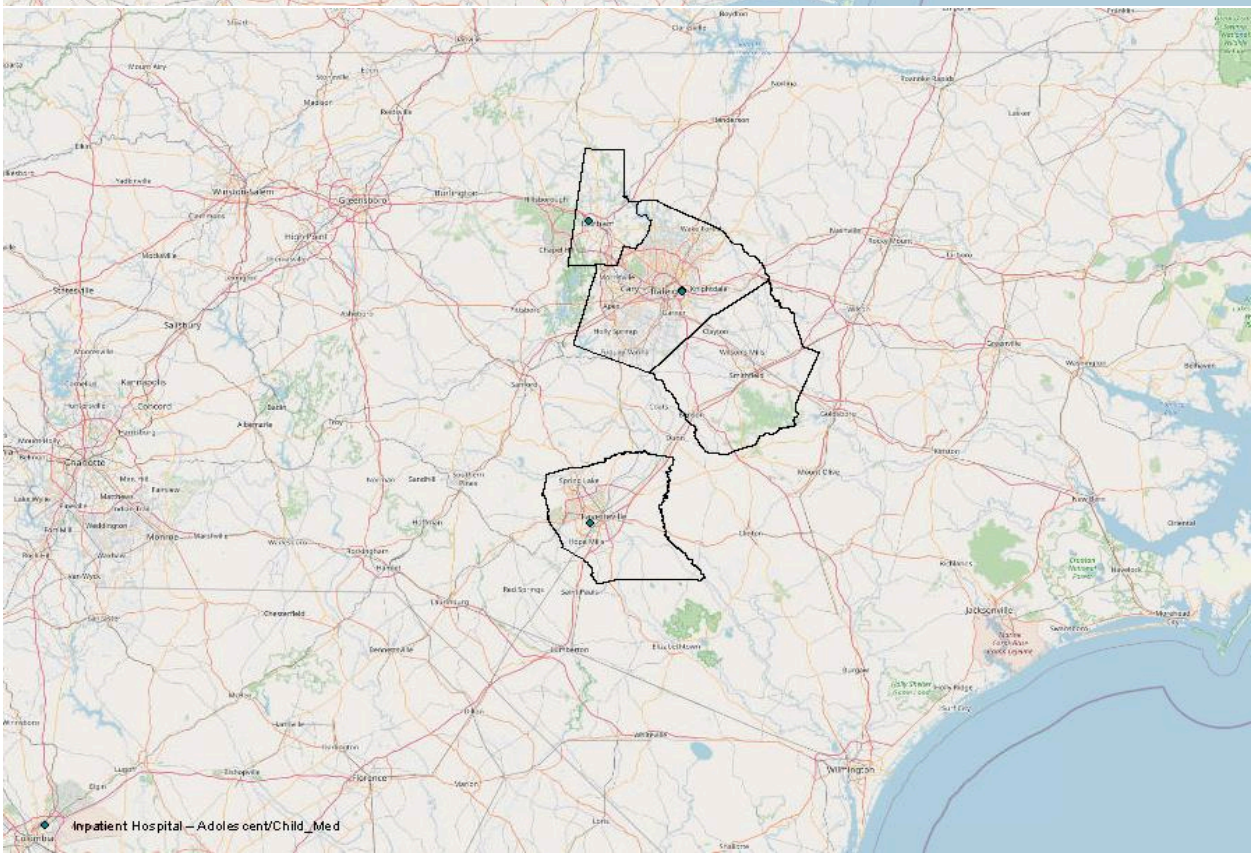
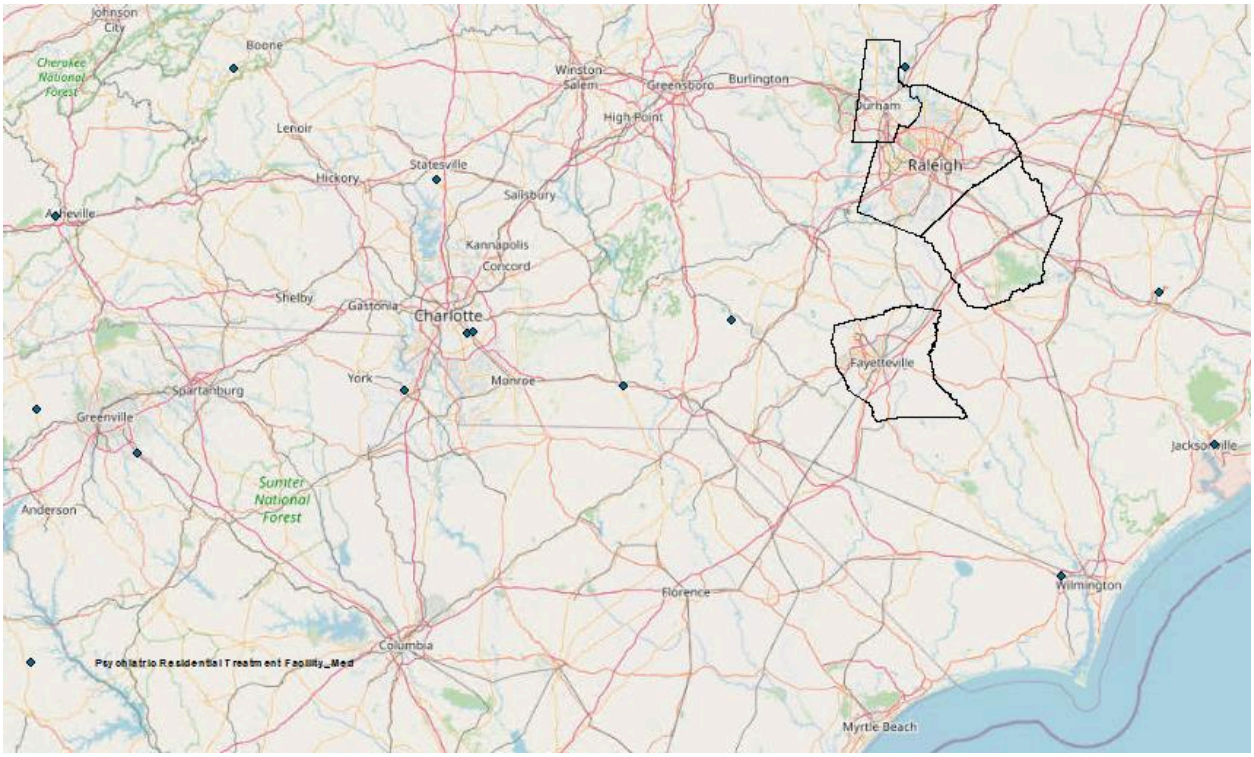

Inpatient Hospital – Adolescent/Child_Med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Winston Salem
Greensboro
Burlington
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High Point
Lenoir
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Statesville
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Kannapolis
Concord
Shelby
Gastonia
Charlotte
Fayetteville
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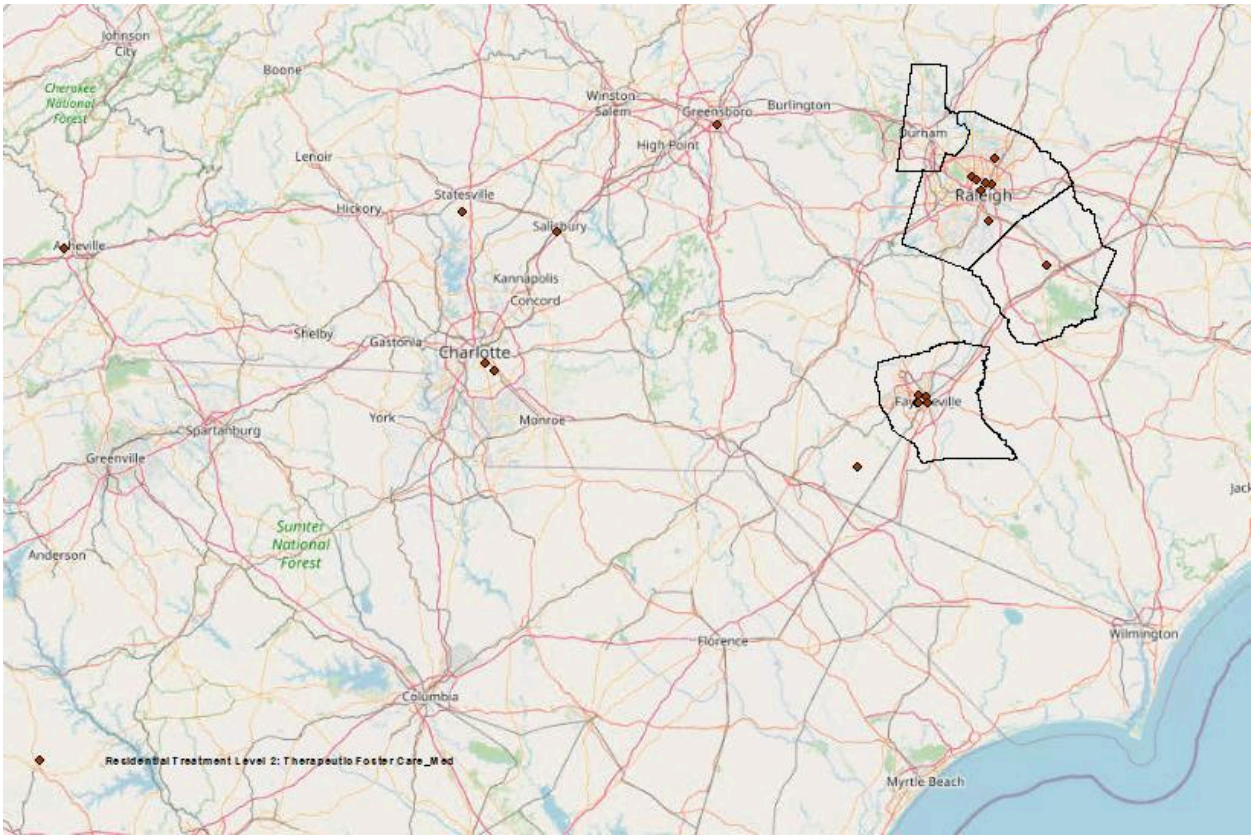
Columbia
Psychiatric Residential Treatment Facility_Med
Myrtle Beach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Kannapolis
Concord
Shelby
Gastonia
Charlotte
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Monroe
Spartanburg
Greenville
Sumter National Forest
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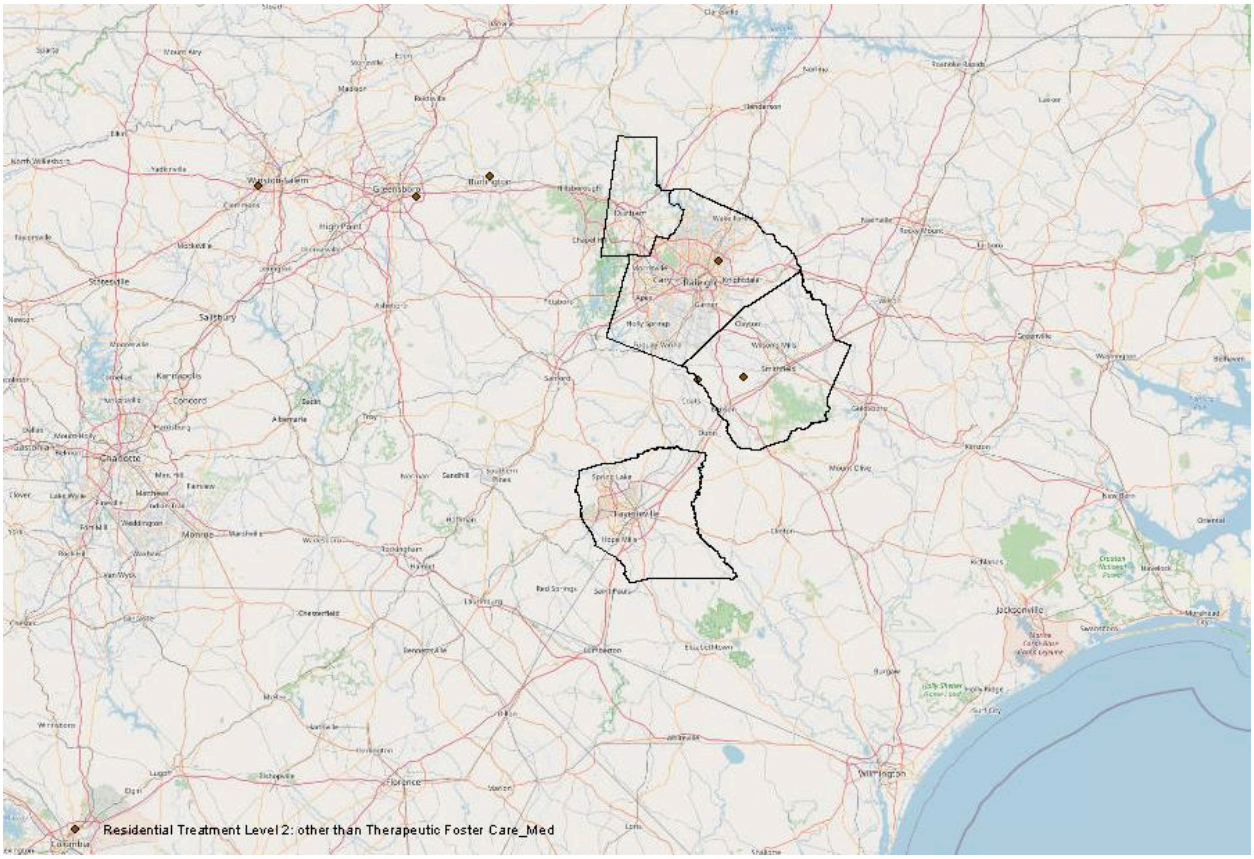
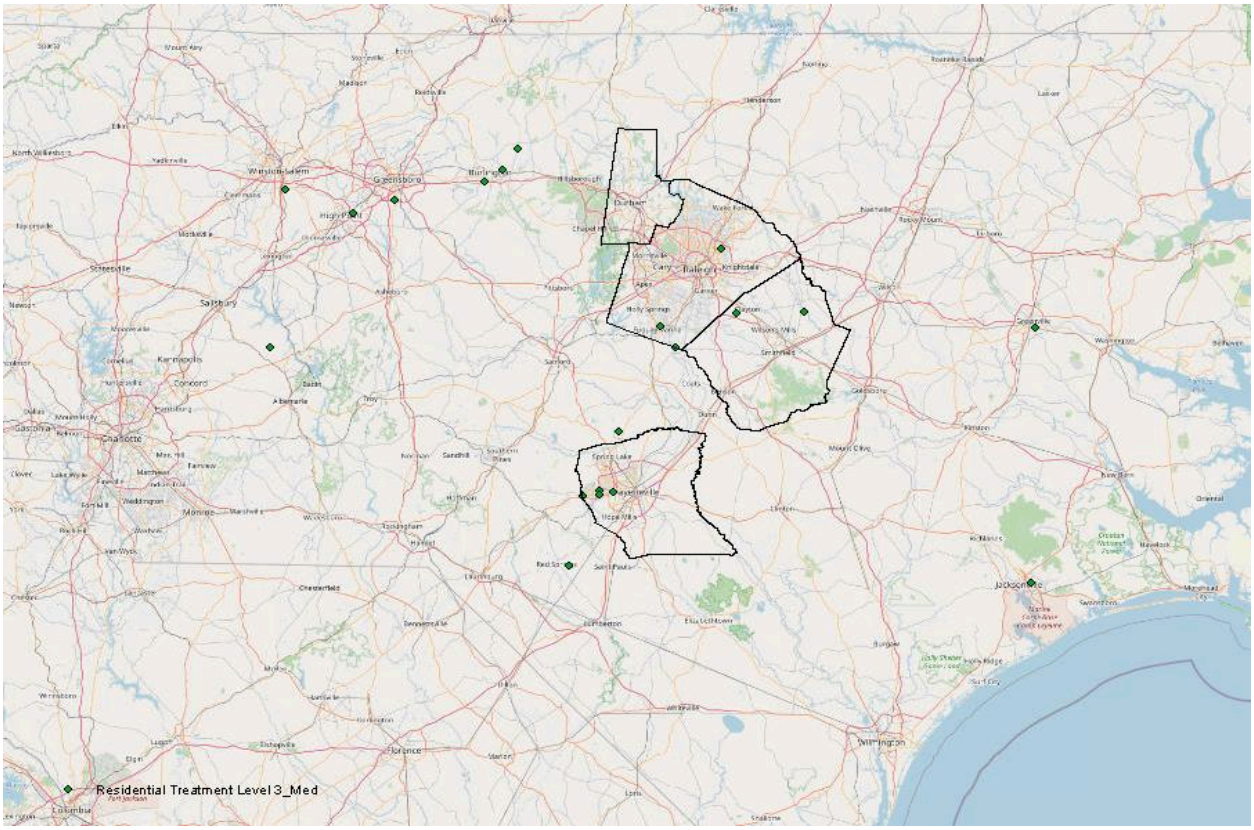
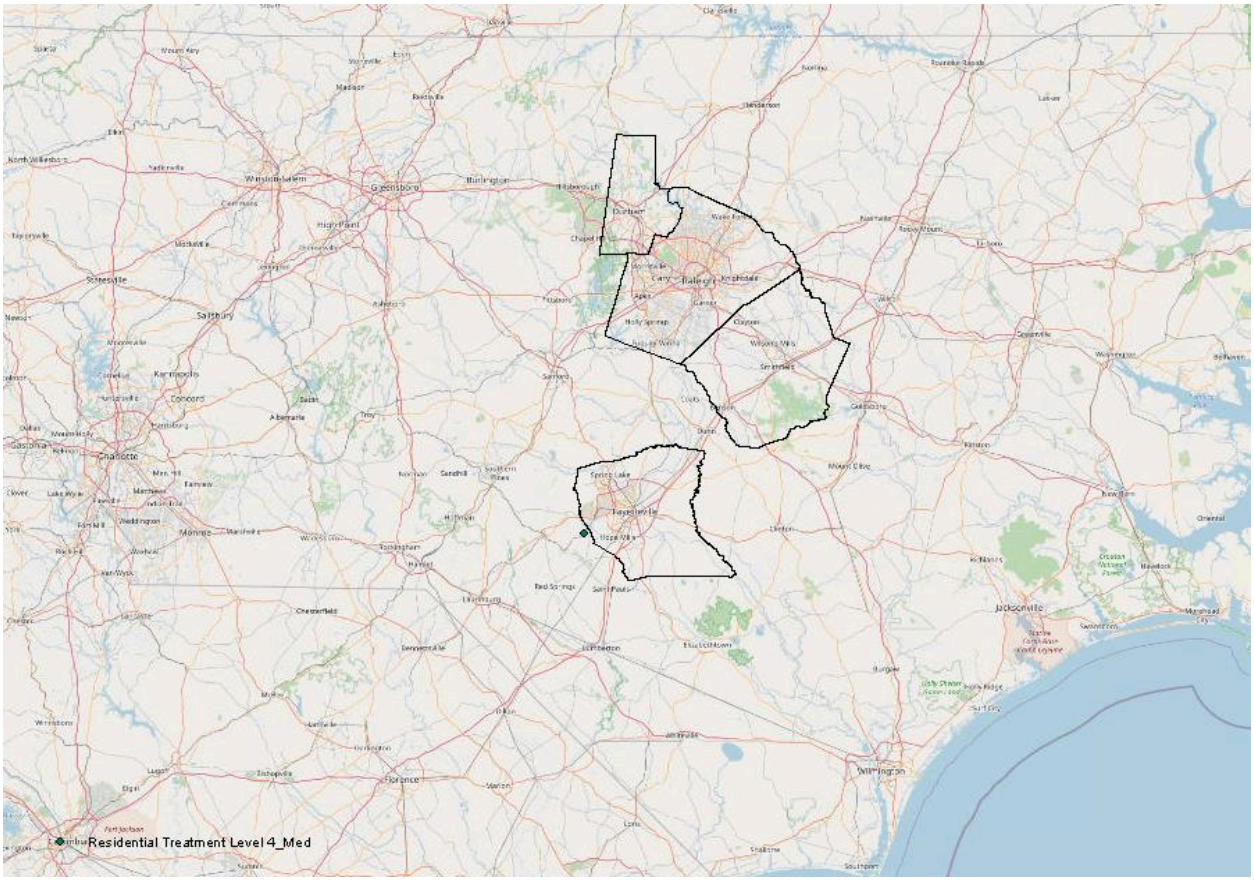
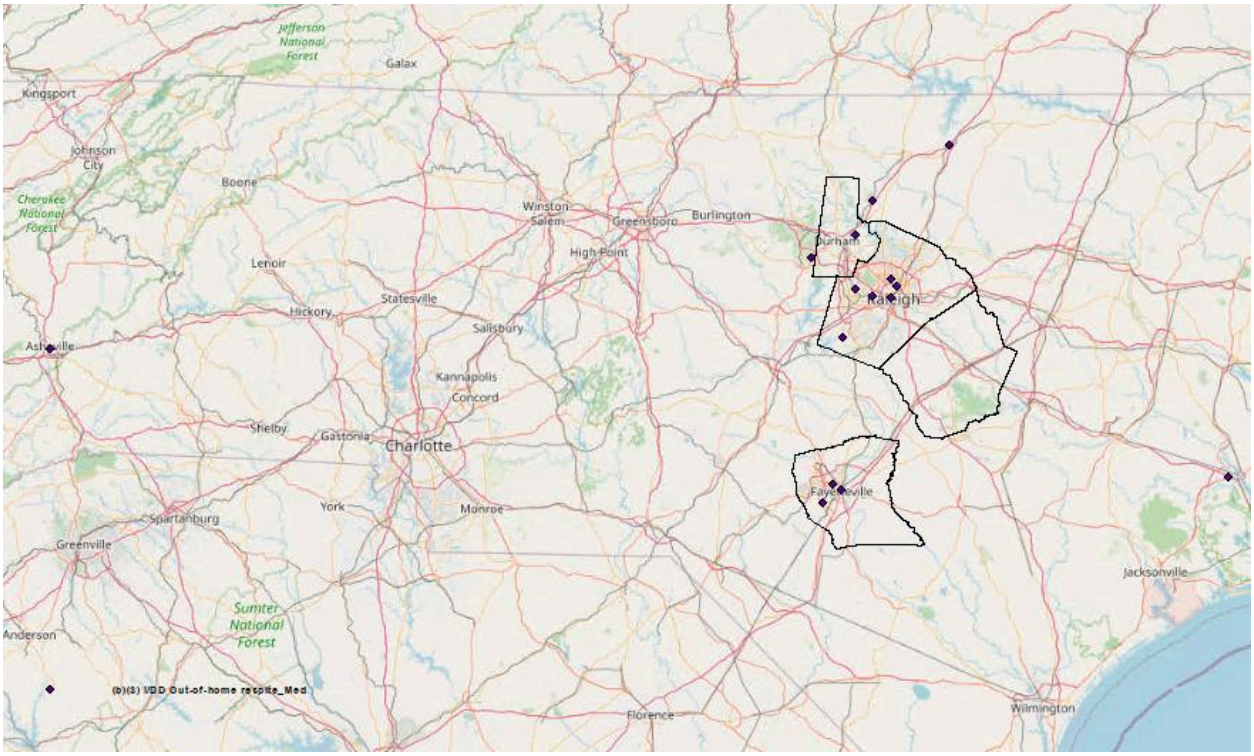
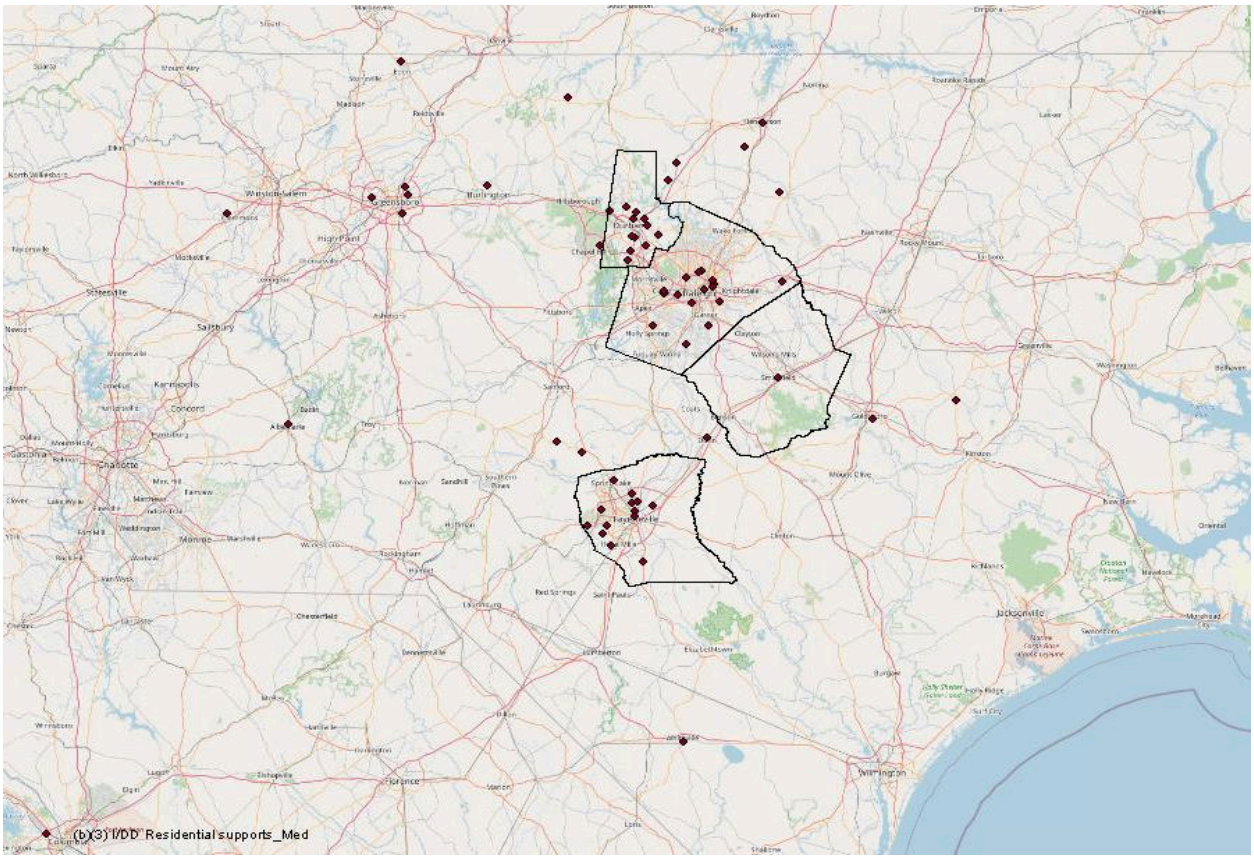
Florence
Wilmington
Columbia
Residential Treatment Level 2: Therapeutic Foster Care_Med
Myrtle Beach

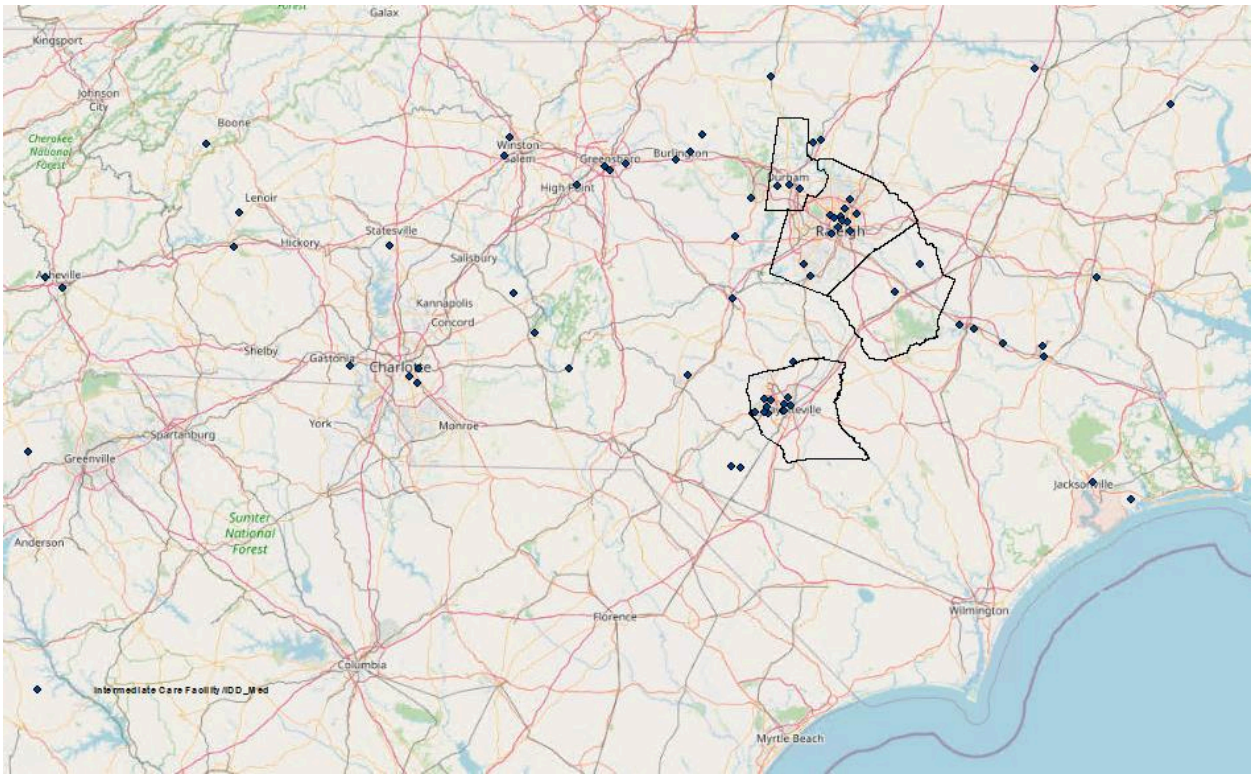

Residential Treatment Level 2: other than Therapeutic Foster Care_Med

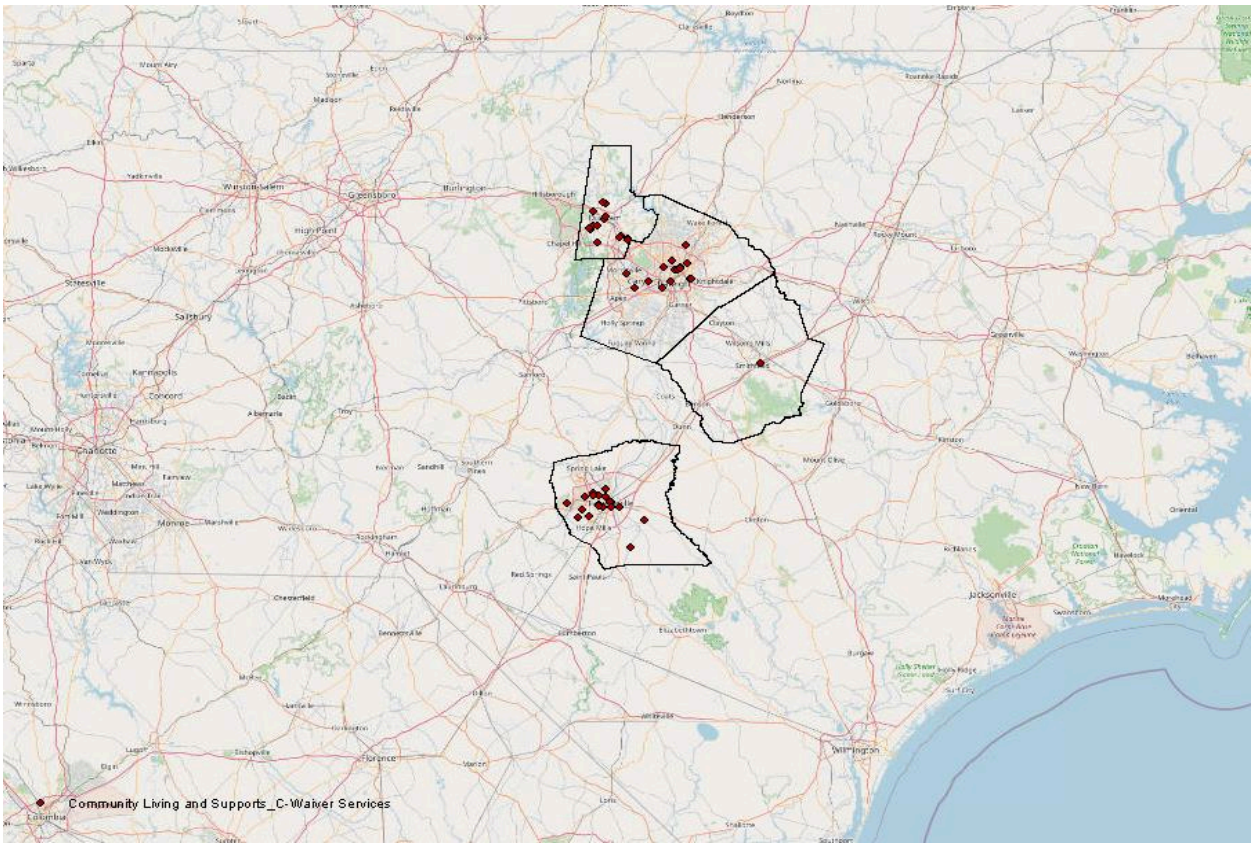

Residential Treatment Level 3_Med

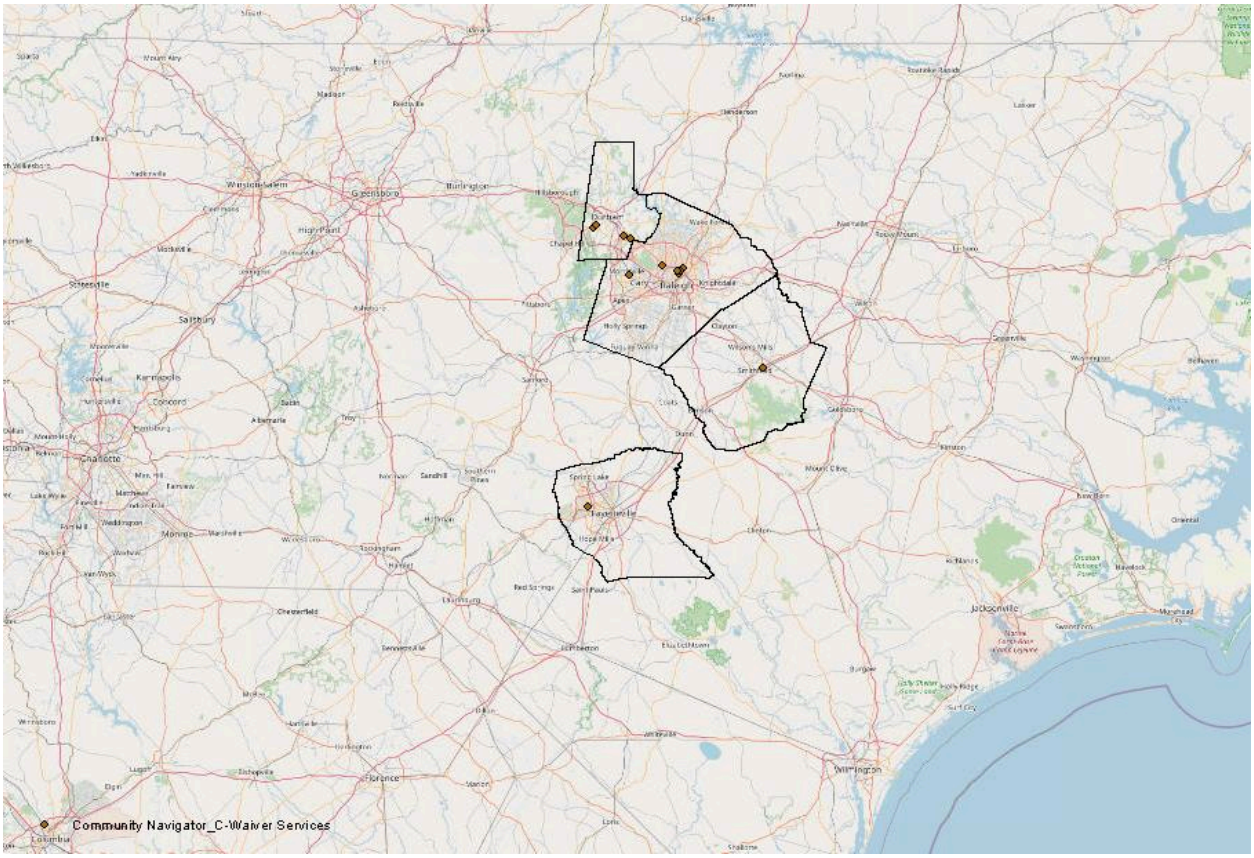

Residential Treatment Level 4_Med

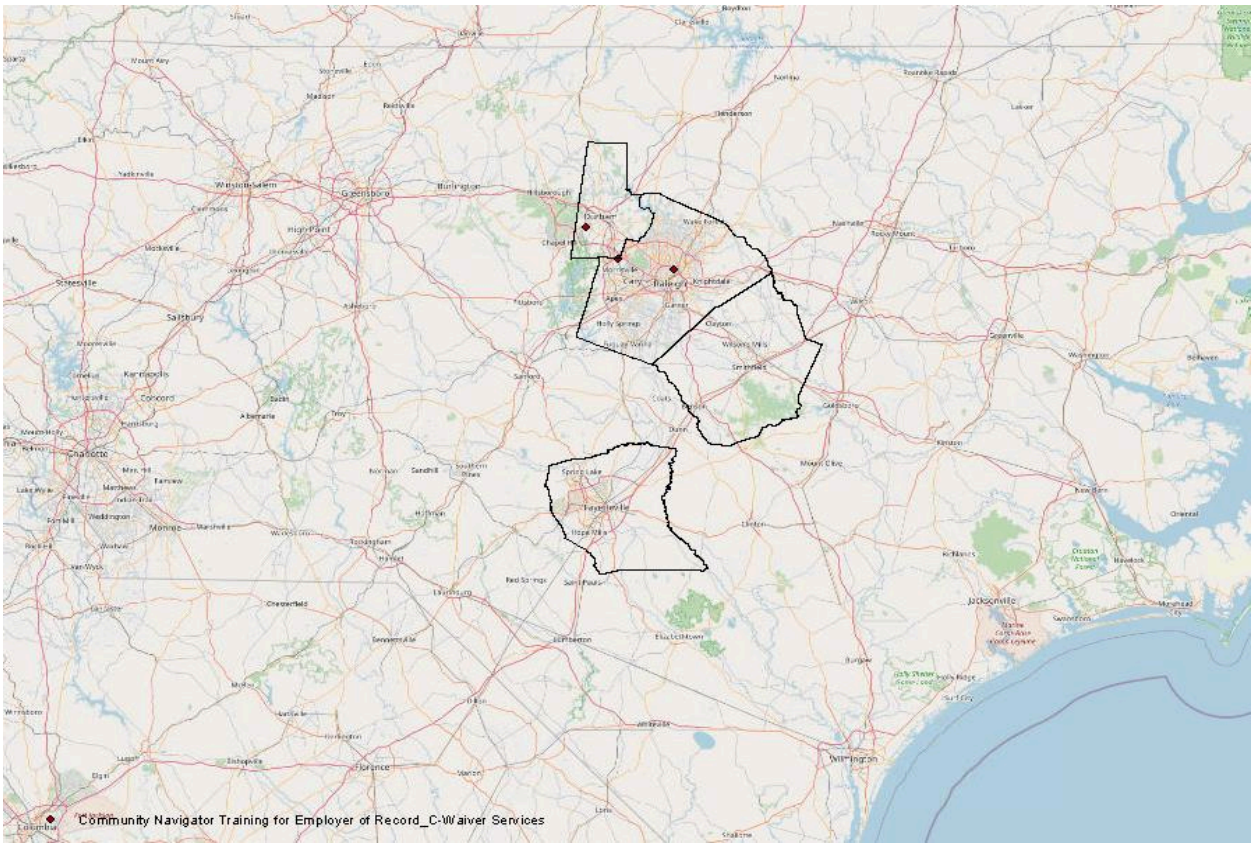

Jefferson National Forest
Galax
Kingsport
Johnson City
Boone
Cherokee National Forest
Winston-Salem
Greensboro
Burlington
High Point
Durham
Raleigh
Lenoir
Hickory
Statesville
Salisbury
Asheville
Kannapolis
Concord
Shelby
Gastonia
Charlotte
York
Monroe
Spartanburg
Greenville
Sumter National Forest
Anderson
(b)(3) IDD Out-of-home respite_Med
Florence
Jacksonville
Wilmington

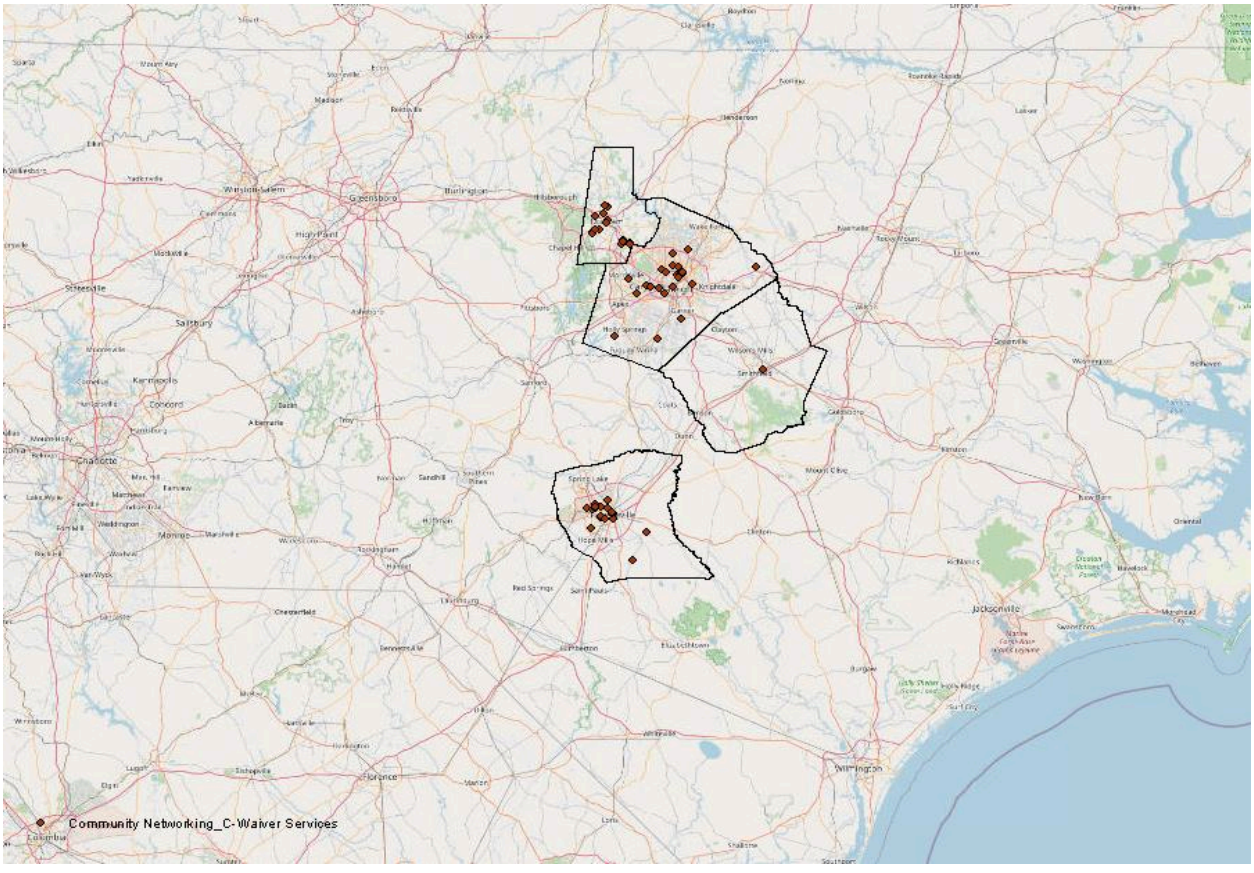

(b)(3) I/DD Residential supports_Med

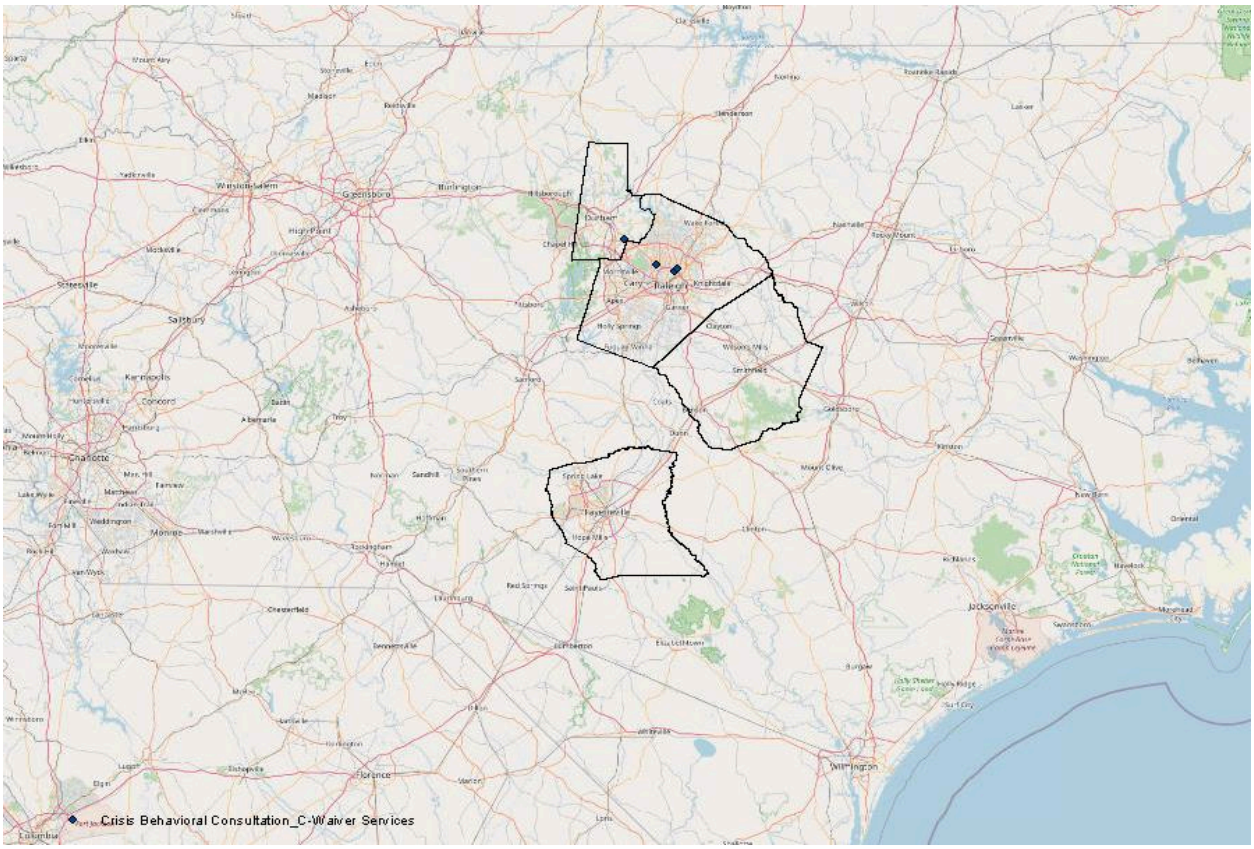

Intermediate Care Facility /IDD_Med

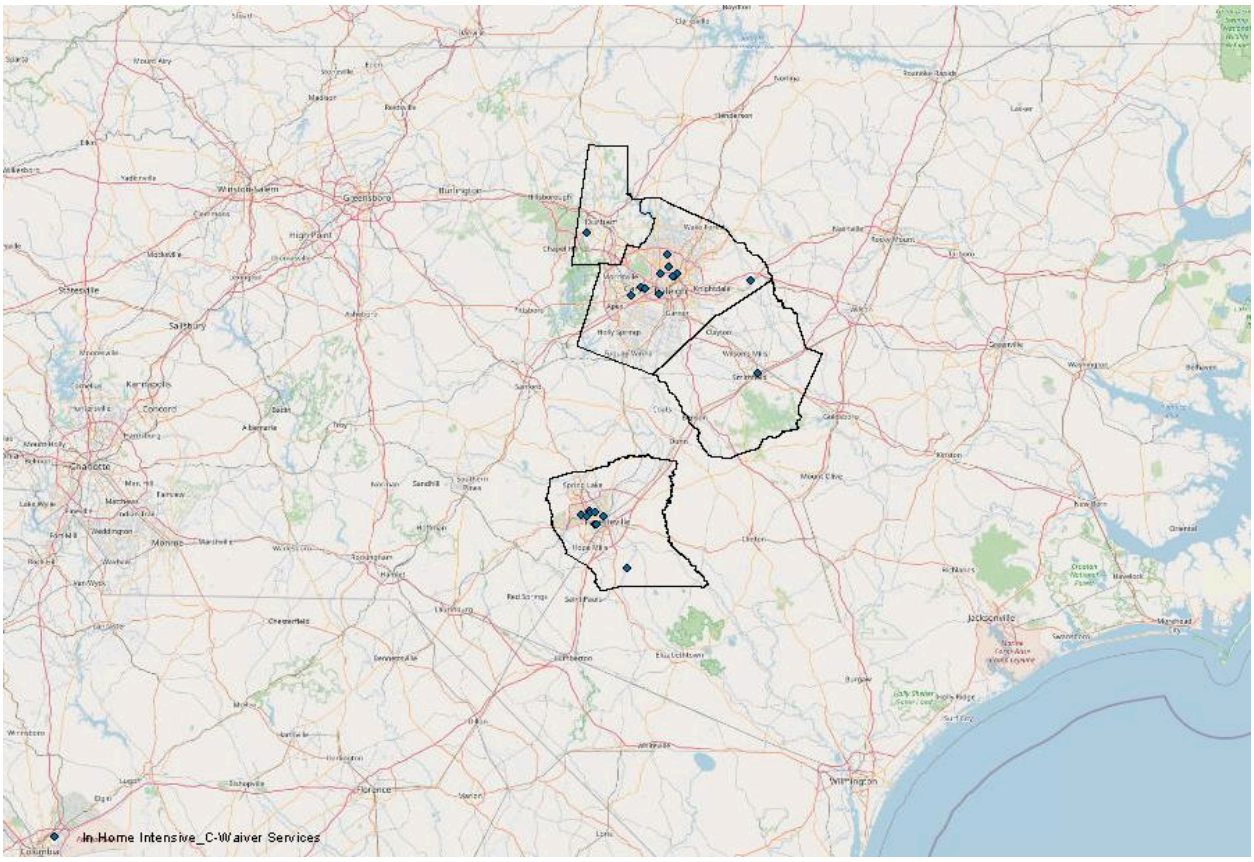

Community Living and Supports_C-Waiver Services

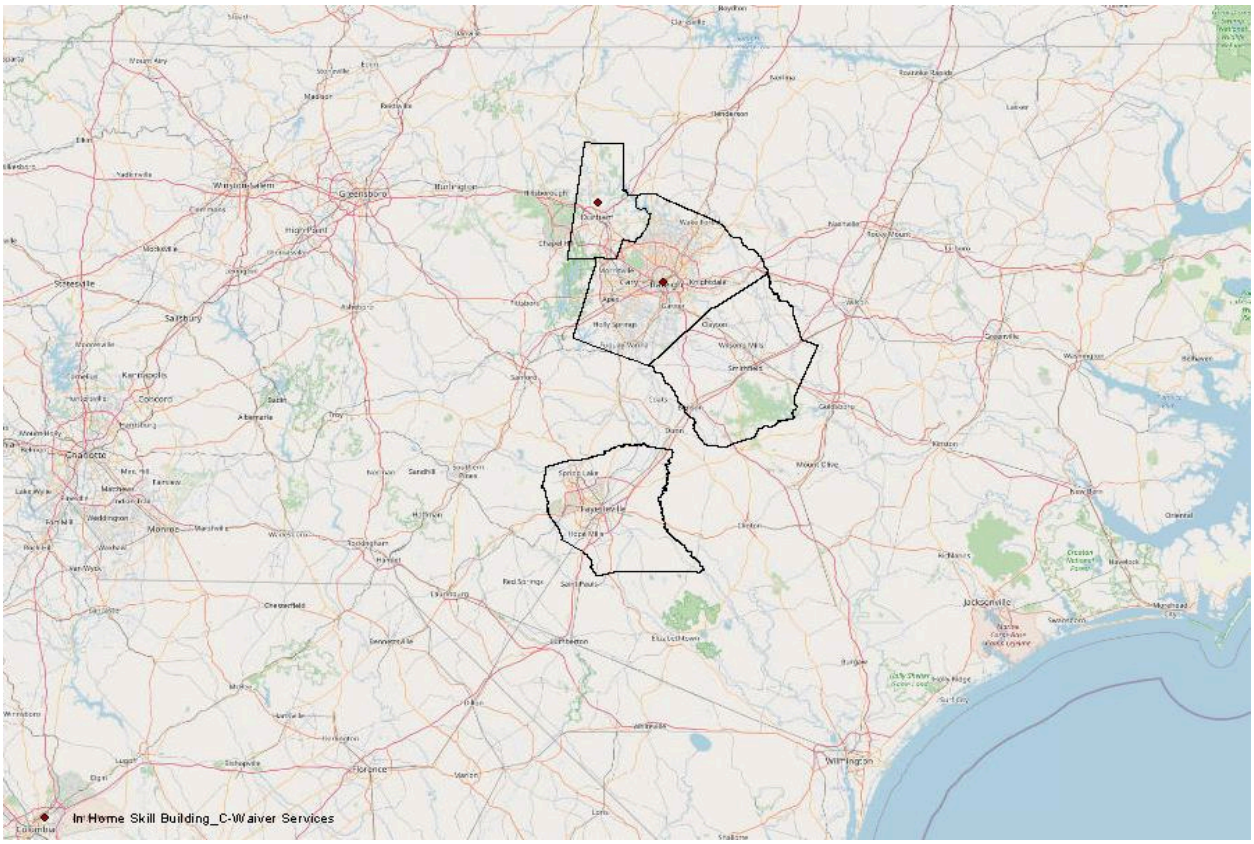

Community Navigator_C-Waiver Services

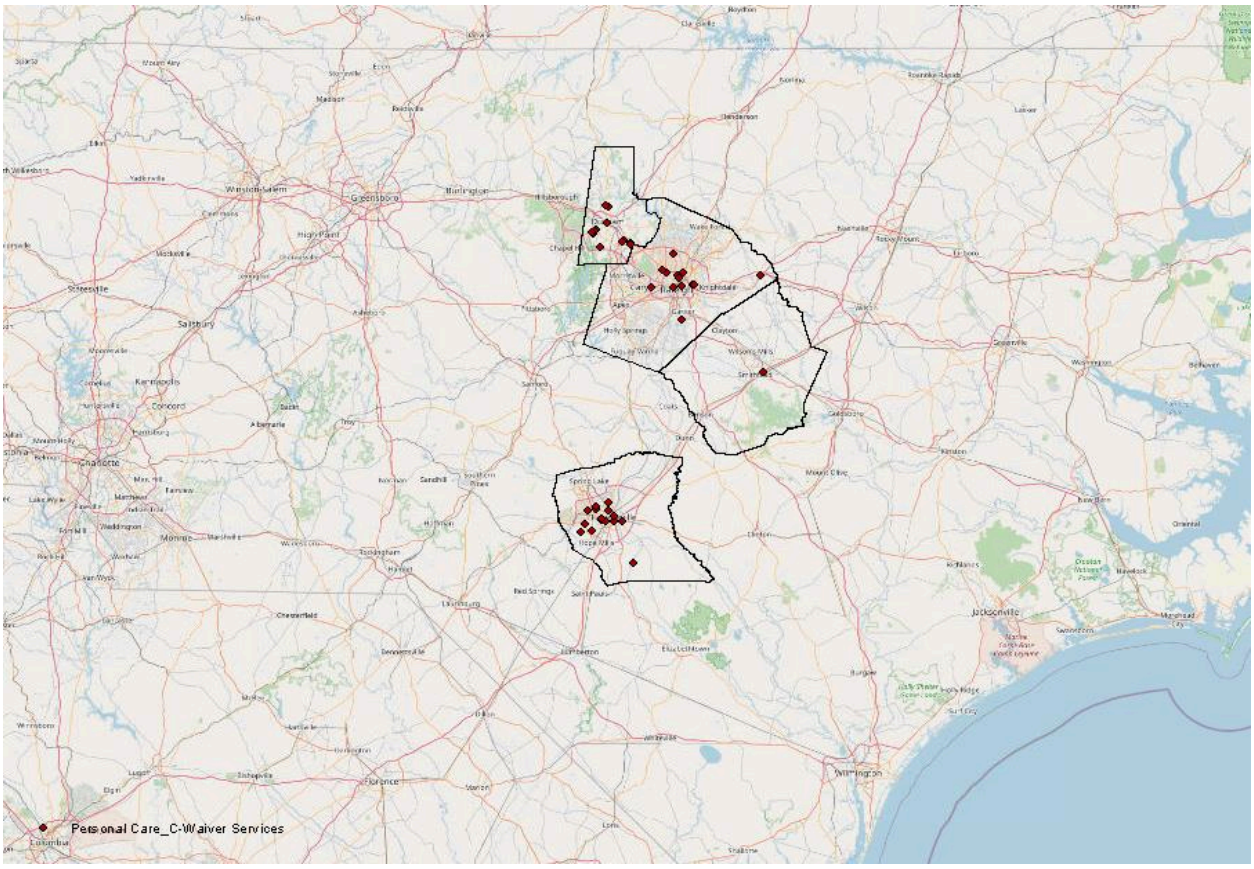

Community Navigator Training for Employer of Record_C-Waiver Services

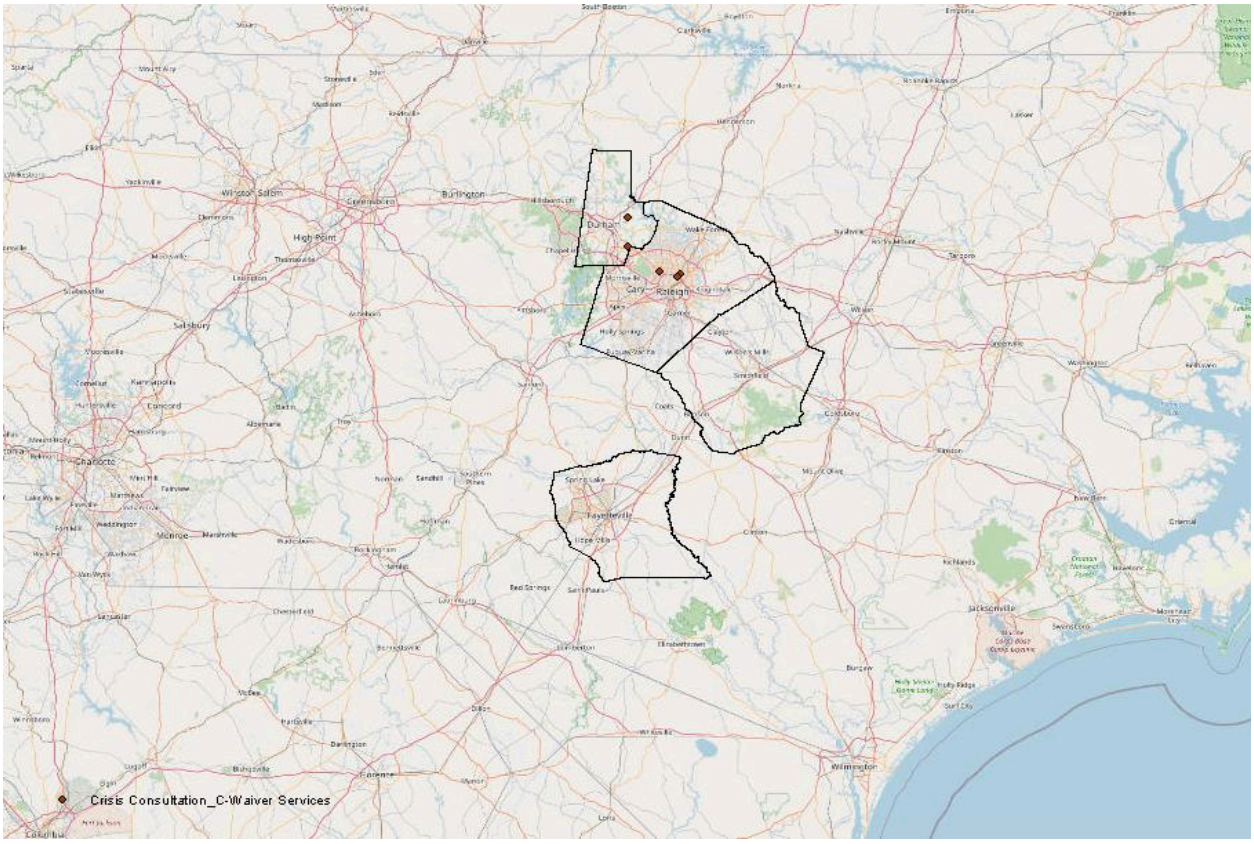

Community Networking_C-Waiver Services

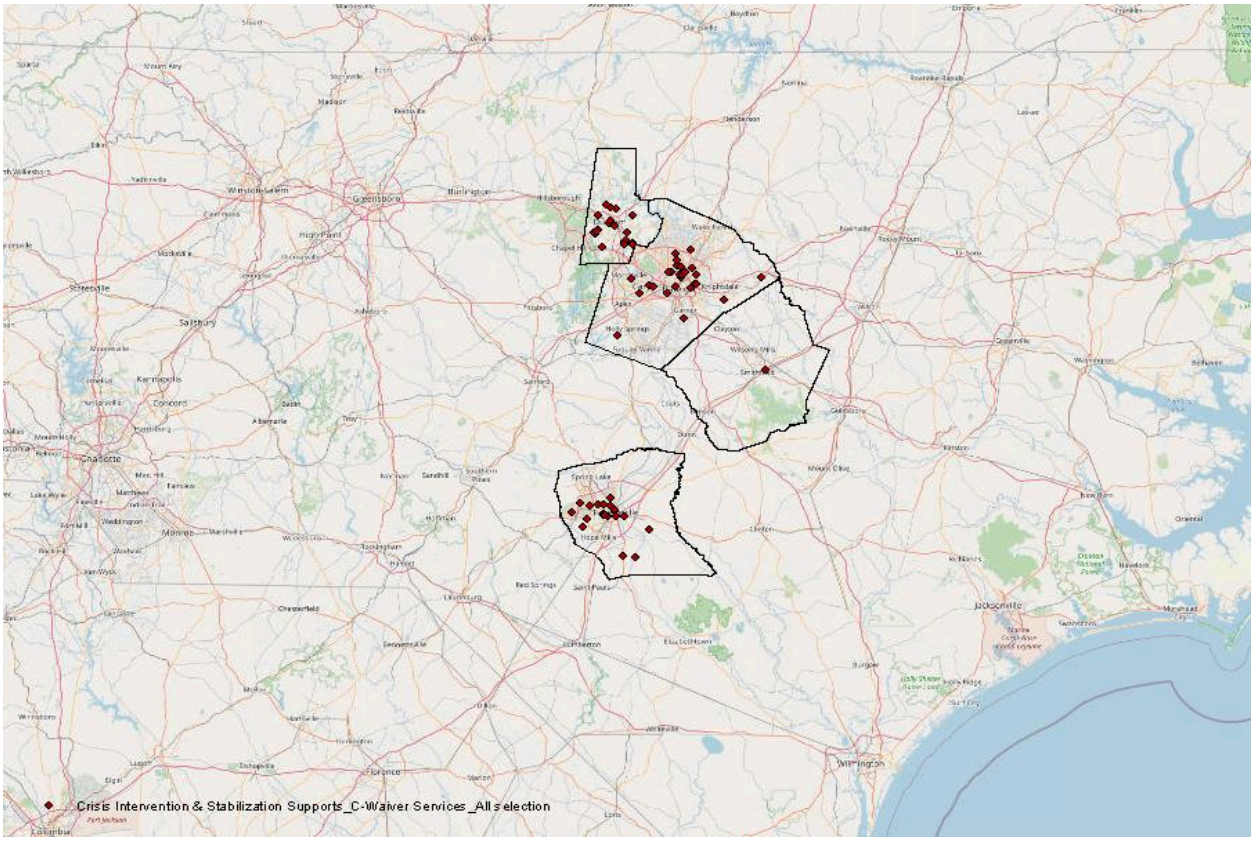

Crisis Behavioral Consultation_C-Waiver Services

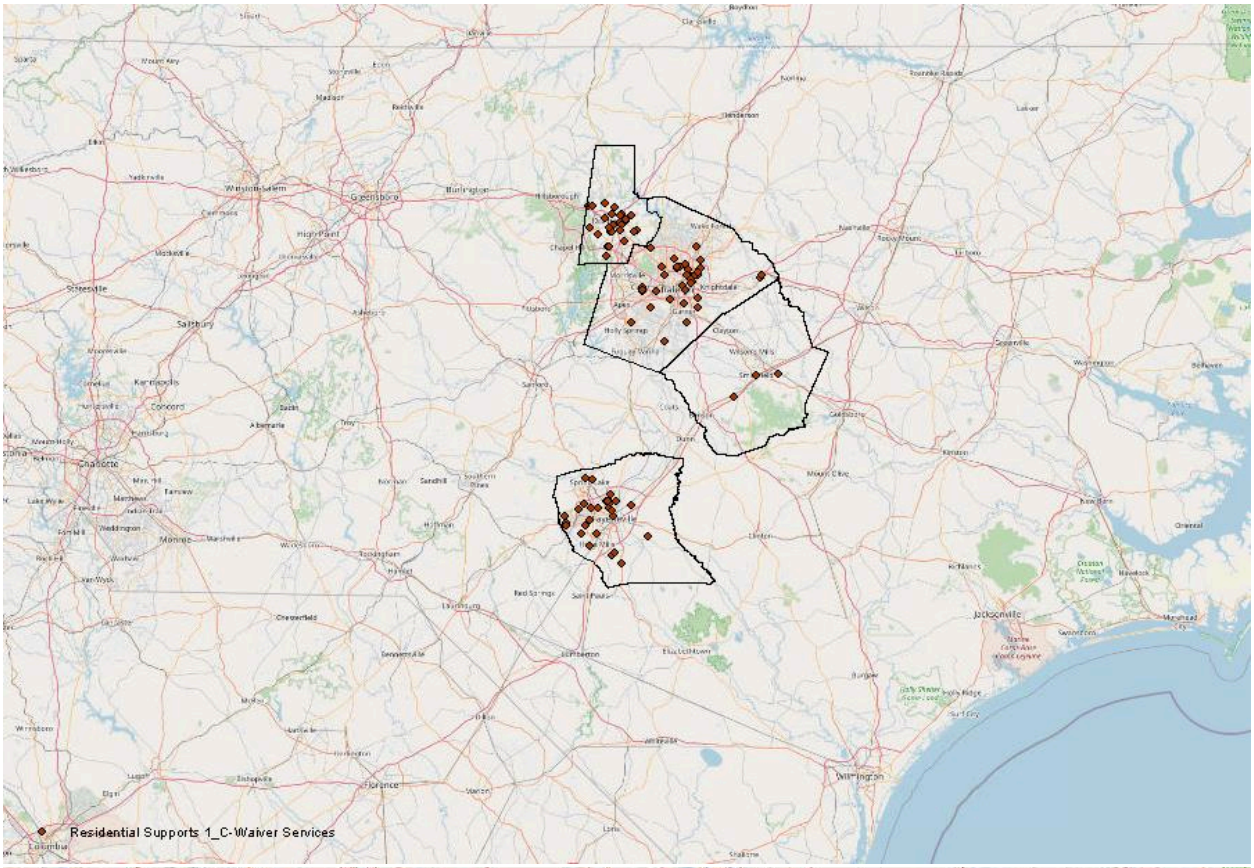

In Home Intensive_C-Waiver Services

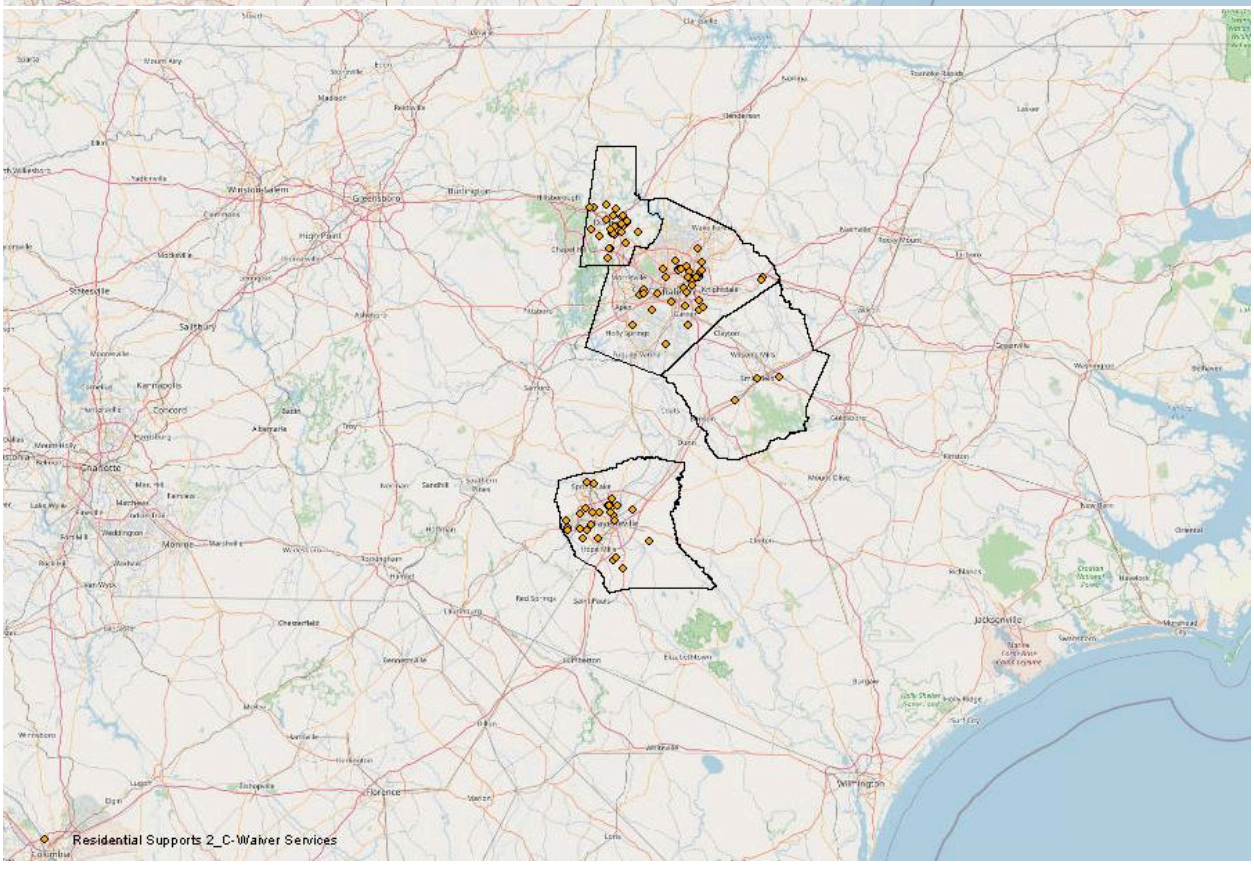

In Home Skill Building_C-Waiver Services

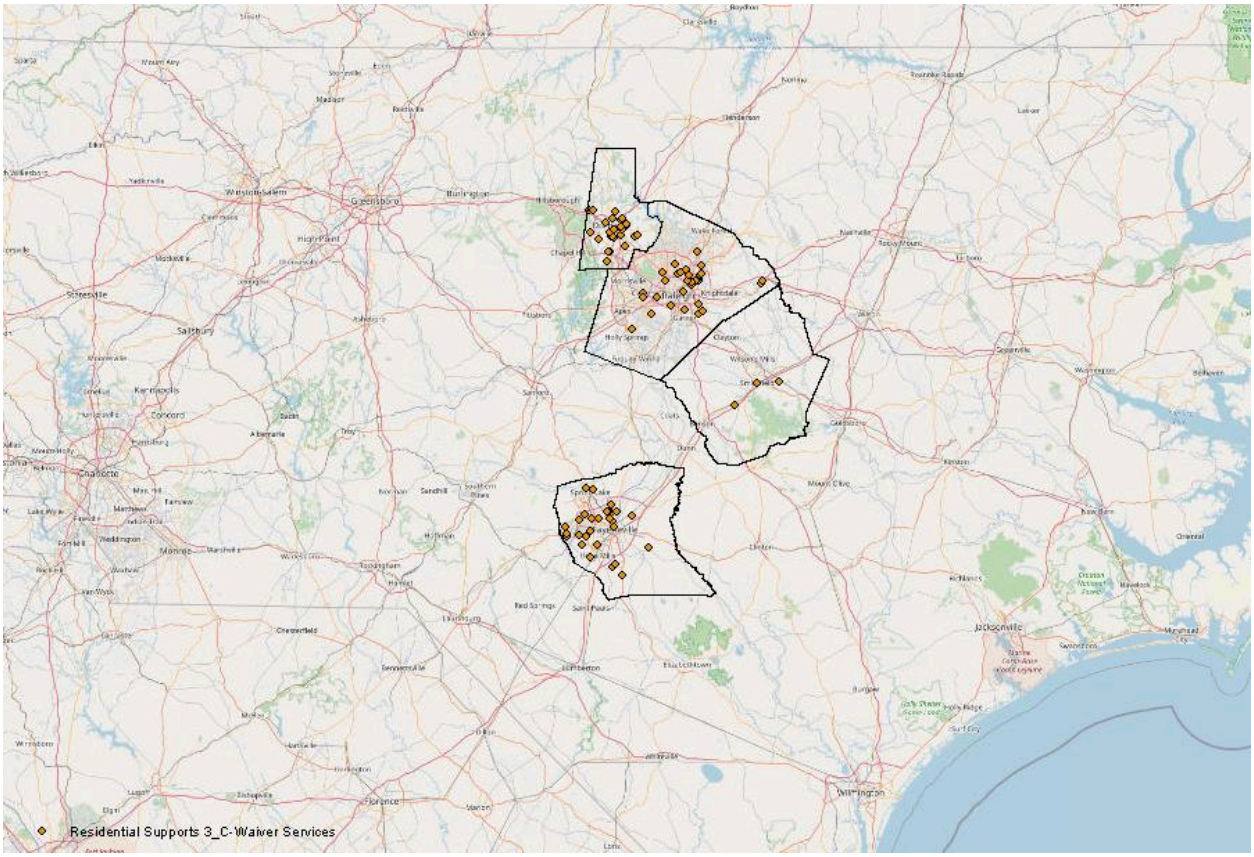

Personal Care_C-Waiver Services

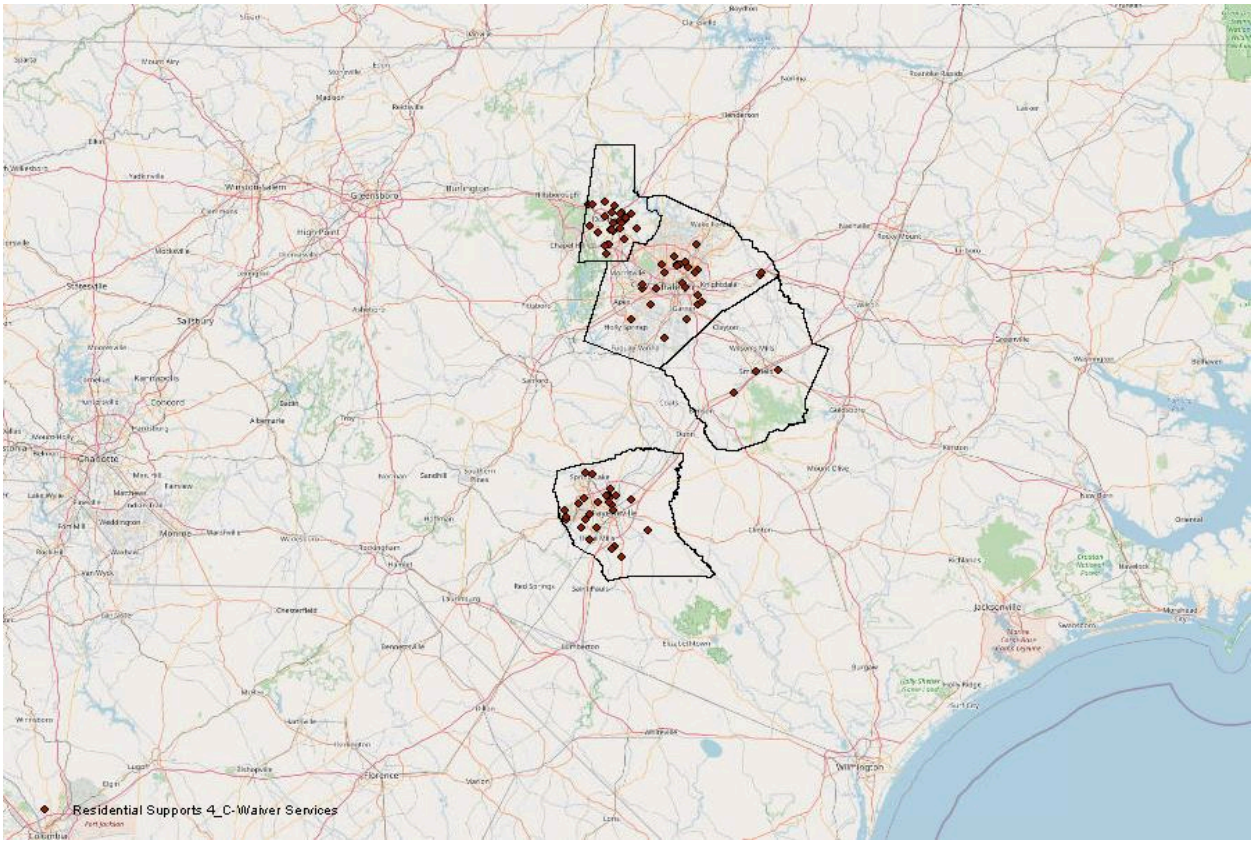

Crisis Consultation_C-Waiver Services

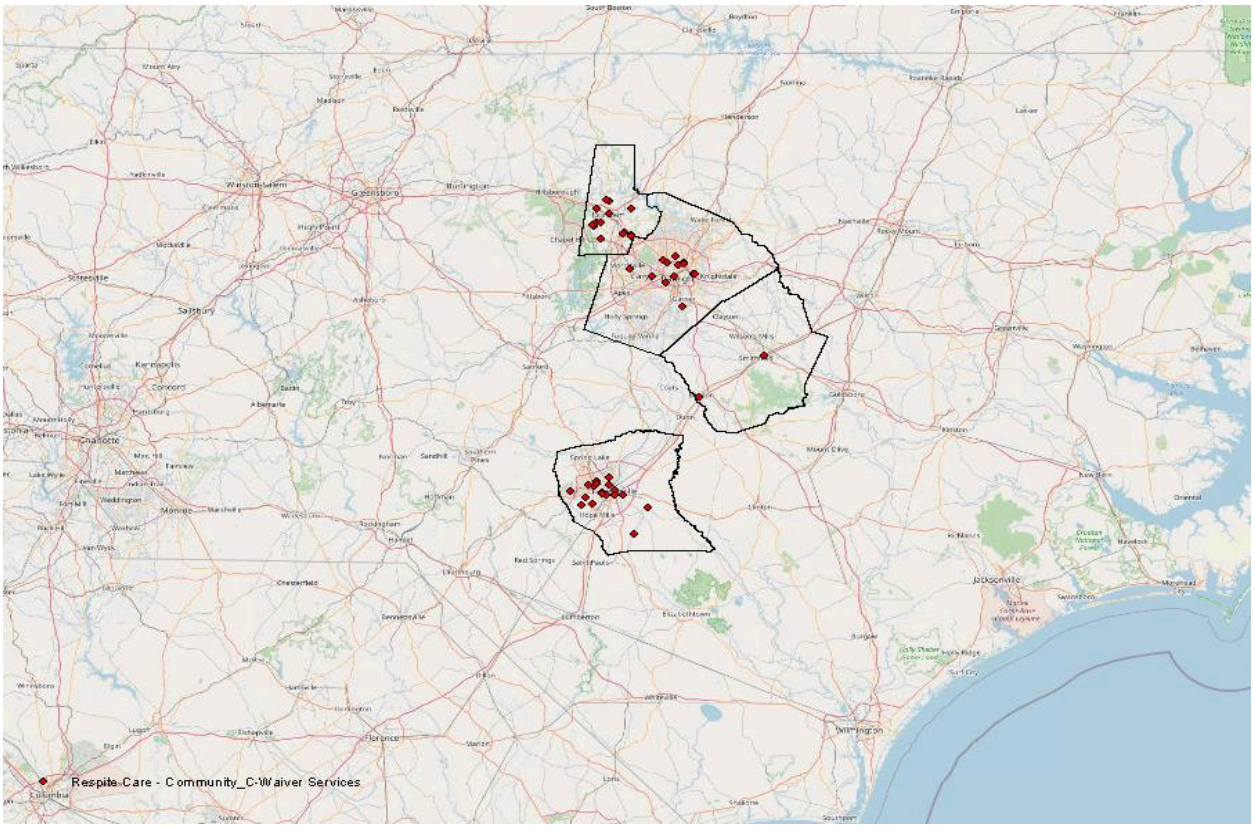

Crisis Intervention & Stabilization Supports_C-Waiver Services_All selection

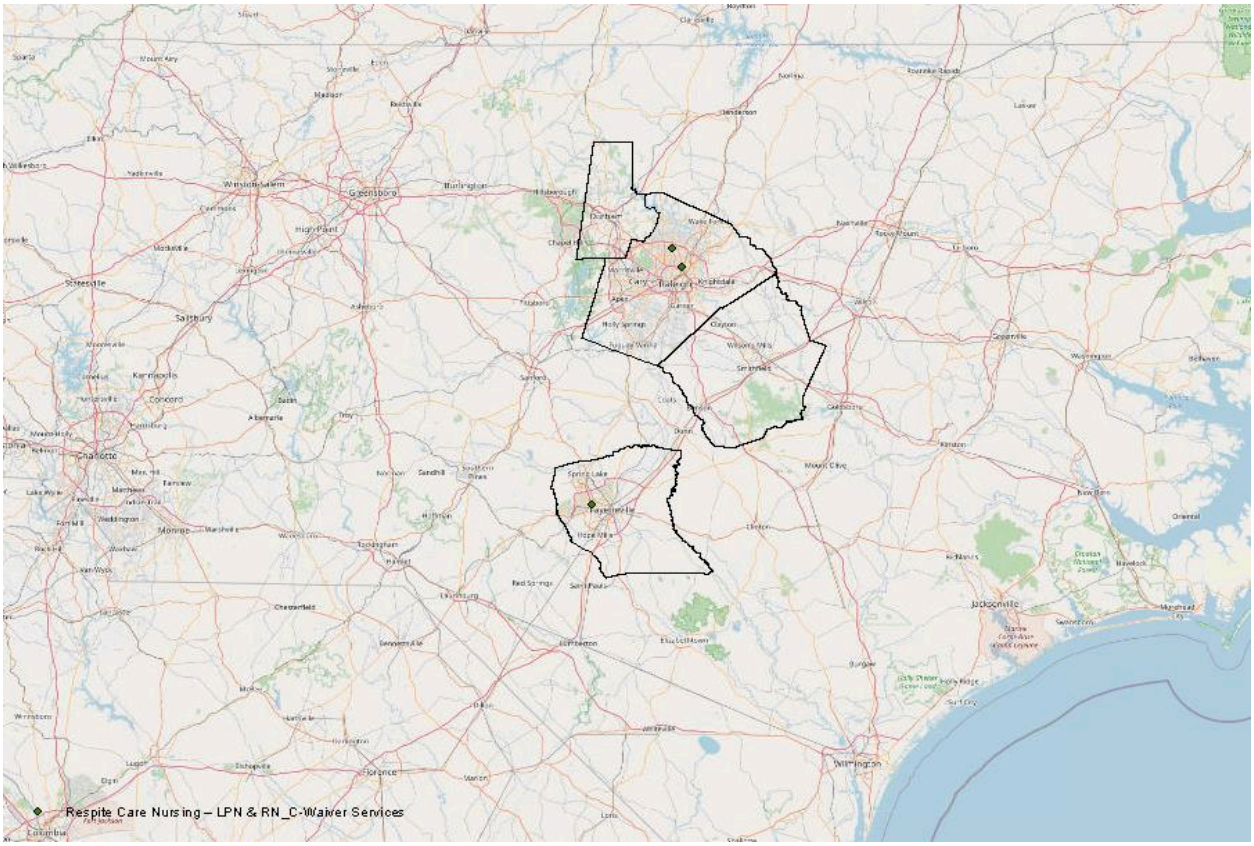

Residential Supports 1_C-Waiver Services

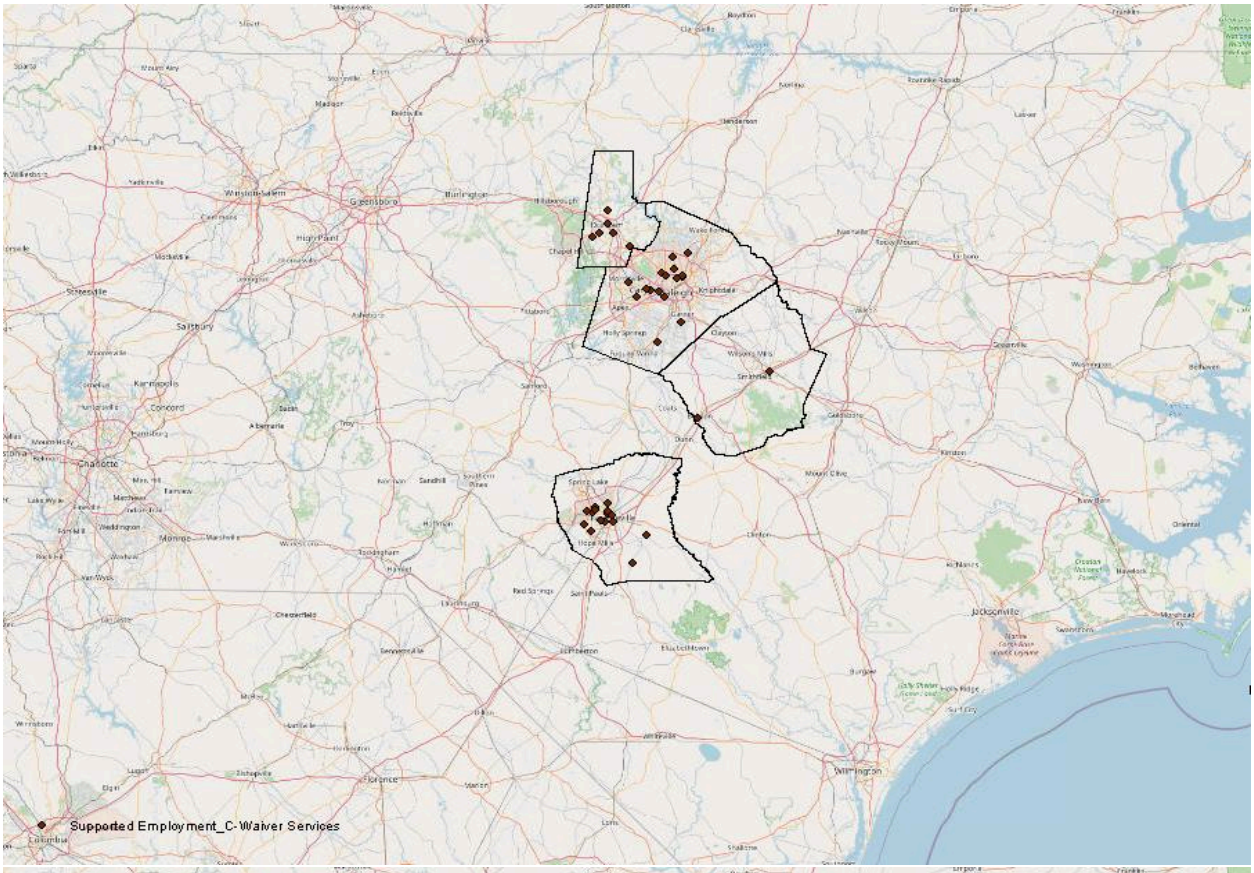

Residential Supports 2_C-Waiver Services

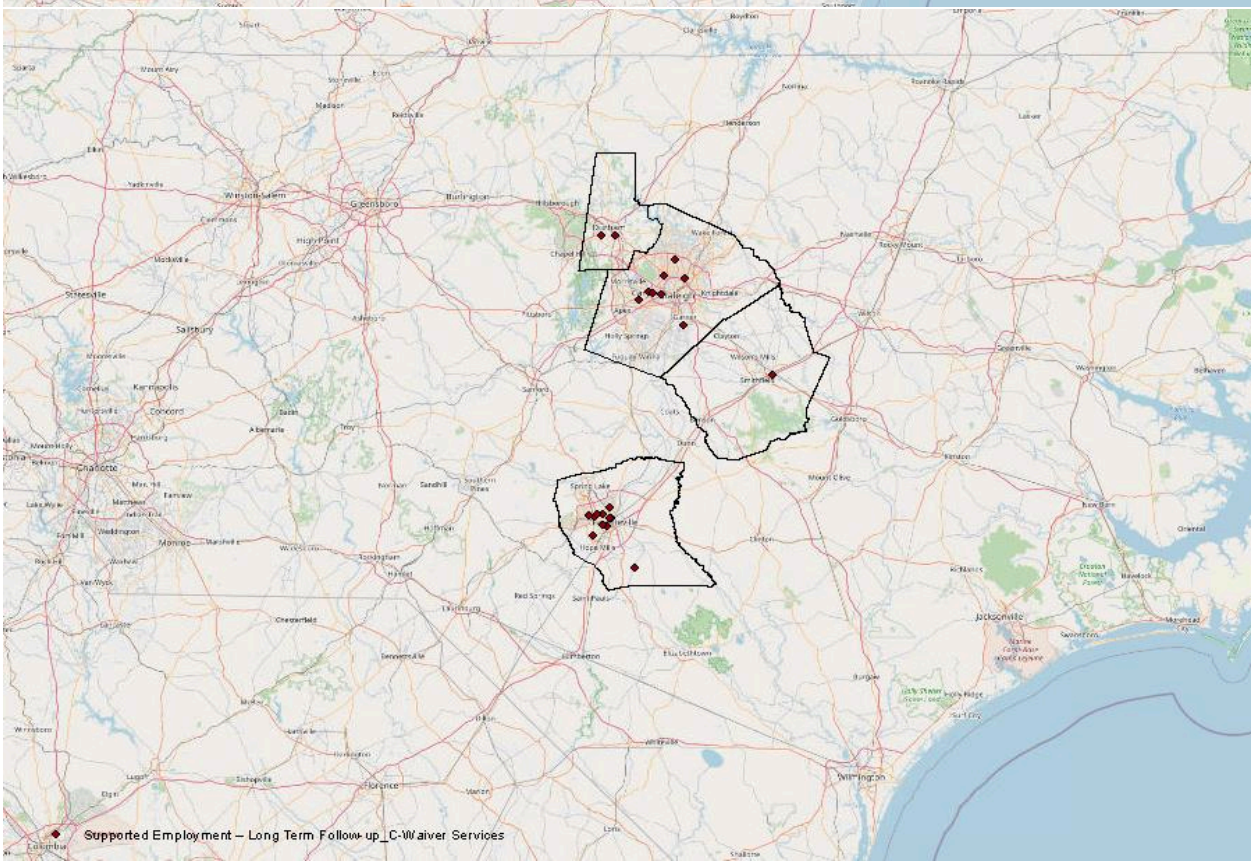

Residential Supports 3_C-Waiver Services

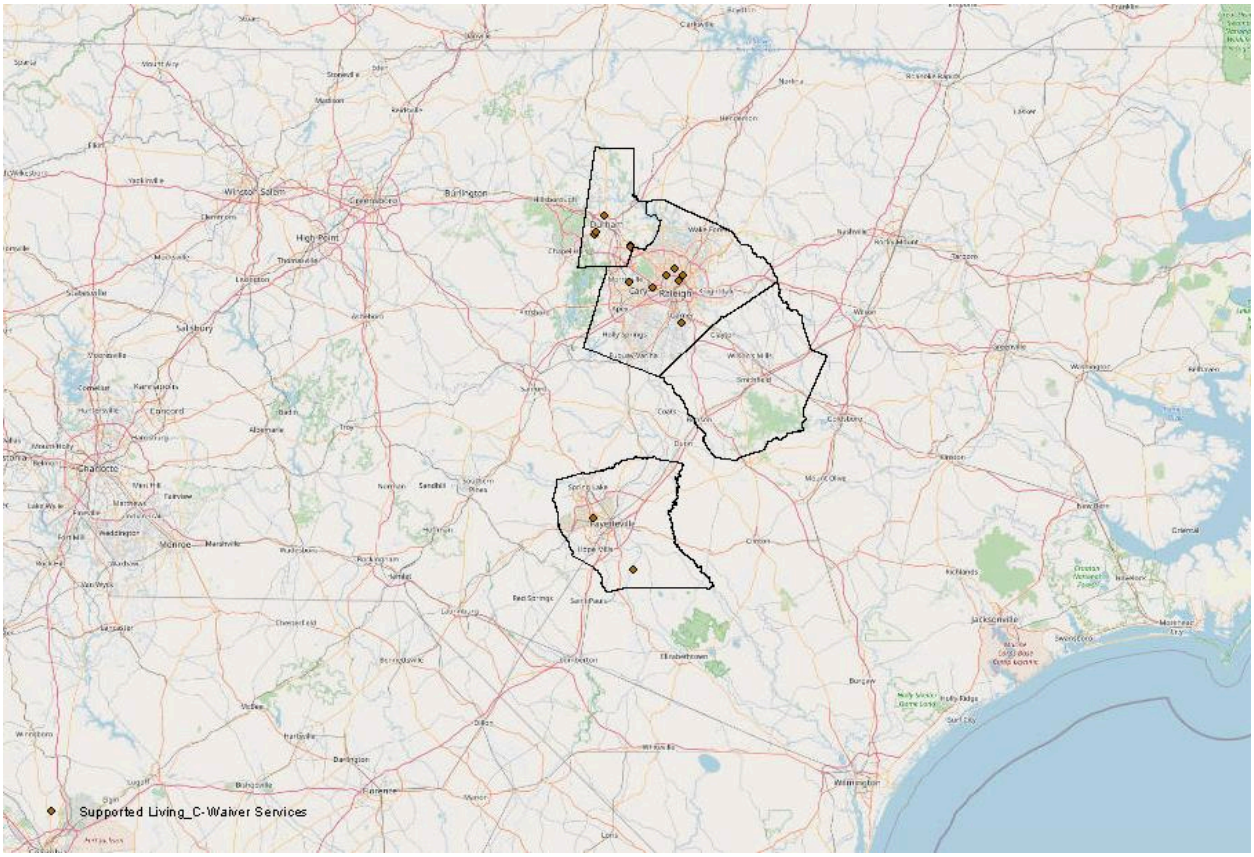

Residential Supports 4_C-Waiver Services

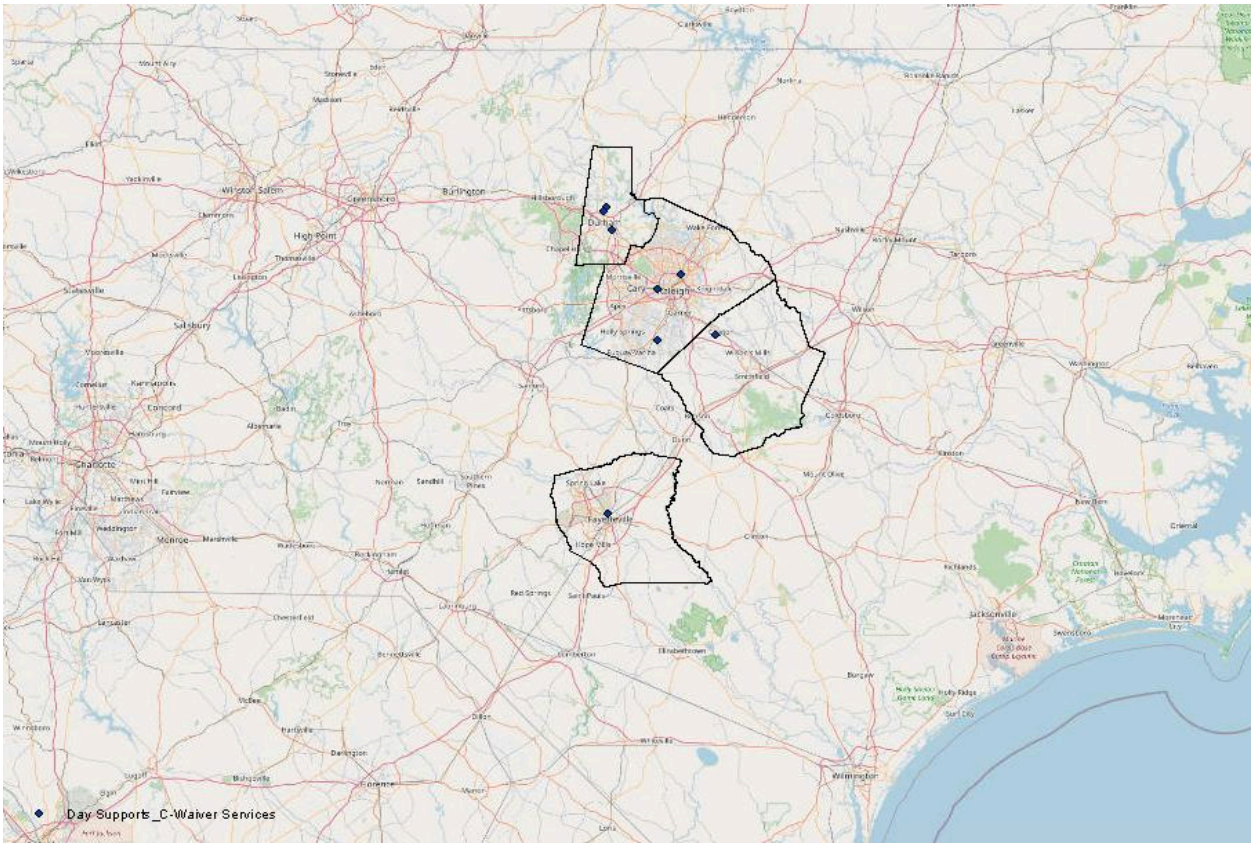

Respite Care - Community_C-Waiver Services

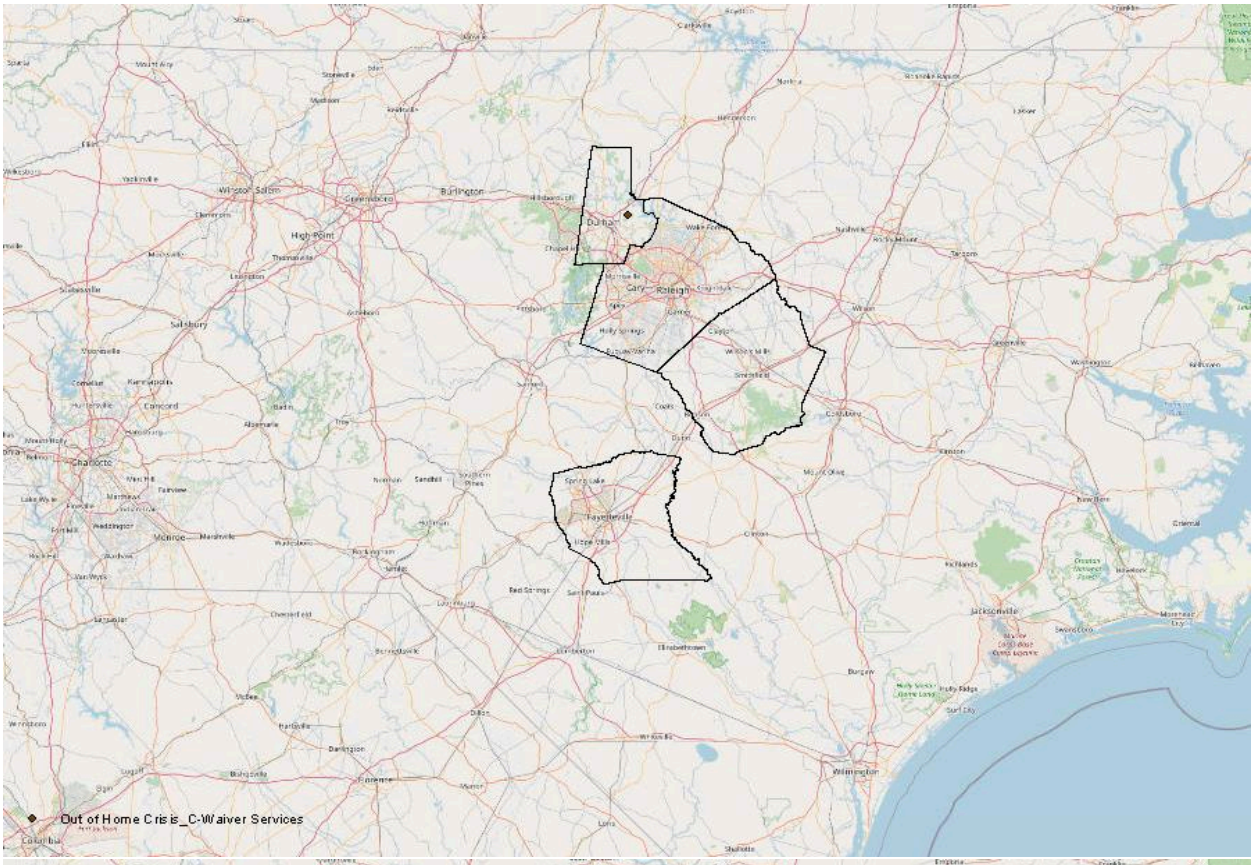

Respite Care Nursing – LPN & RN_C-Waiver Services

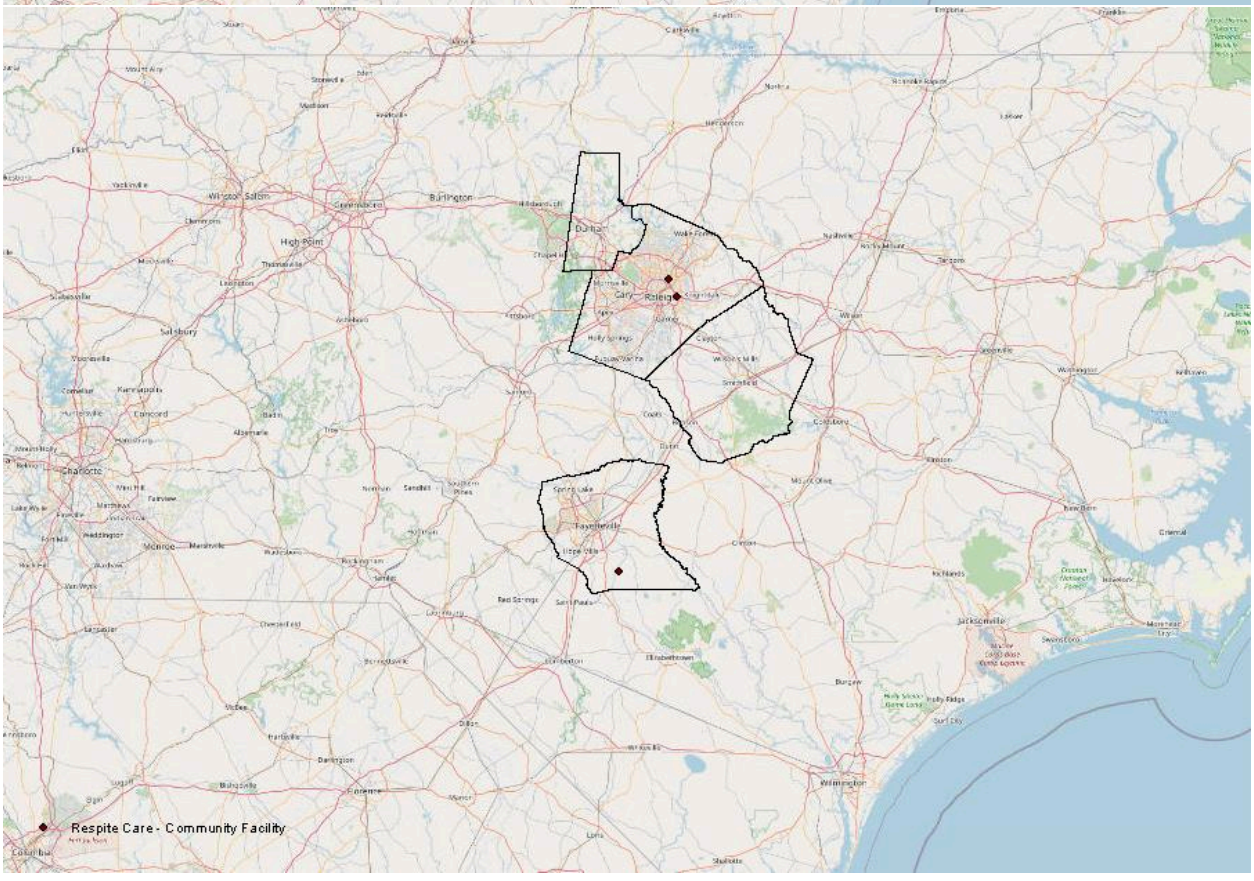

Supported Employment_C-Waiver Services

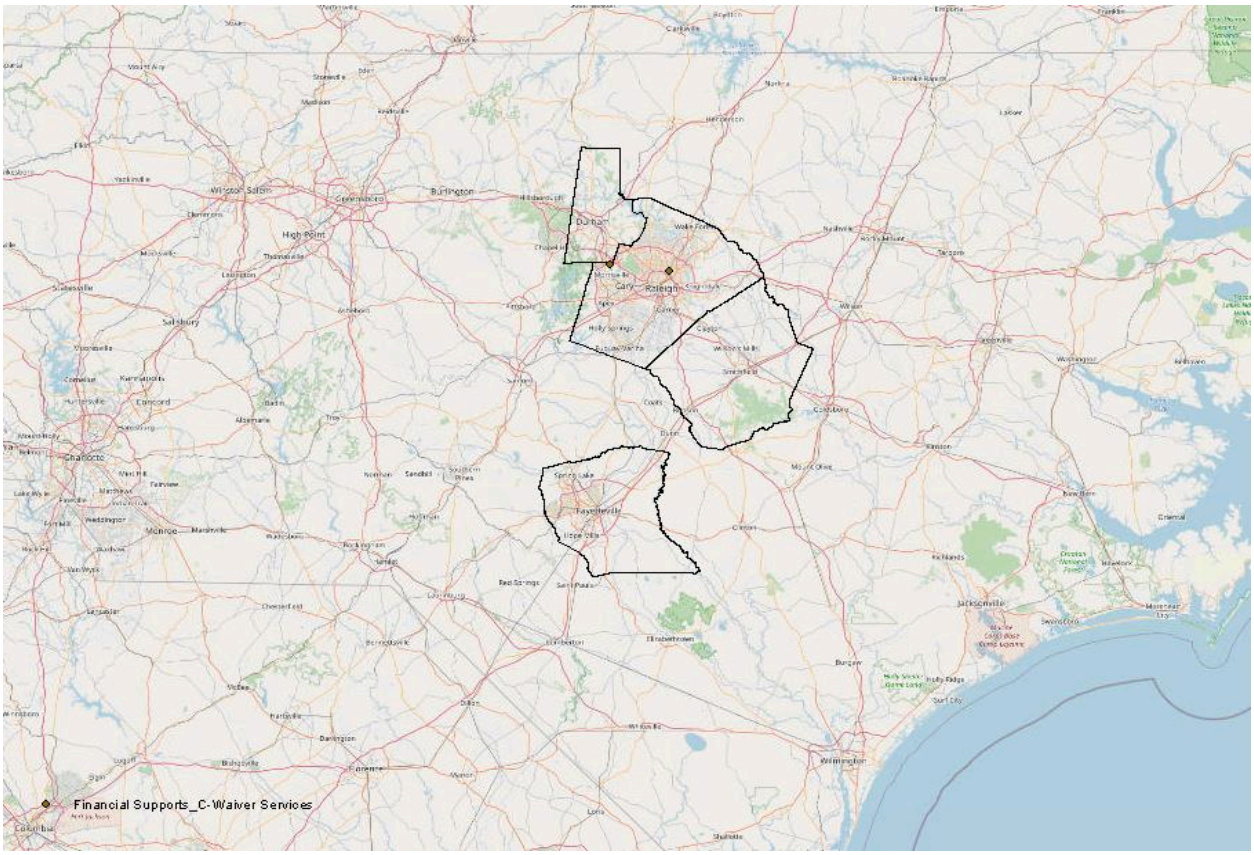

Supported Employment – Long Term Follow-up_C-Waiver Services

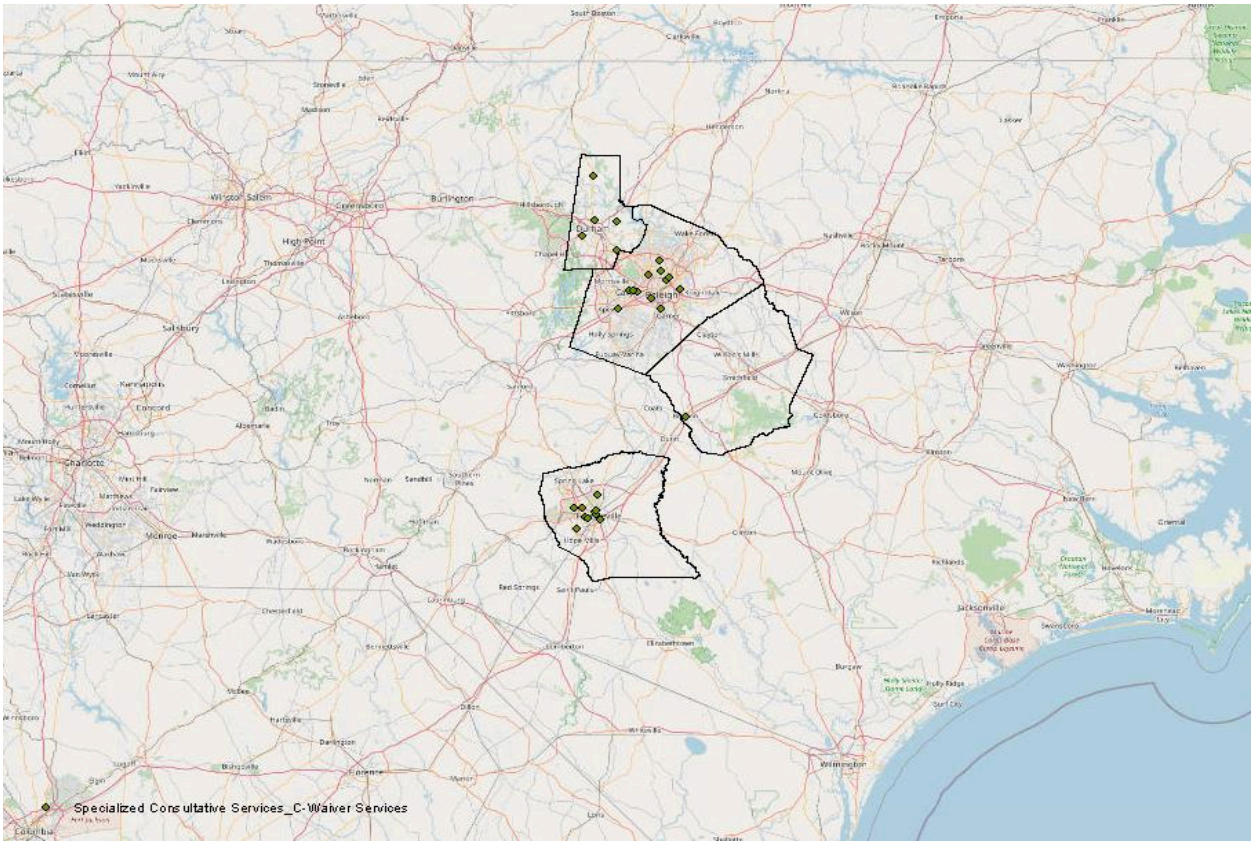

Supported Living_C-Waiver Services

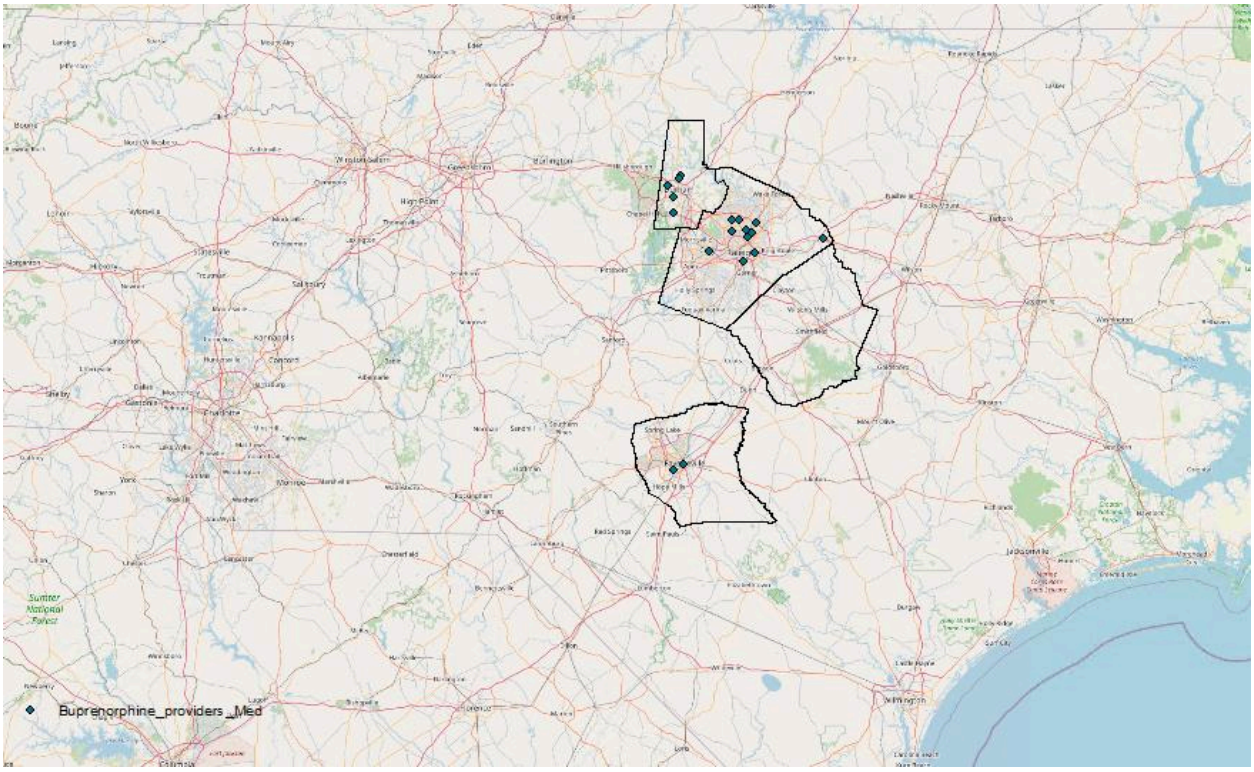

Day Supports_C-Waiver Services


Out of Home Crisis_C-Waiver Services


Respite Care - Community Facility

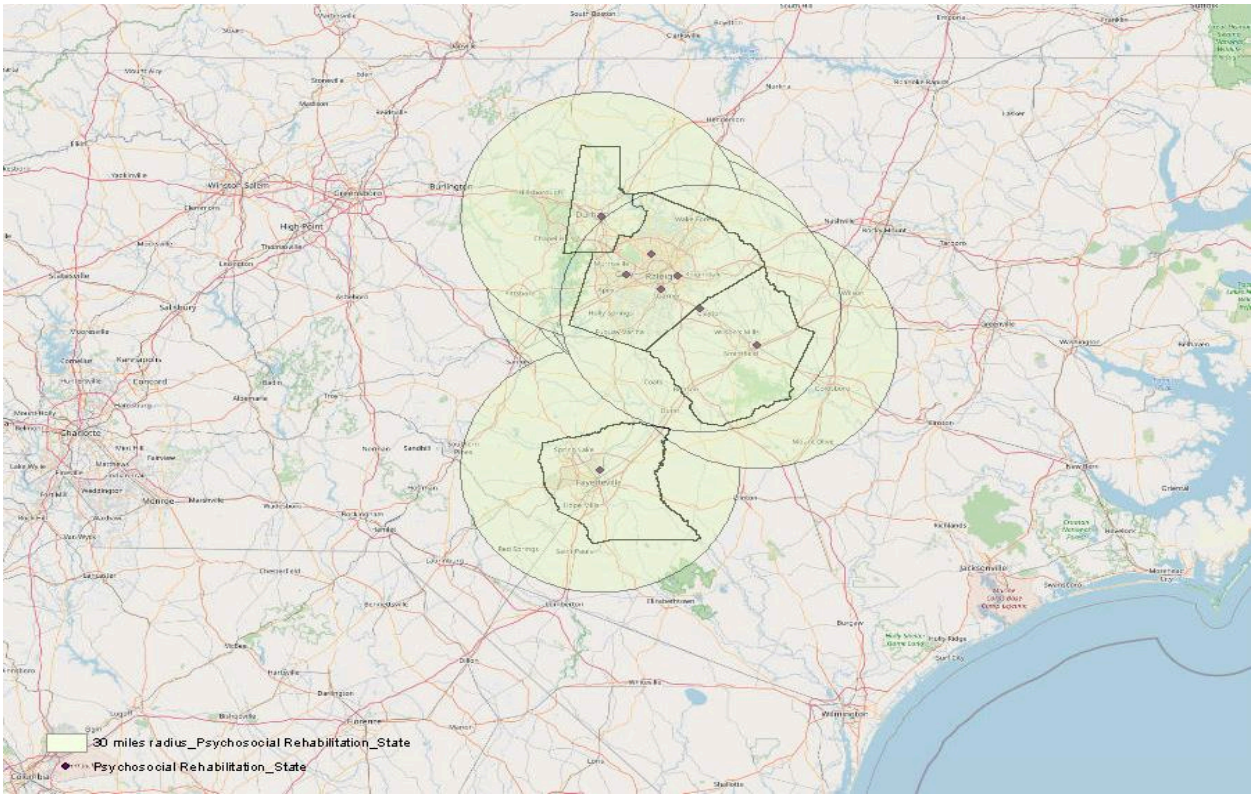

Financial Supports_C-Waiver Services

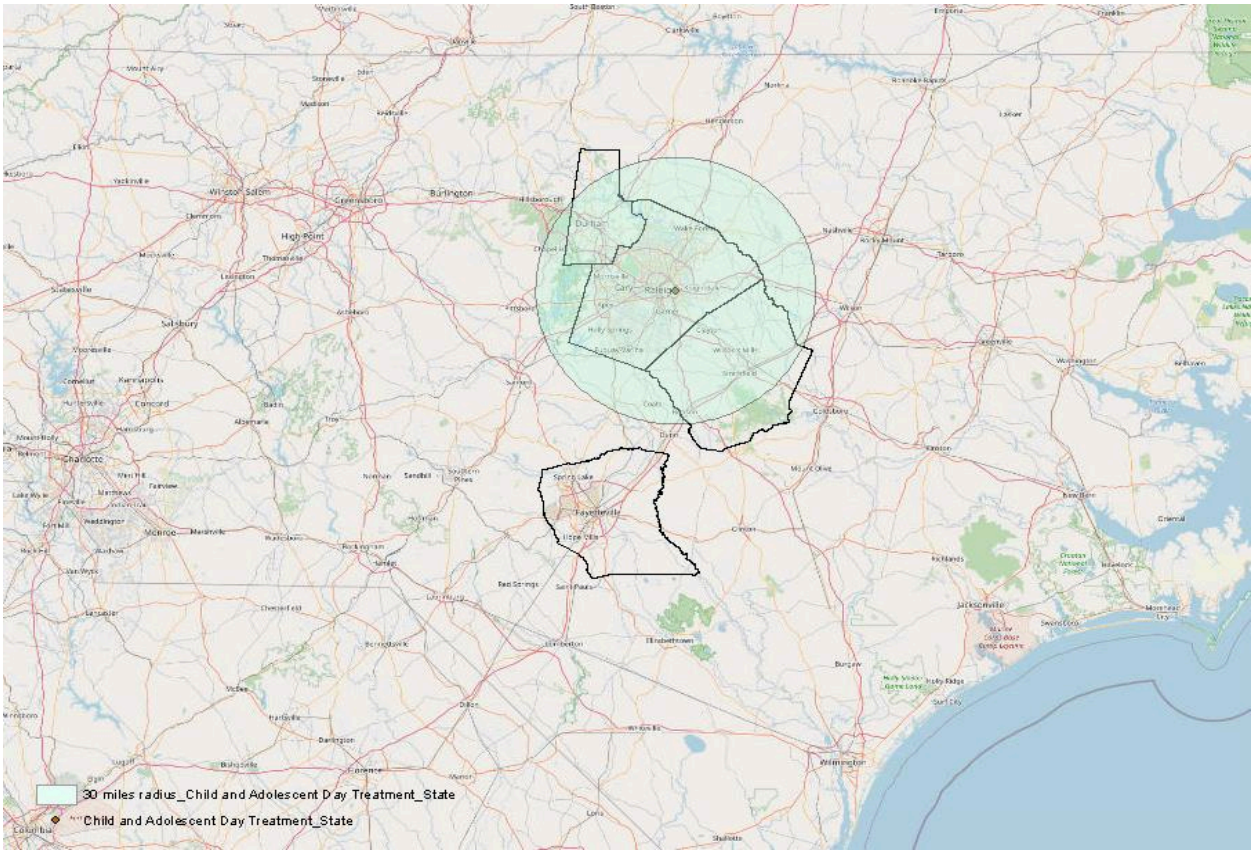

Specialized Consultative Services_C-Waiver Services

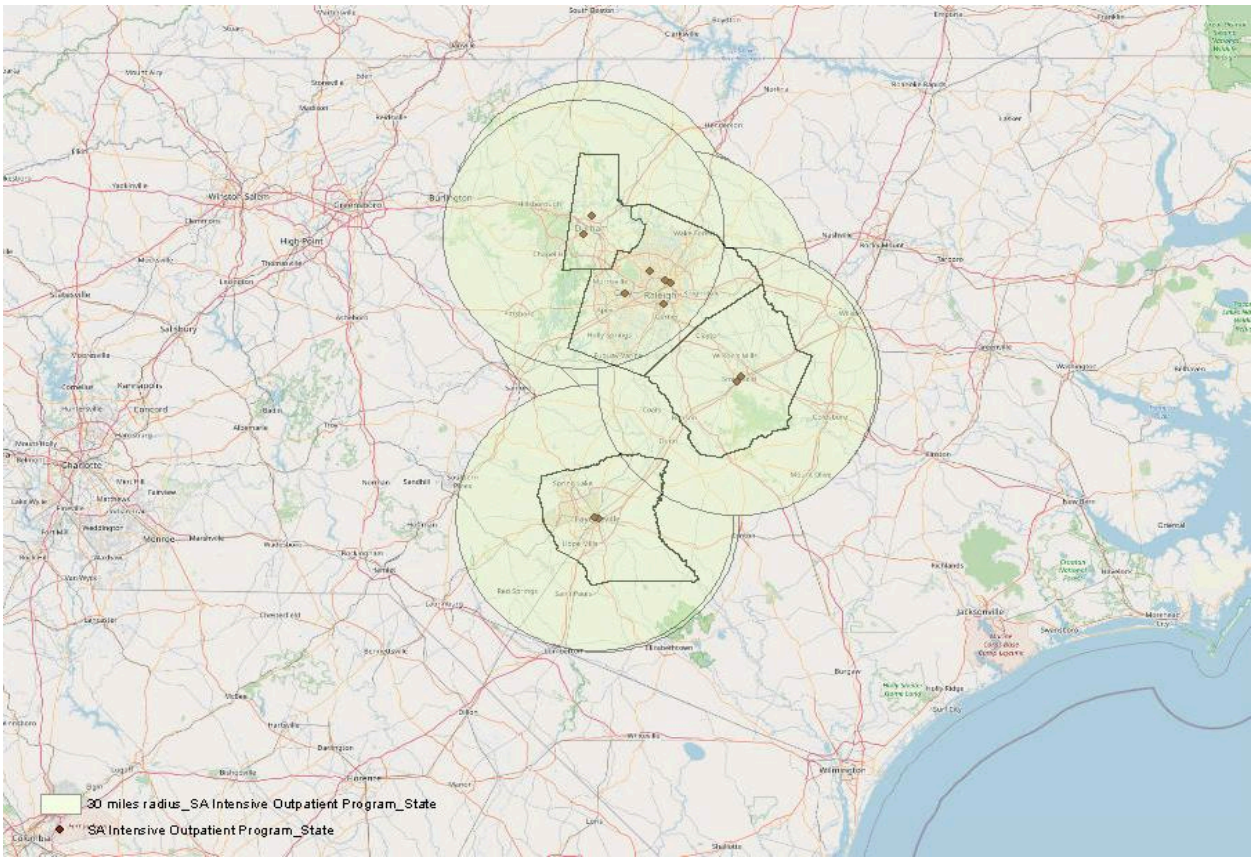

Buprenorphine_providers_Med

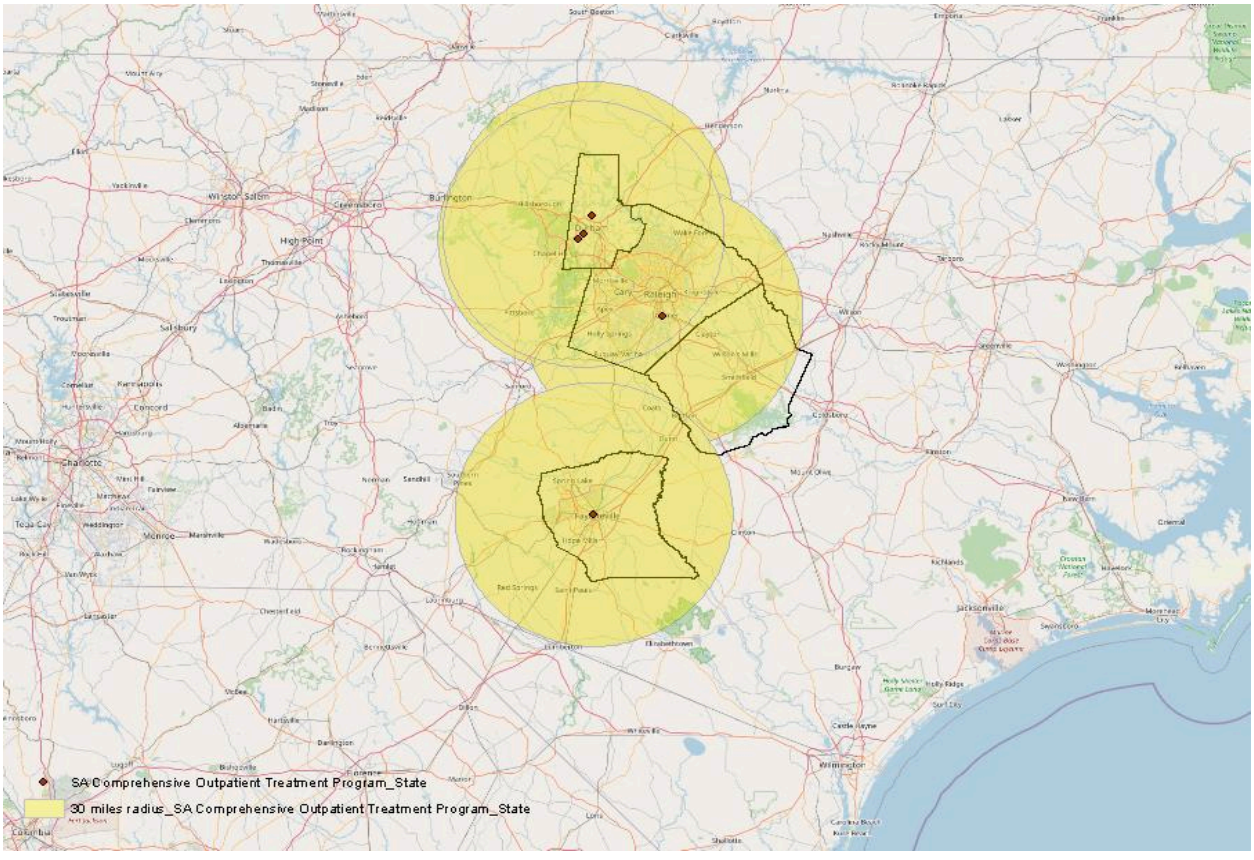
2020 Maps

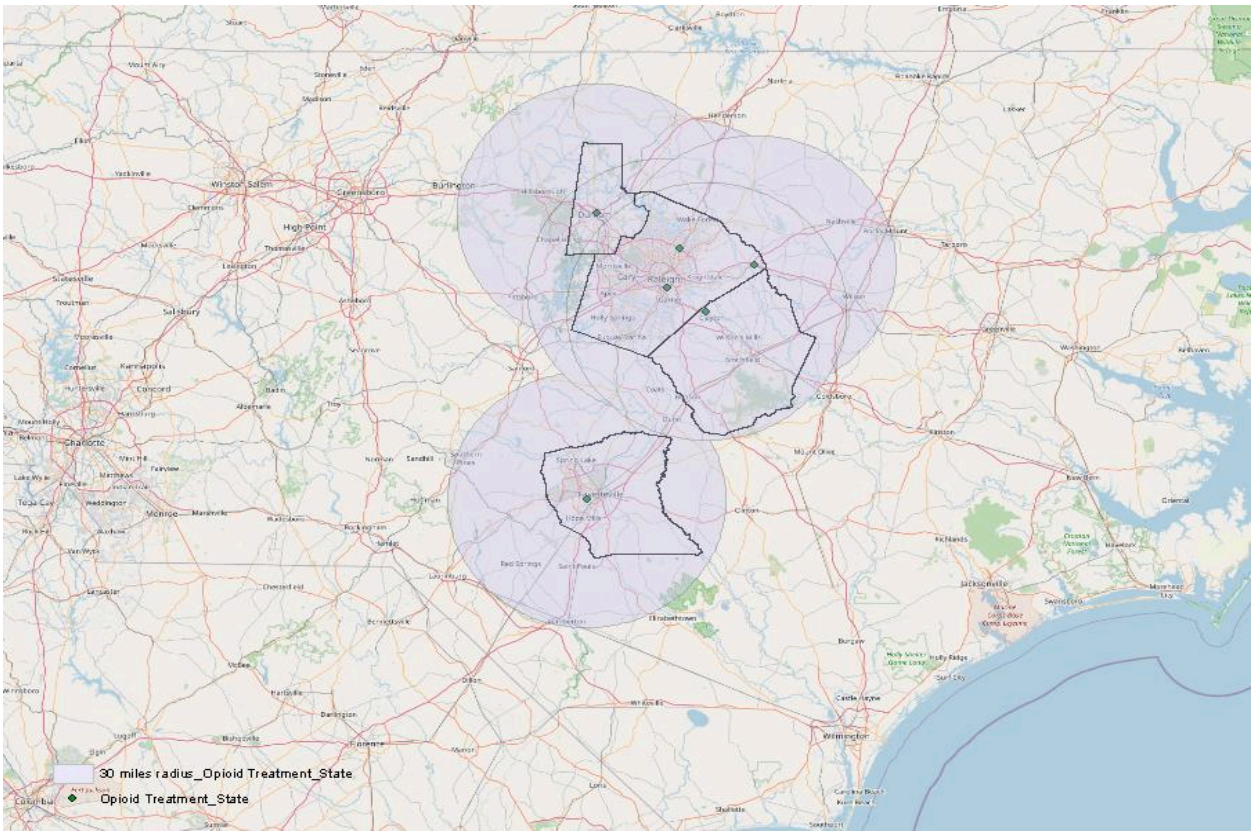
Non-Medicaid Funded

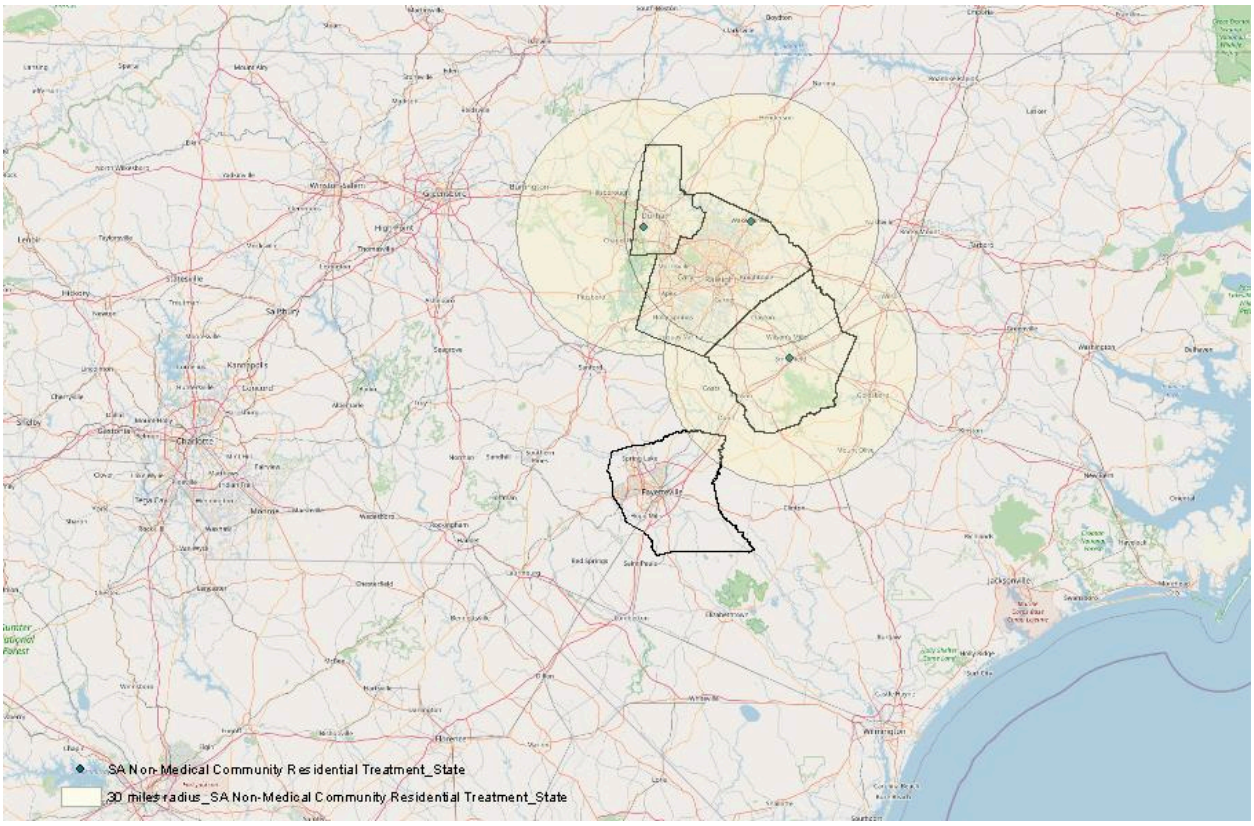

30 miles radius_Psychosocial Rehabilitation_State
Psychosocial Rehabilitation_State

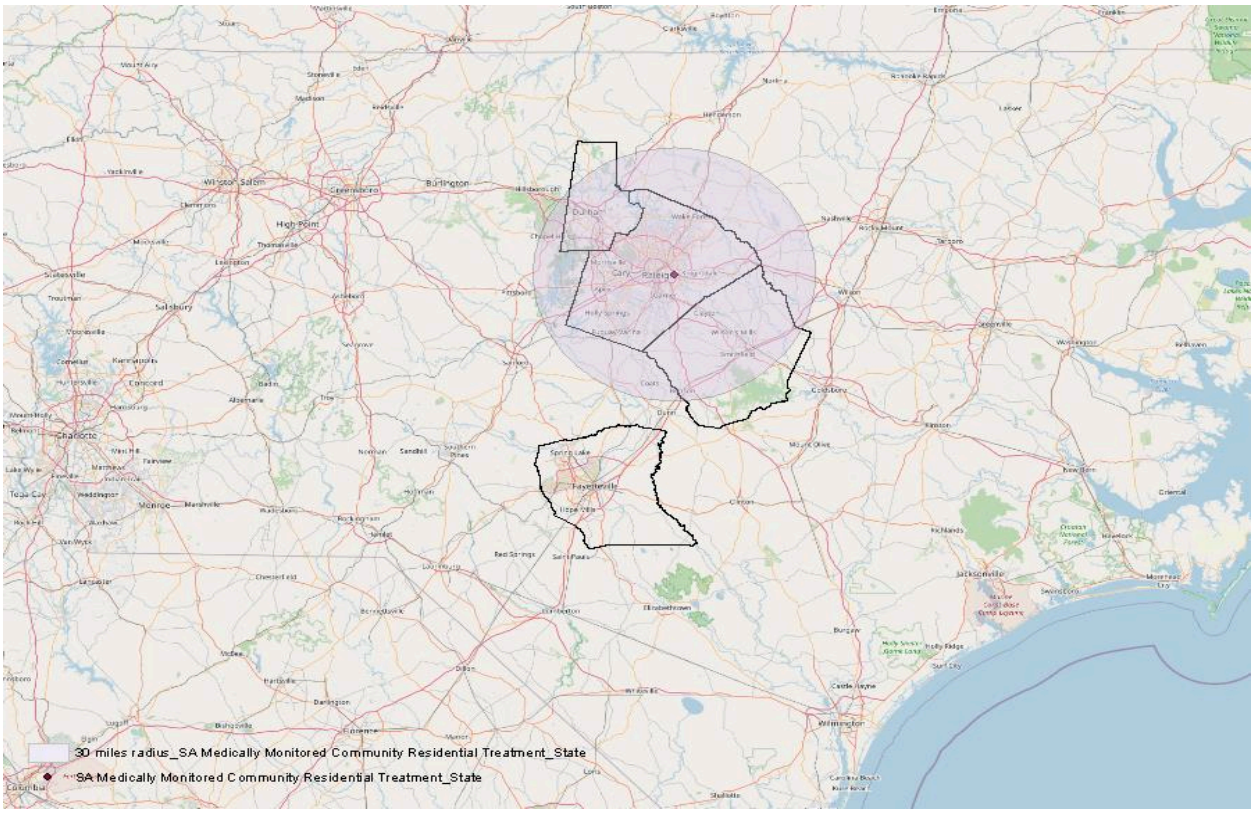

30 miles radius_Child and Adolescent Day Treatment_State
Child and Adolescent Day Treatment_State

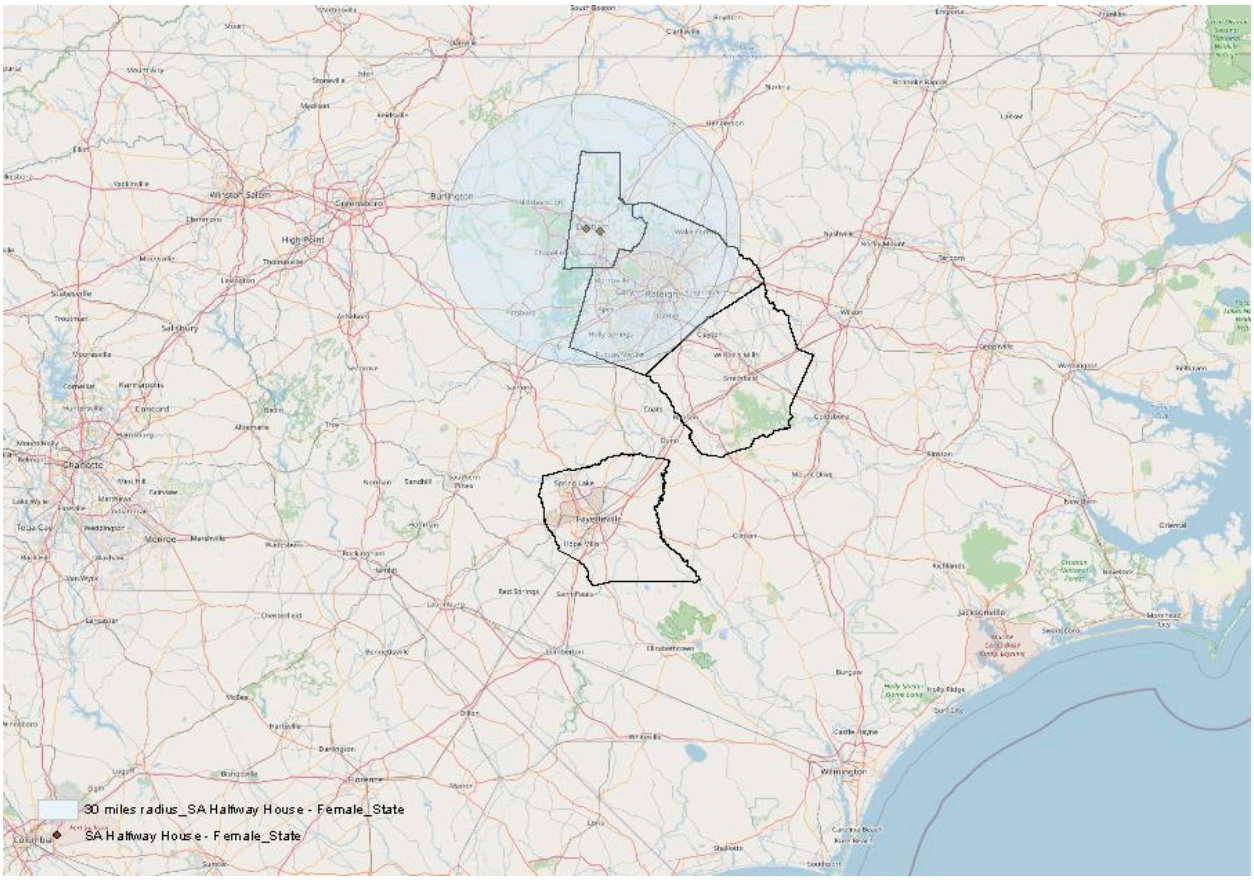

30 miles radius_SA Intensive Outpatient Program_State
SA Intensive Outpatient Program_State

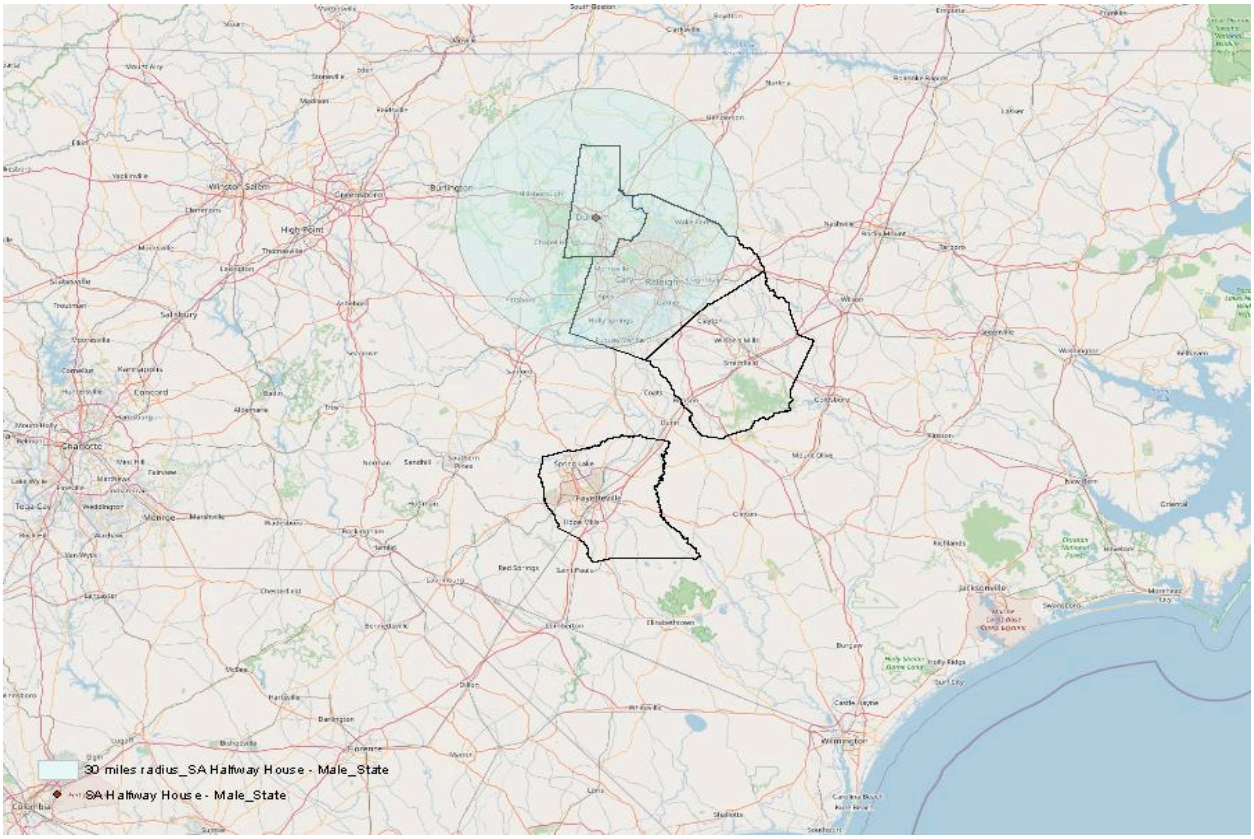

SA Comprehensive Outpatient Treatment Program_State
30 miles radius_SA Comprehensive Outpatient Treatment Program_State

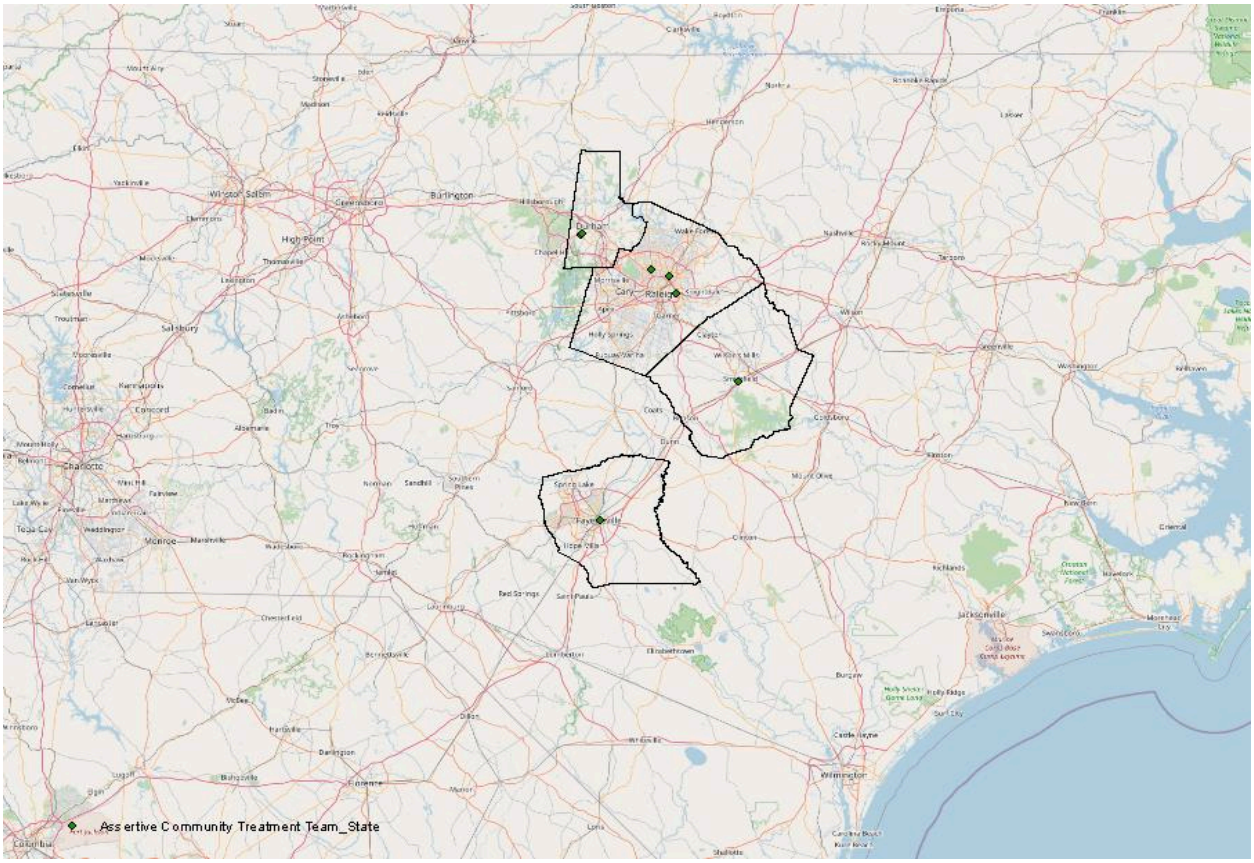

30 miles radius_Opioid Treatment_State
Opioid Treatment_State

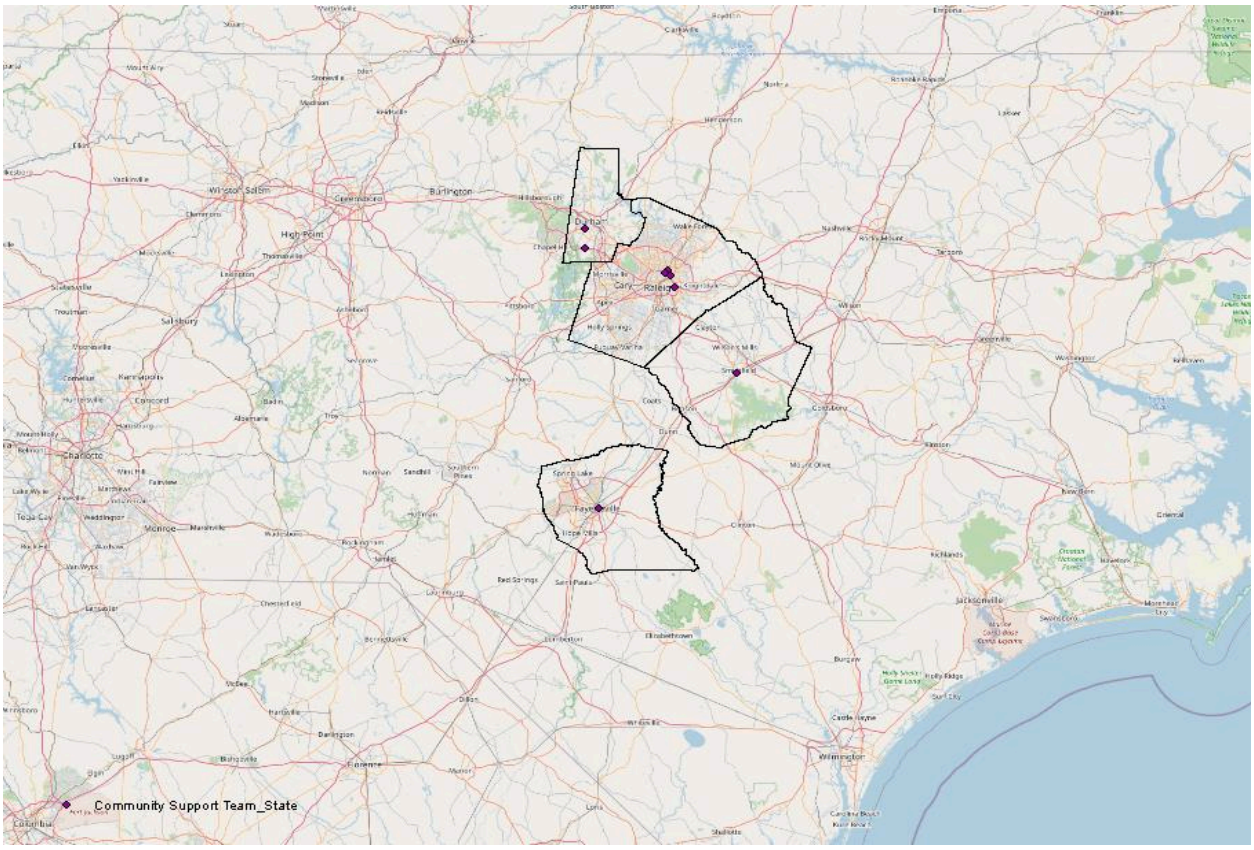

SA Non-Medical Community Residential Treatment_State
30 miles radius_SA Non-Medical Community Residential Treatment_State

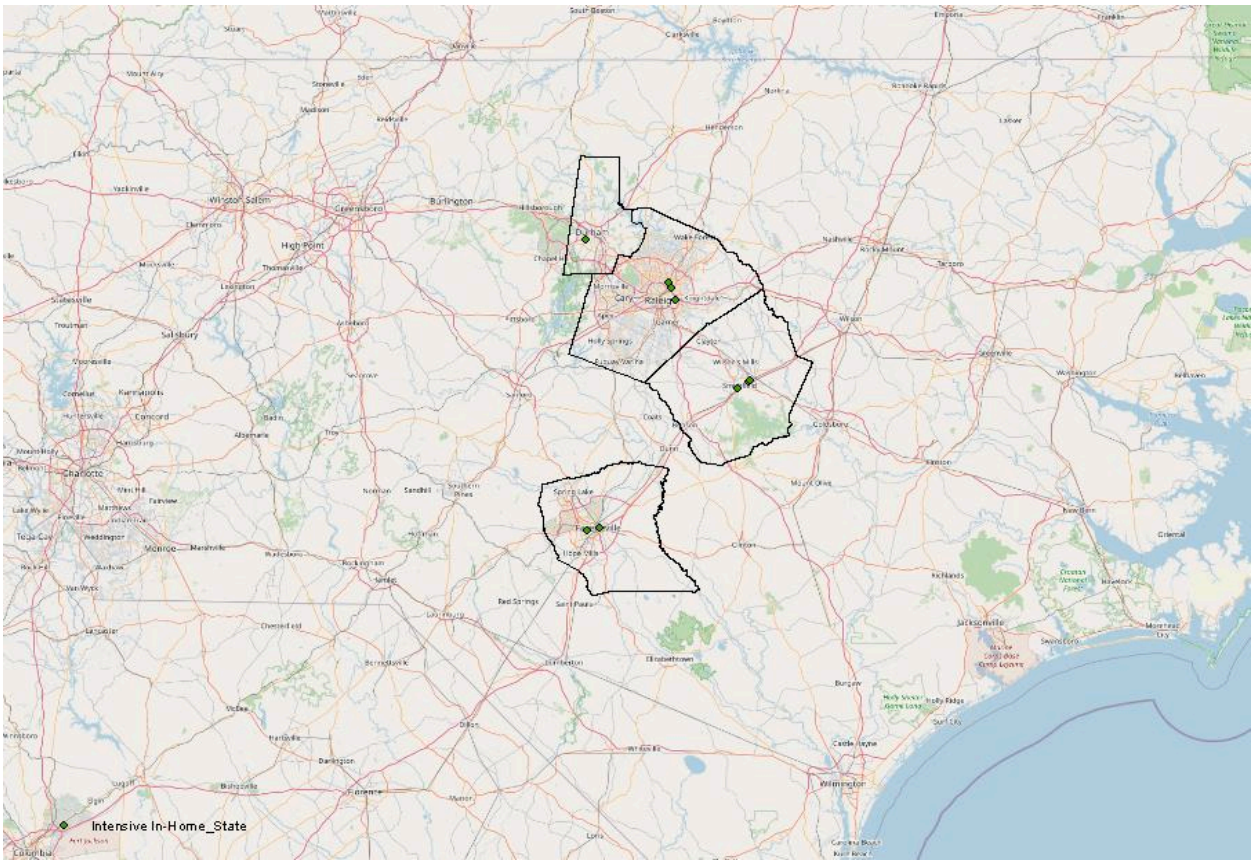

30 miles radius_SA Medically Monitored Community Residential Treatment_State
SA Medically Monitored Community Residential Treatment_State

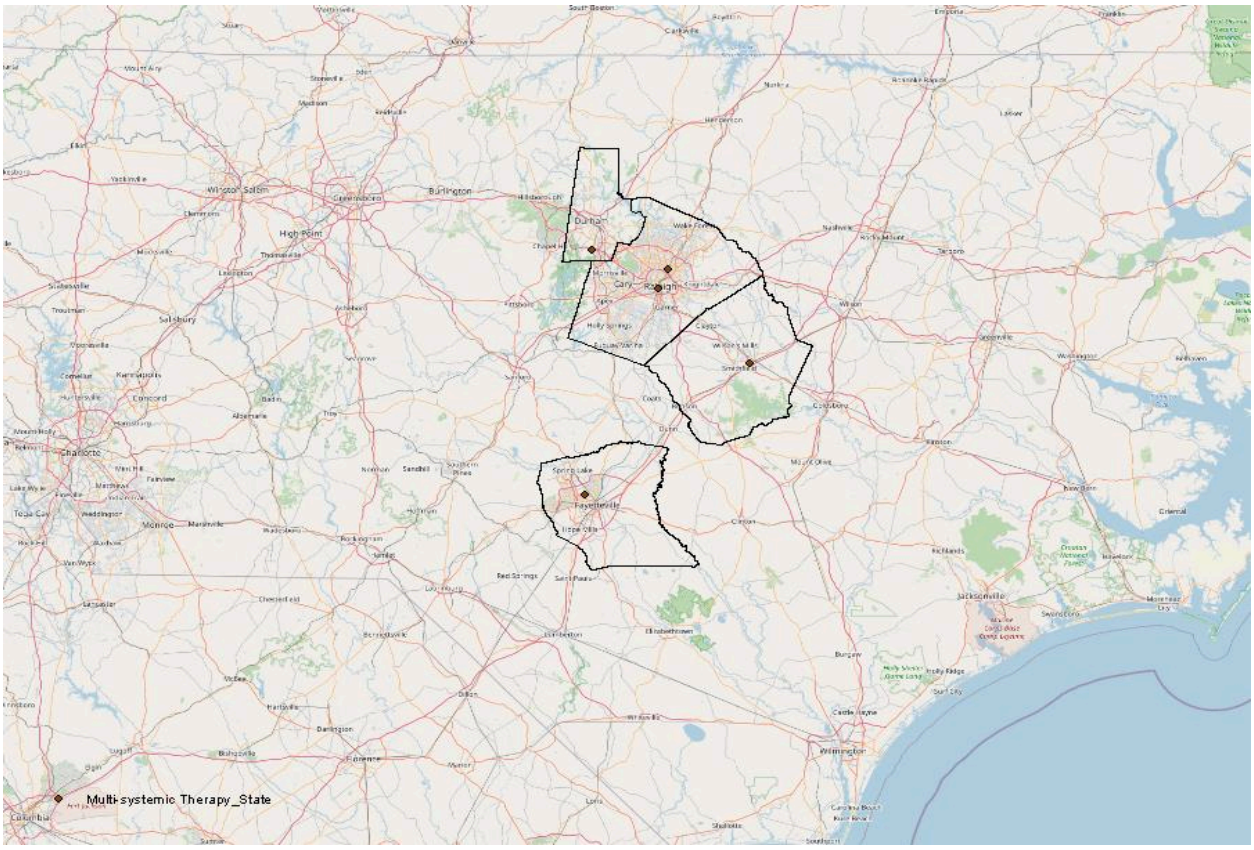

30 miles radius_SA Halfway House - Female_State
SA Halfway House - Female_State

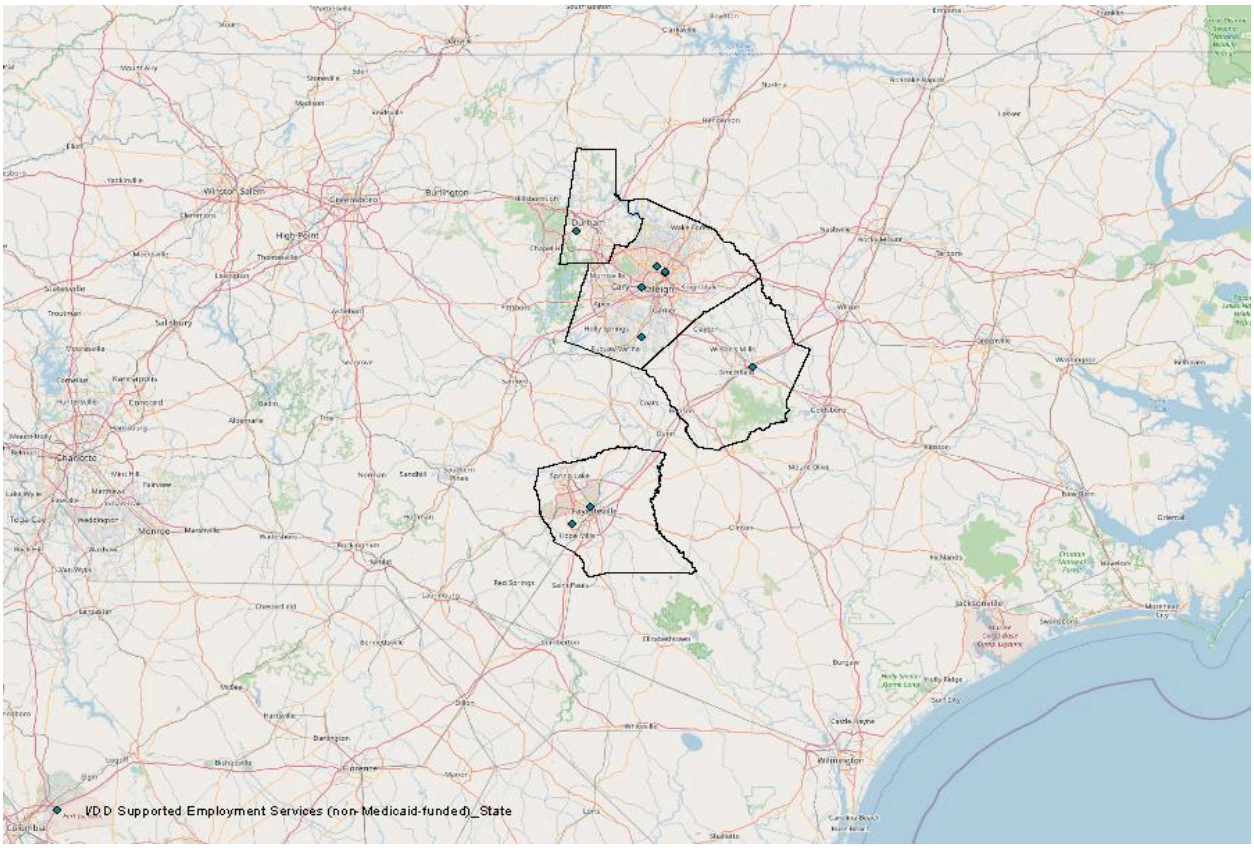

30 miles radius_SA Halfway House - Male_State
SA Halfway House - Male_State

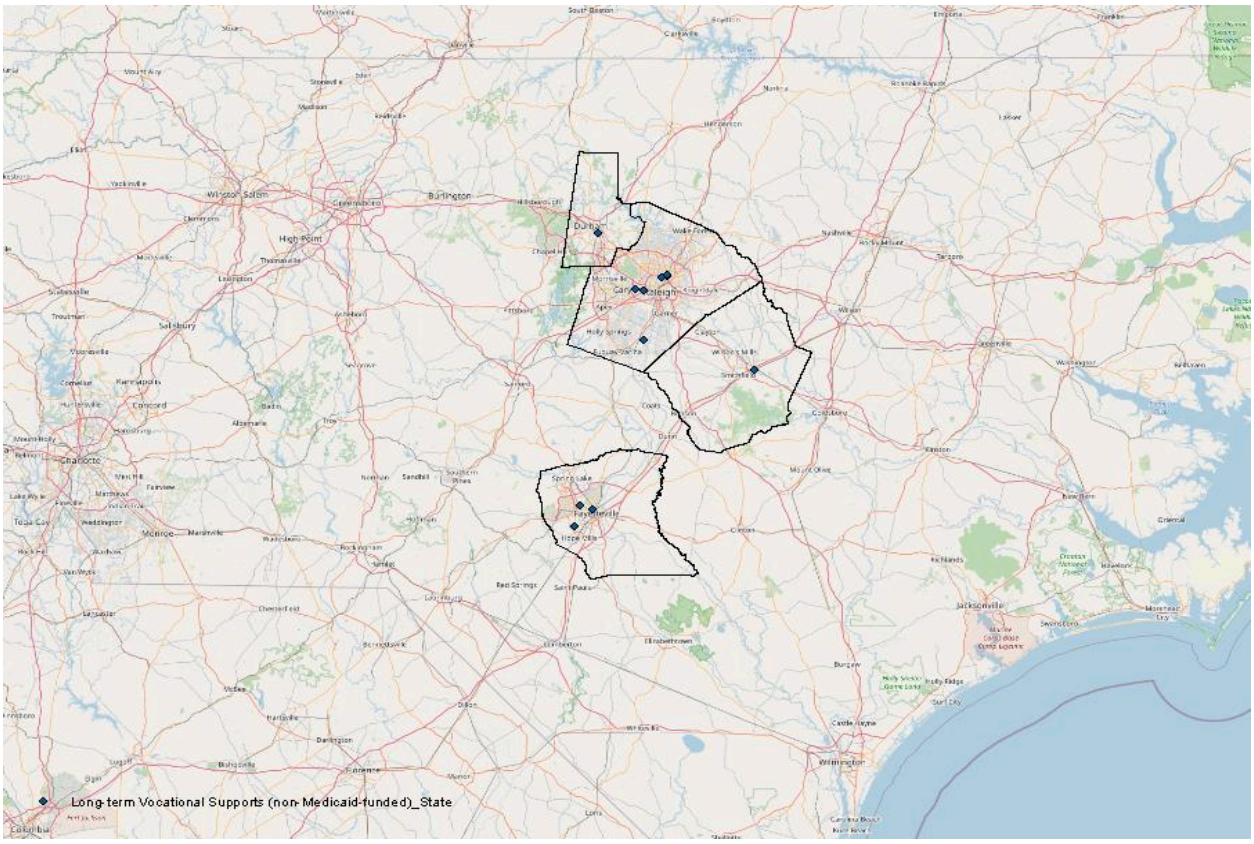

Assertive Community Treatment Team_State

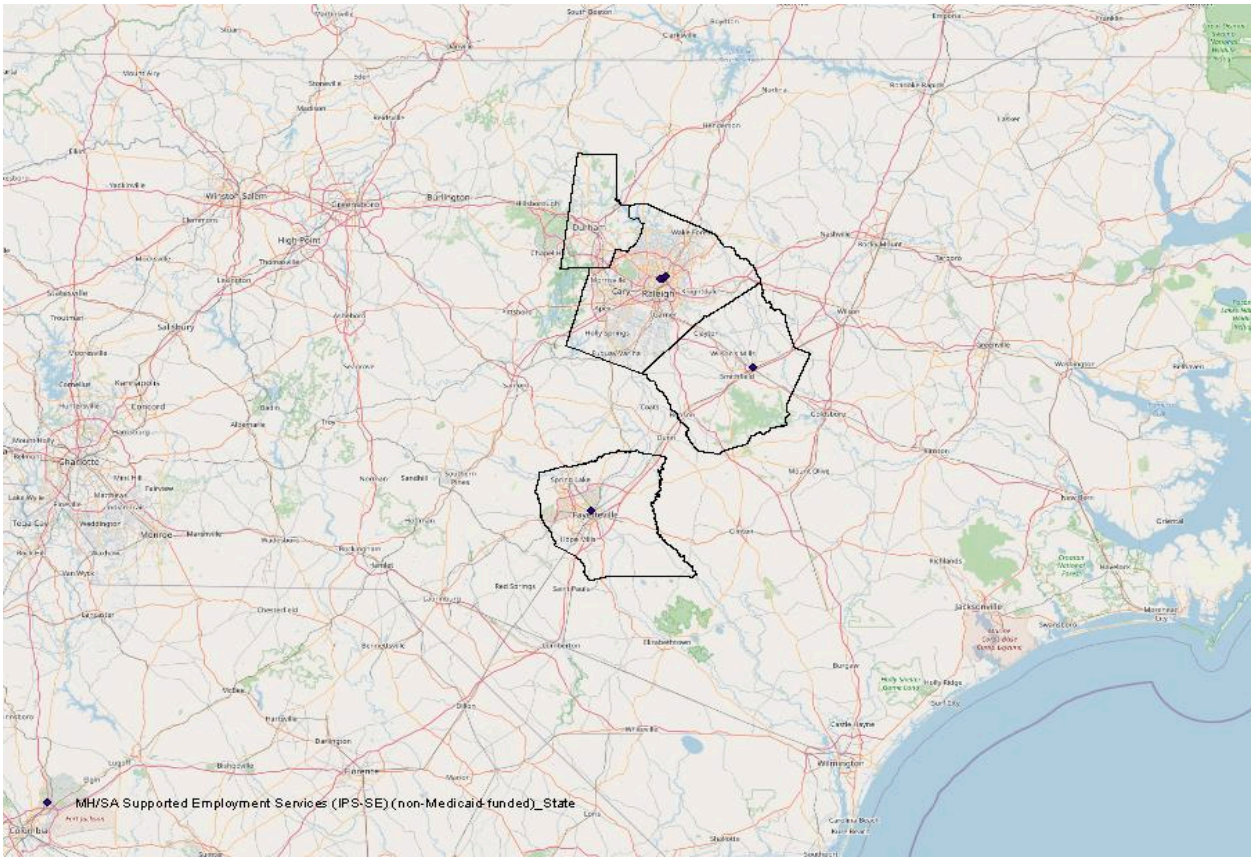

Community Support Team_State

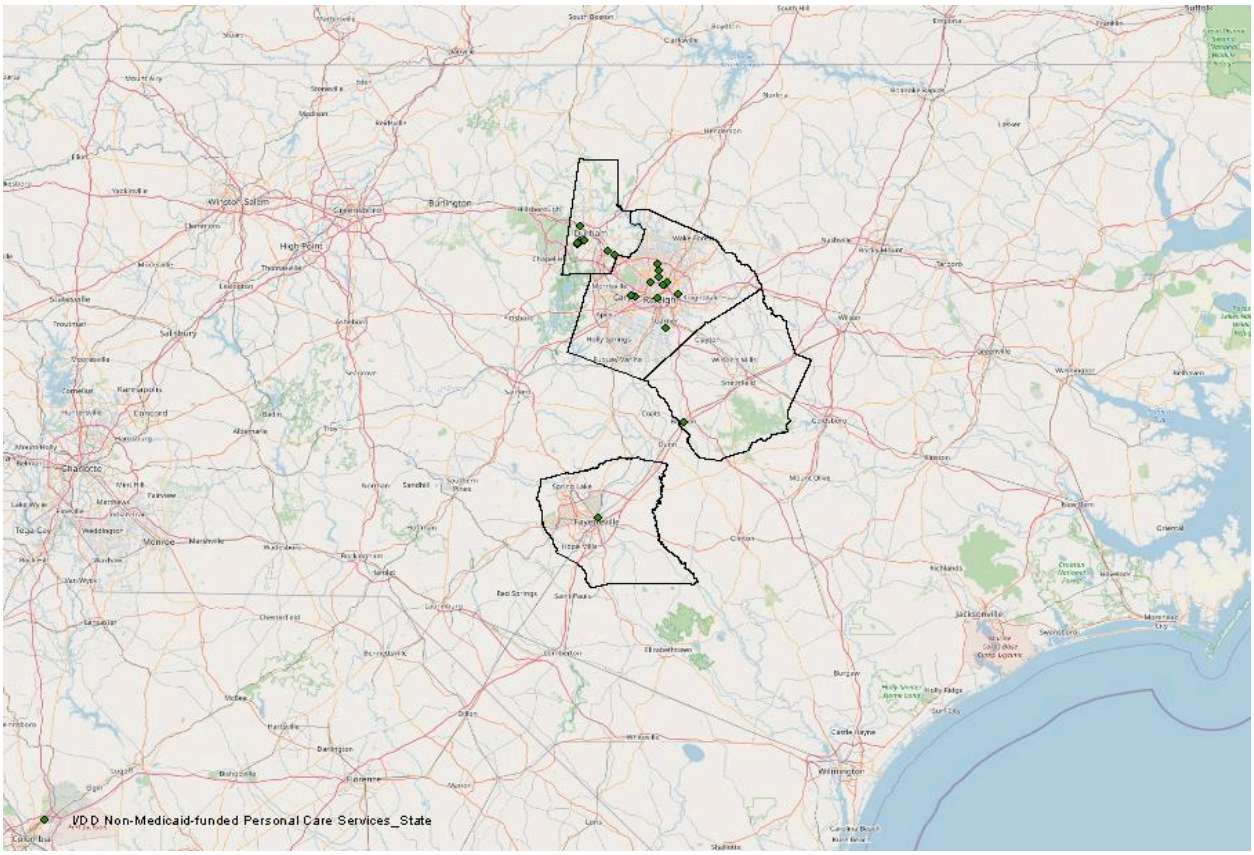

Intensive In-Home_State

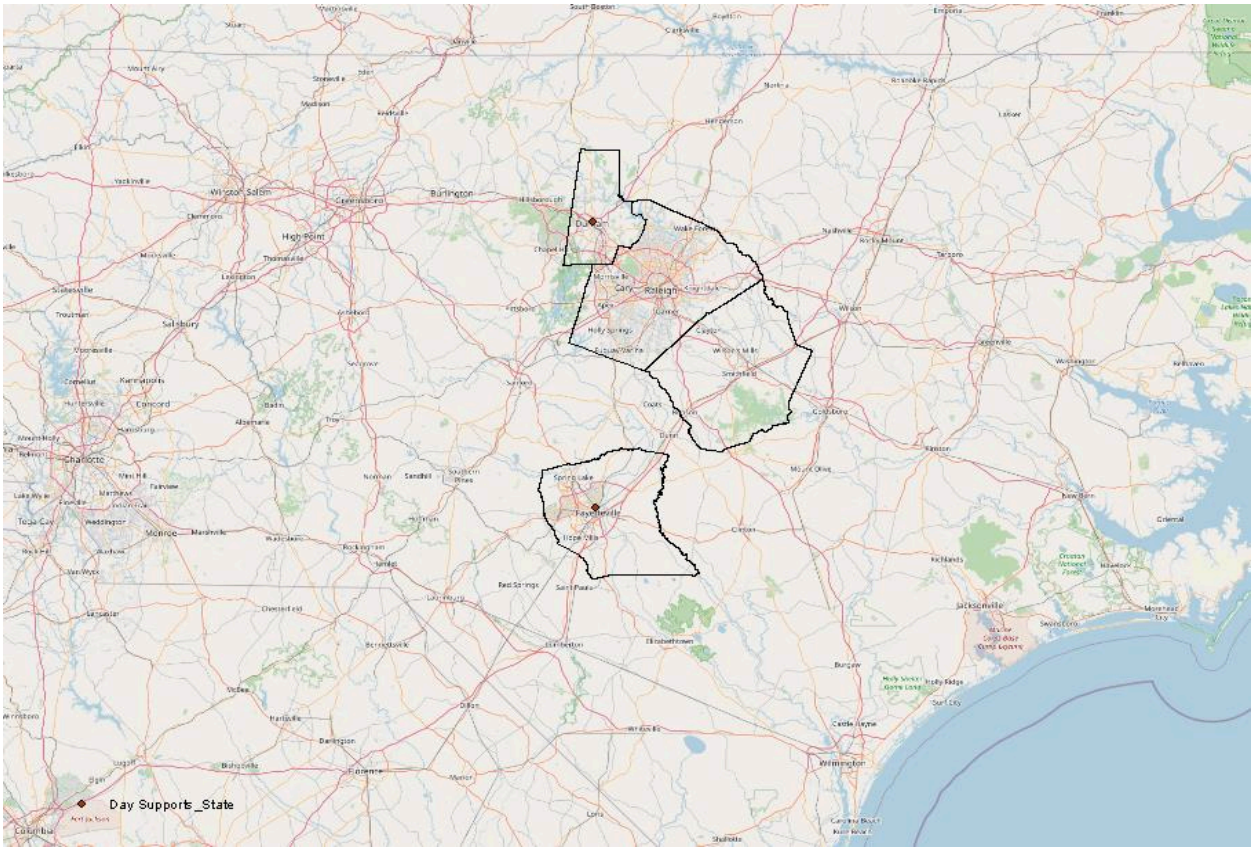

Multi-systemic Therapy_State

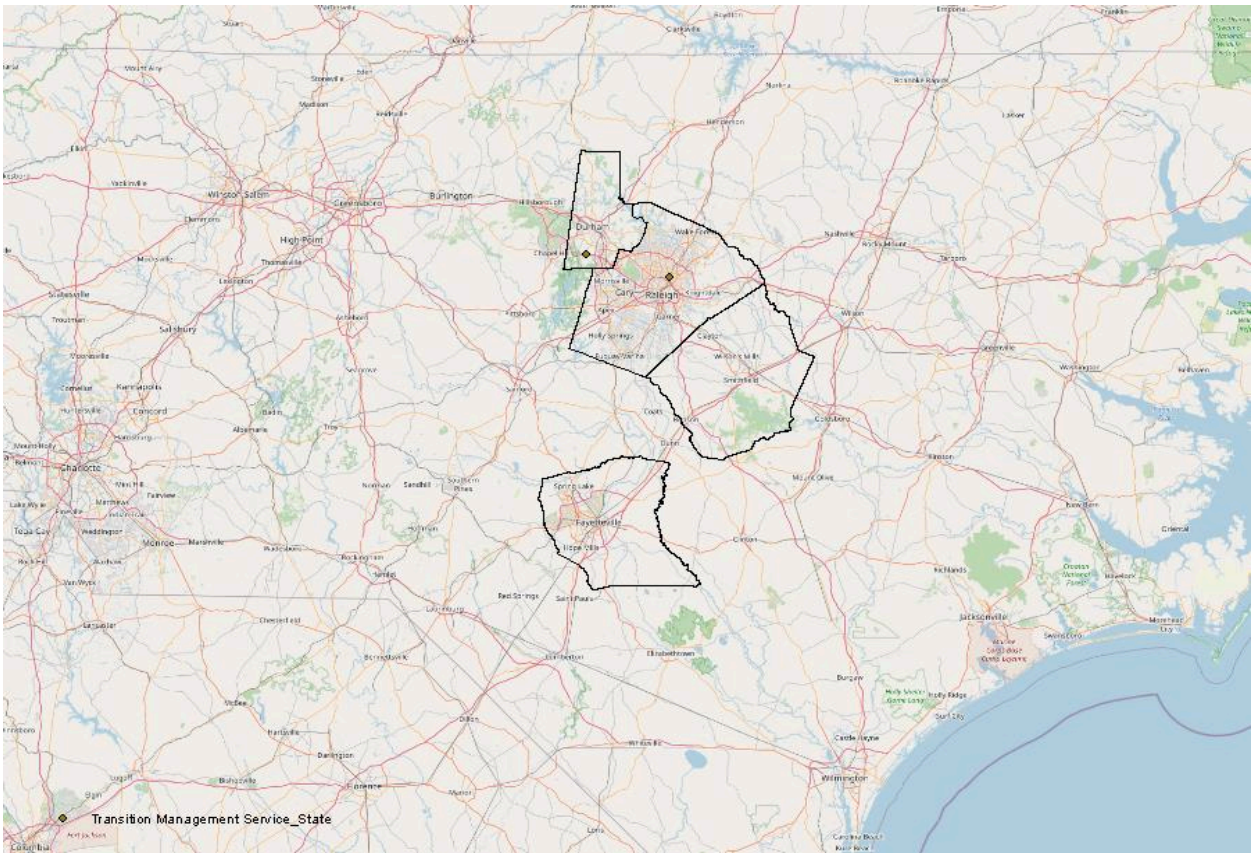

VDD Supported Employment Services (non-Medicaid-funded)_State

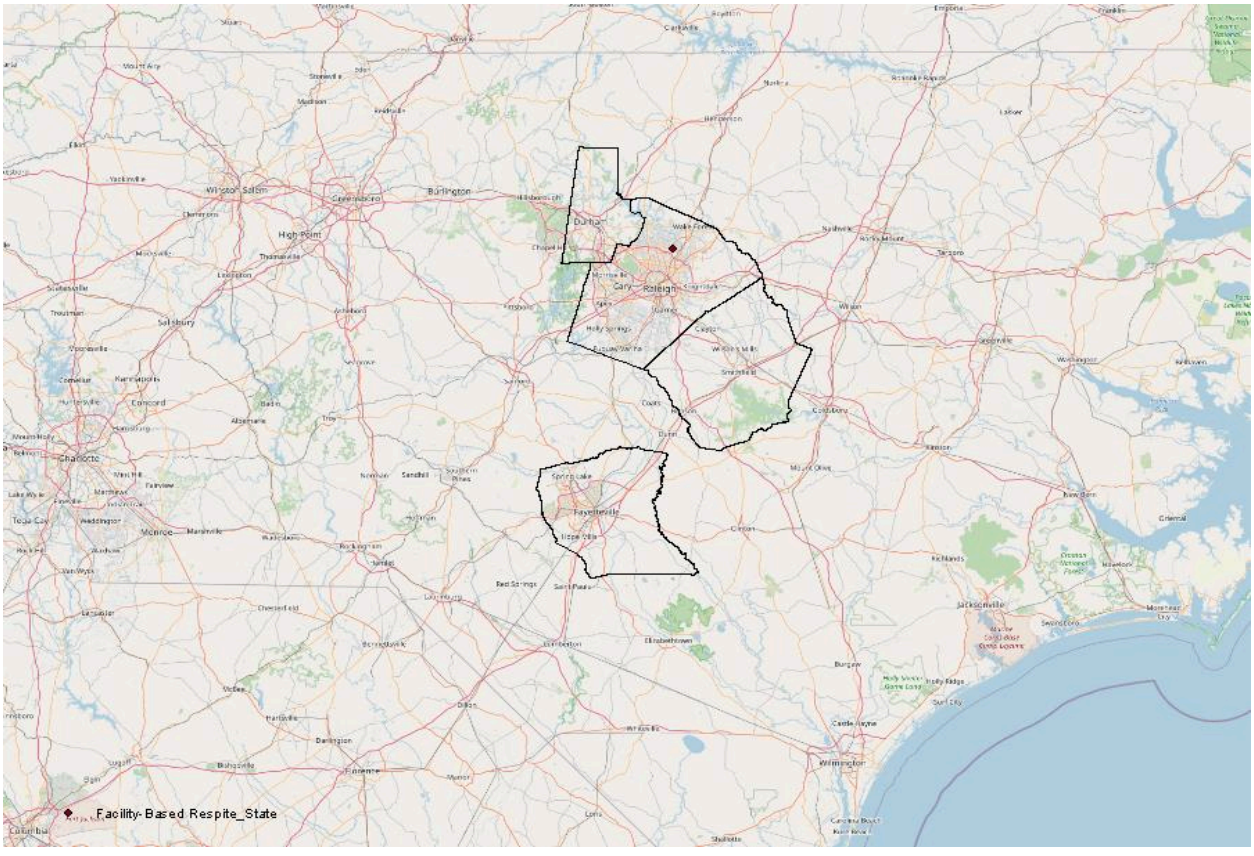

Long-term Vocational Supports (non-Medicaid-funded)_State

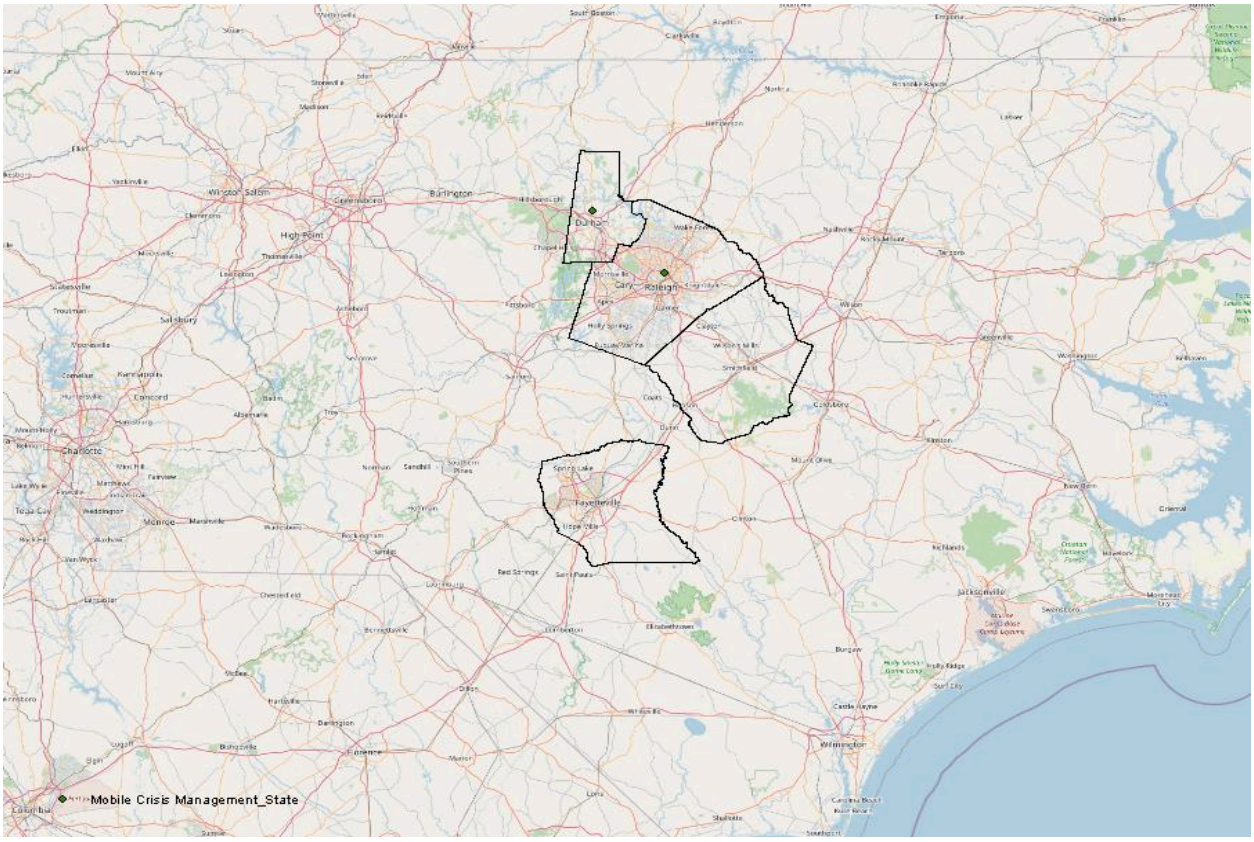

MH/SA Supported Employment Services (IPS-SE) (non-Medicaid-funded)_State

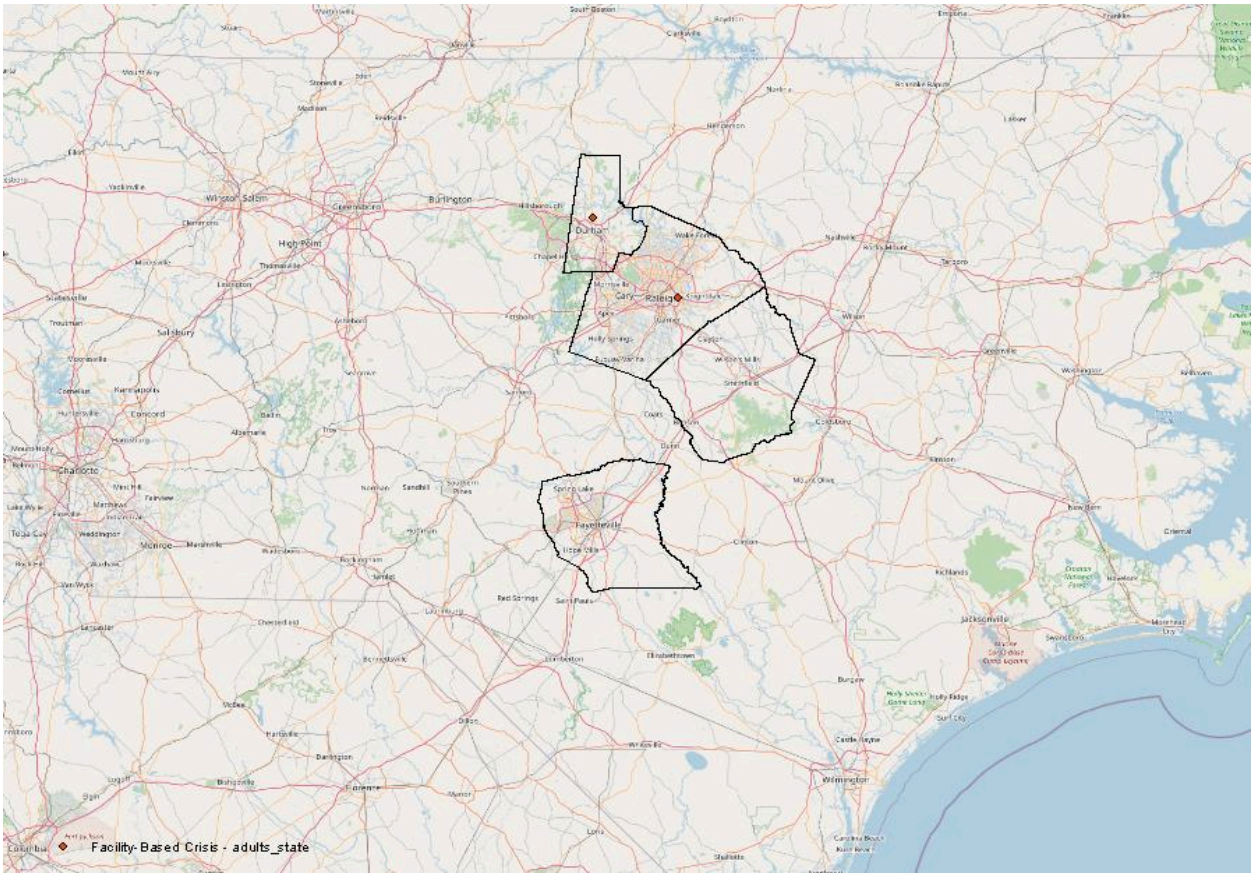

VDD Non-Medicaid-funded Personal Care Services_State

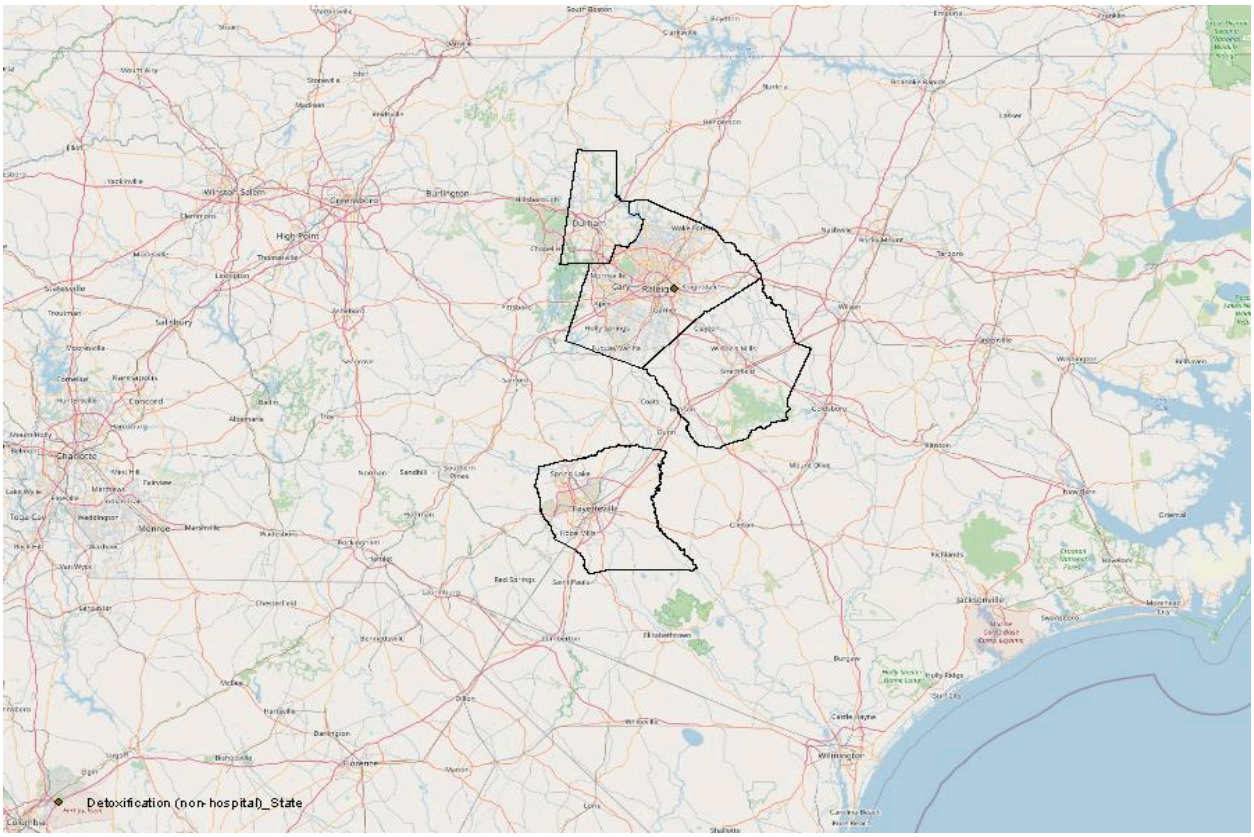

Day Supports_State

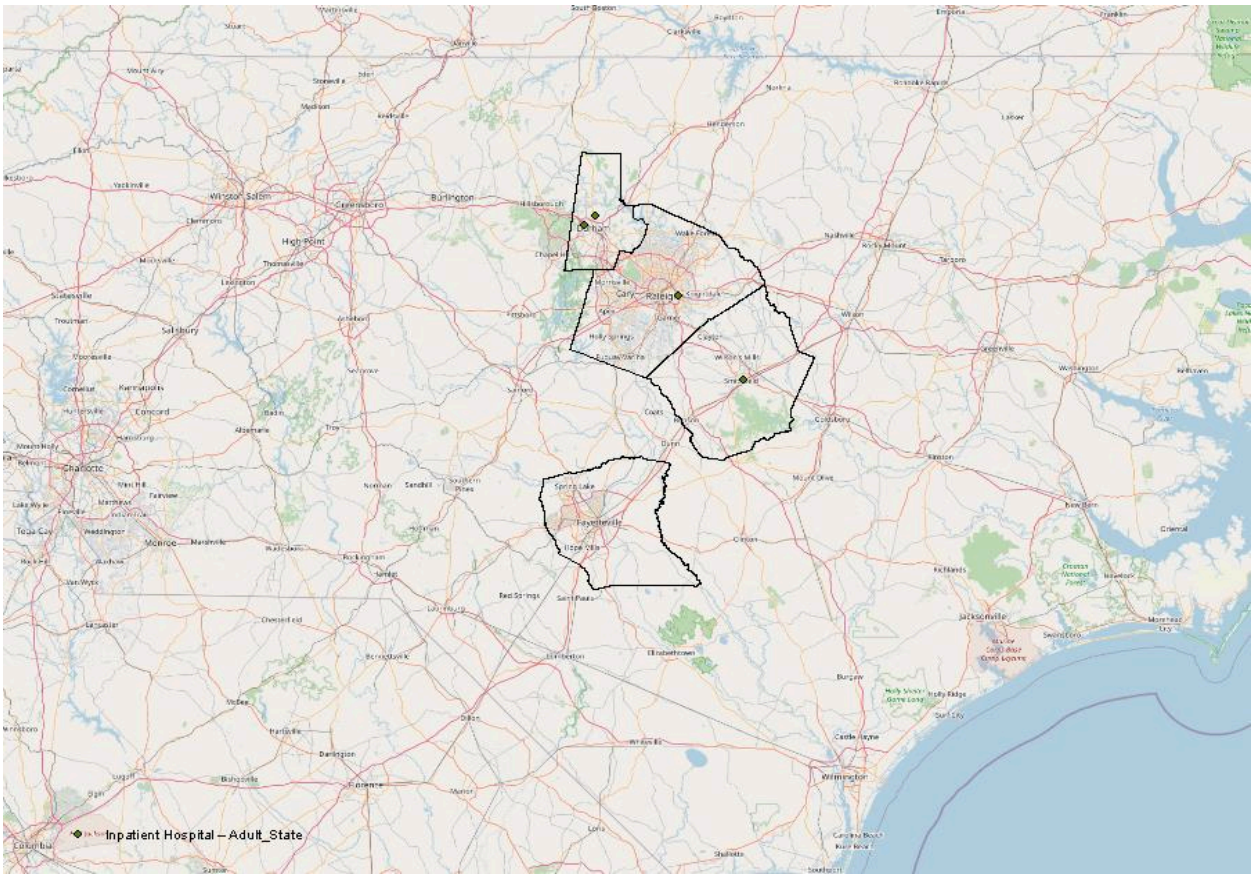

Transition Management Service_State

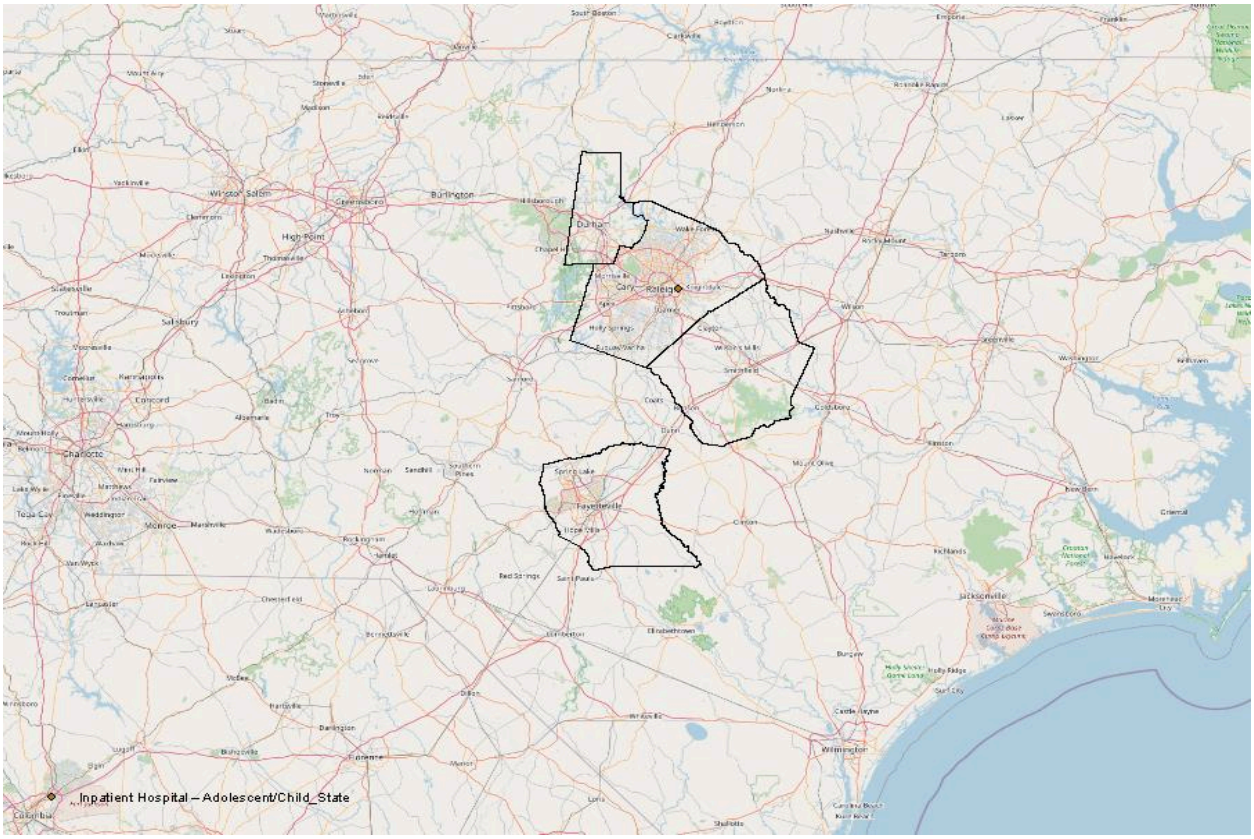

Facility-Based Respite_State

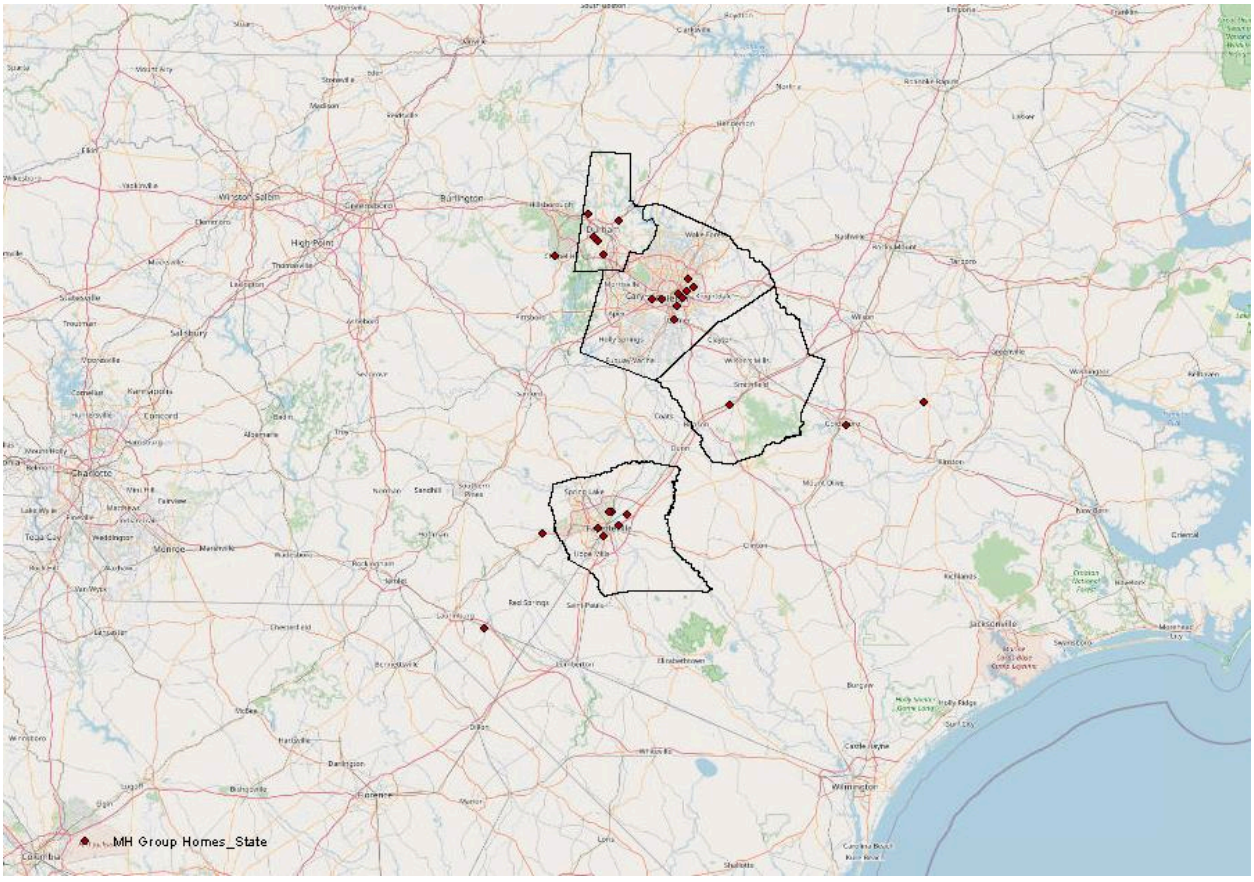

Mobile Crisis Management_State

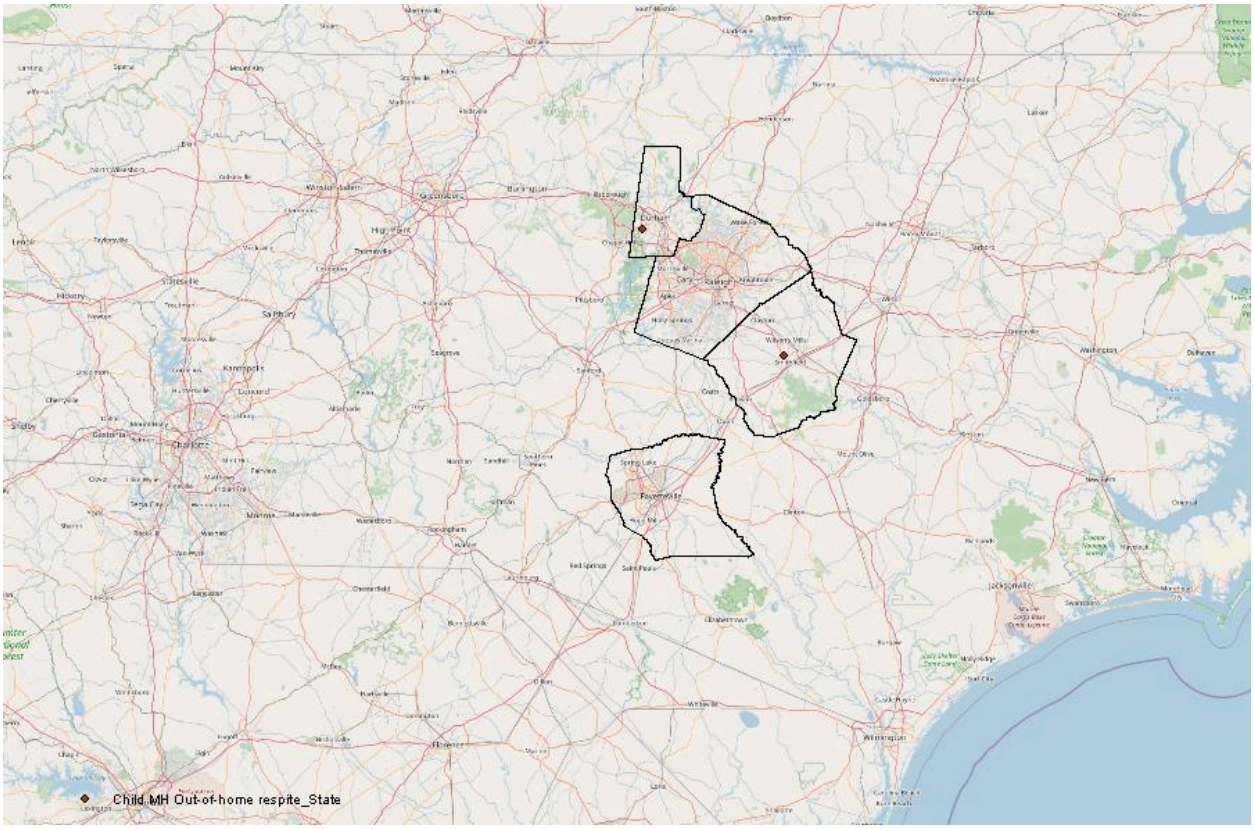

Facility-Based Crisis - adults_state

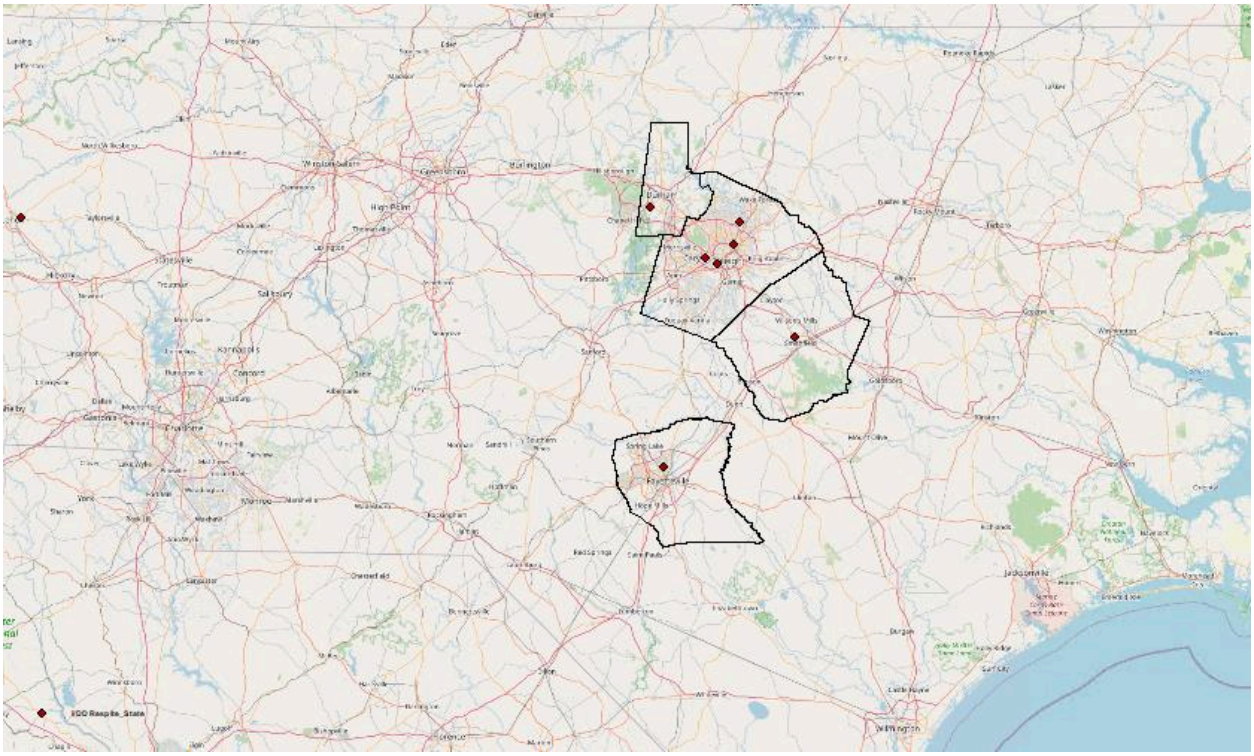

Detoxification (non-hospital)_State


Inpatient Hospital – Adult_State


Inpatient Hospital – Adolescent/Child_State

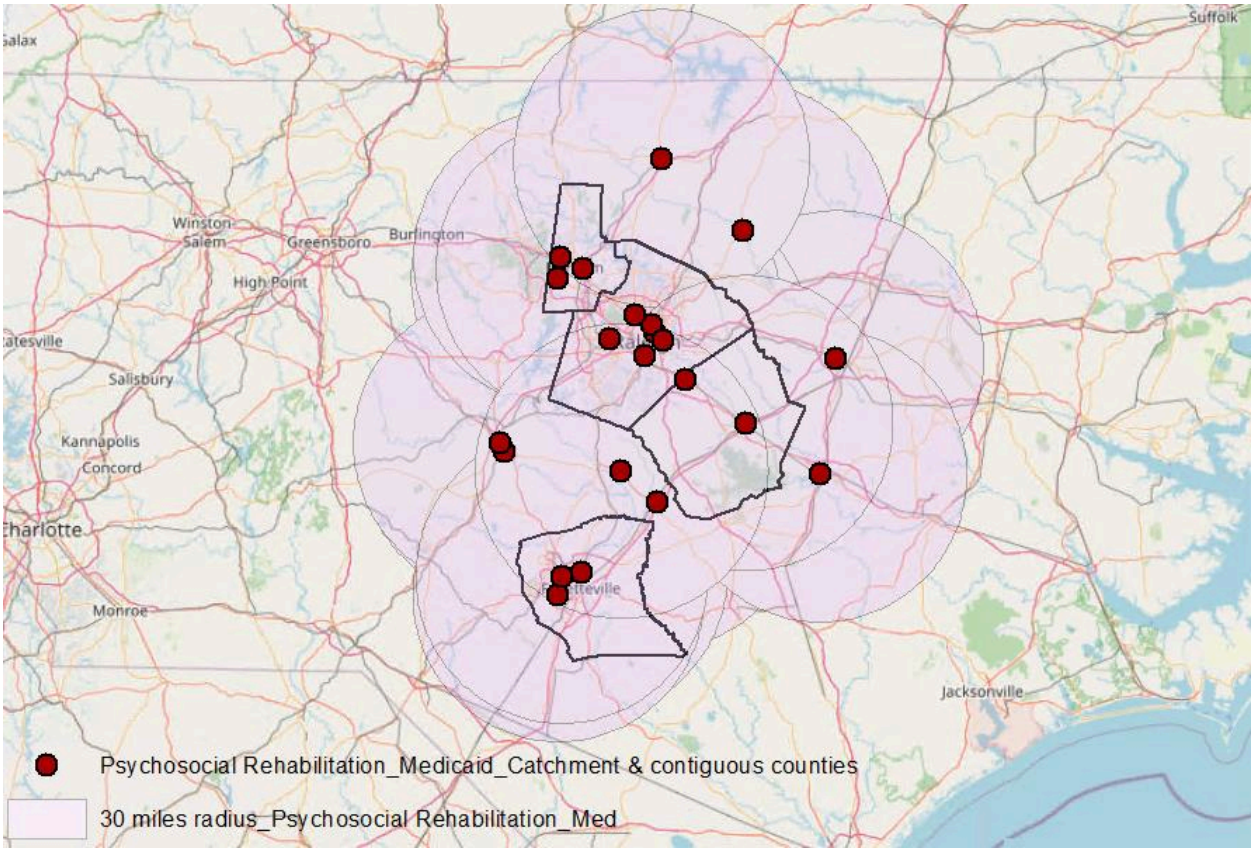

MH Group Homes_State


Child MH Out-of-home respite_State


IDD Respite_State

2021 Maps

Medicaid-Funded


Suffolk
Winston-Salem
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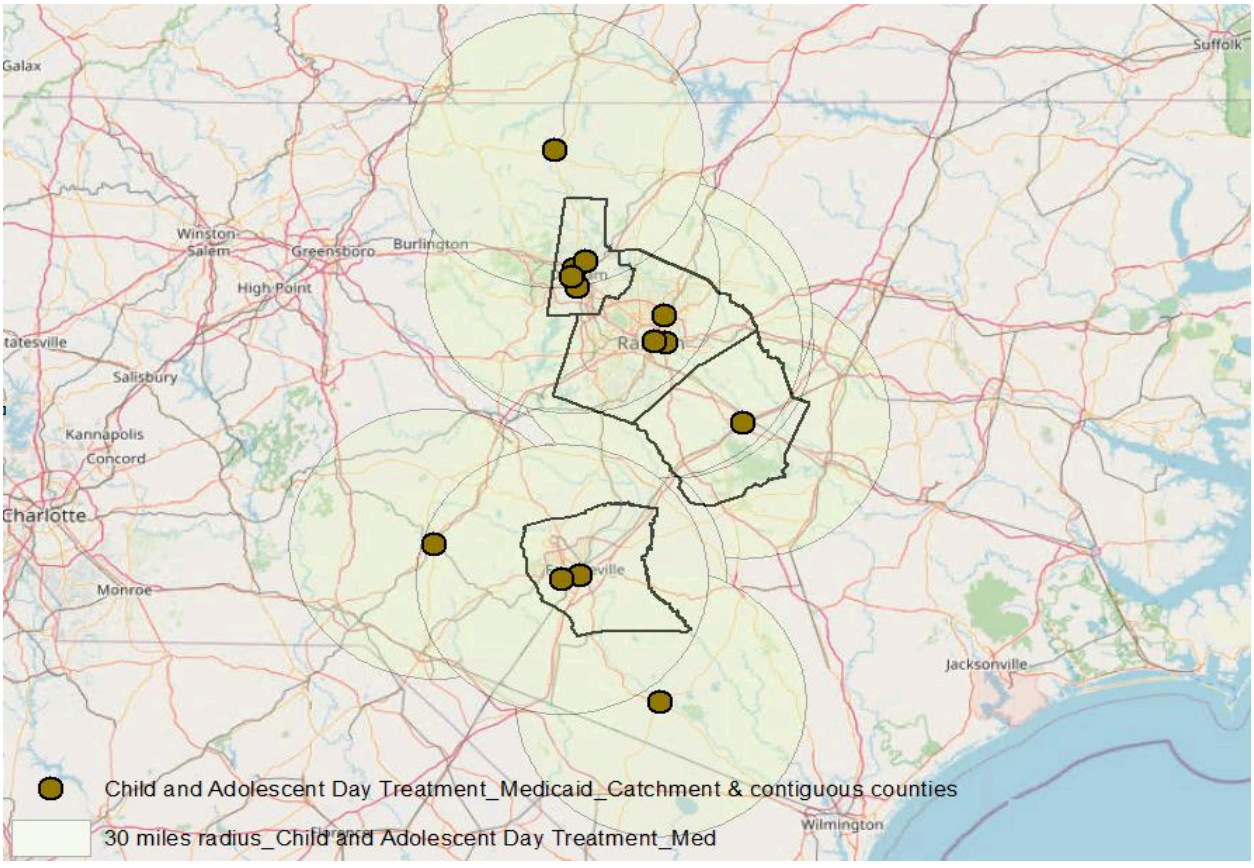
Salisbury
Kannapolis
Concord
Monroe
Jacksonville
Psychosocial Rehabilitation_Medicaid_Catchment & contiguous counties
30 miles radius_Psychosocial Rehabilitation_Med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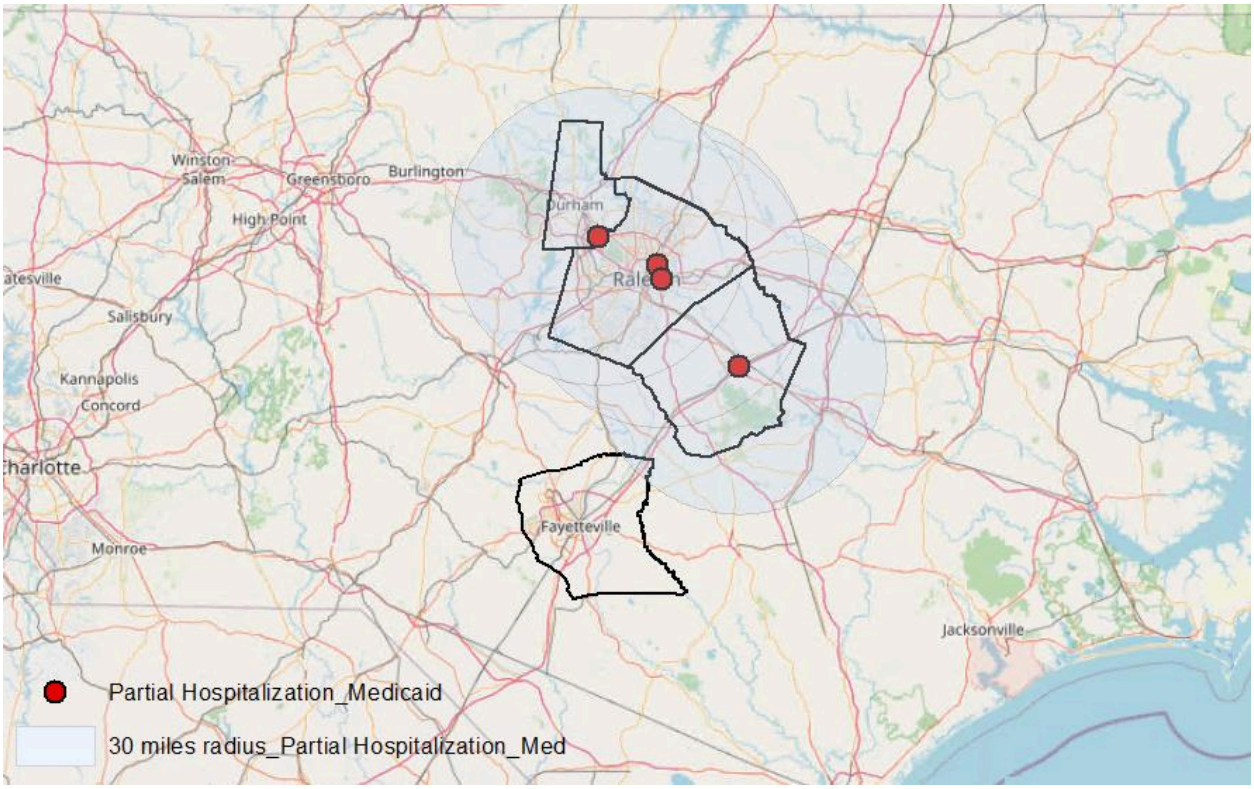
Jacksonville
Wilmington
Child and Adolescent Day Treatment_Medicaid_Catchment & contiguous counties
30 miles radius_Child and Adolescent Day Treatment_Med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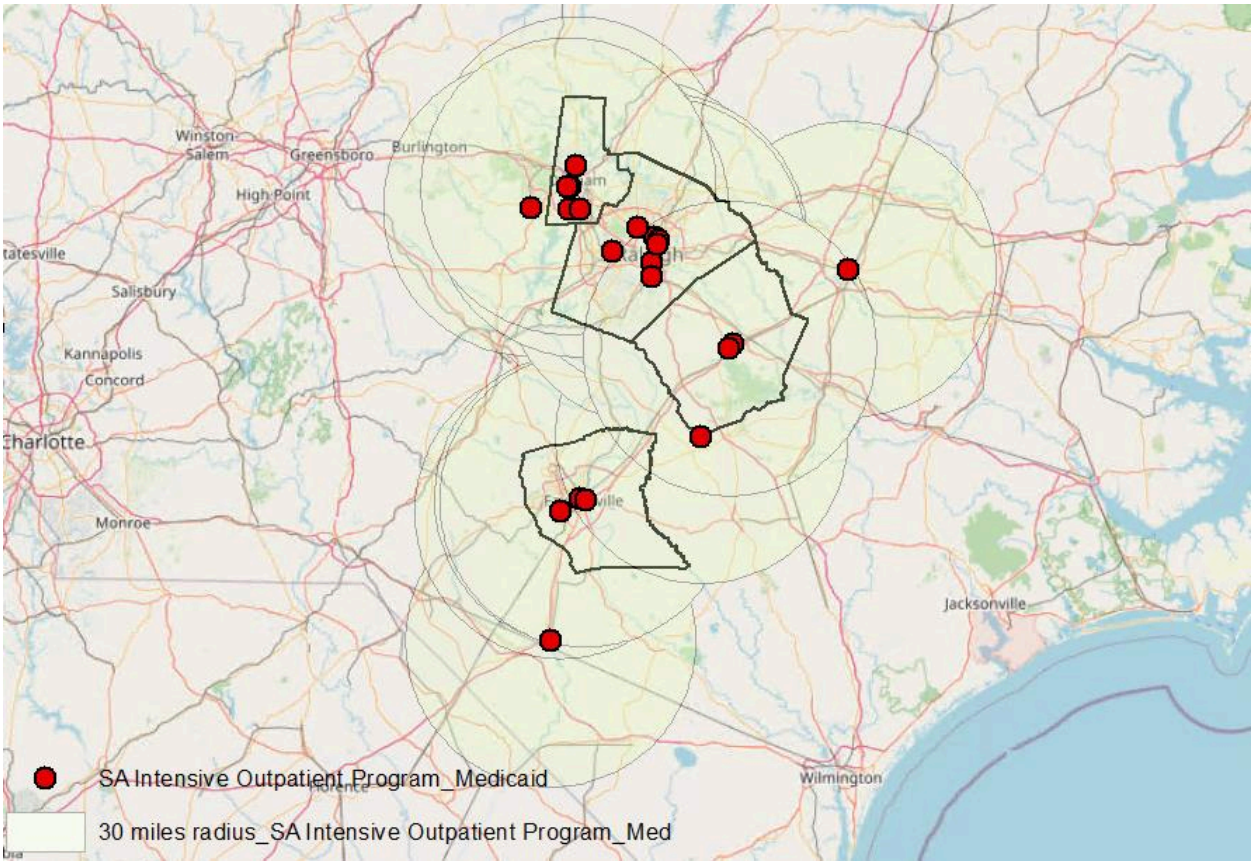
Fayetteville
Jacksonville
Partial Hospitalization_Medicaid
30 miles radius_Partial Hospitalization_Med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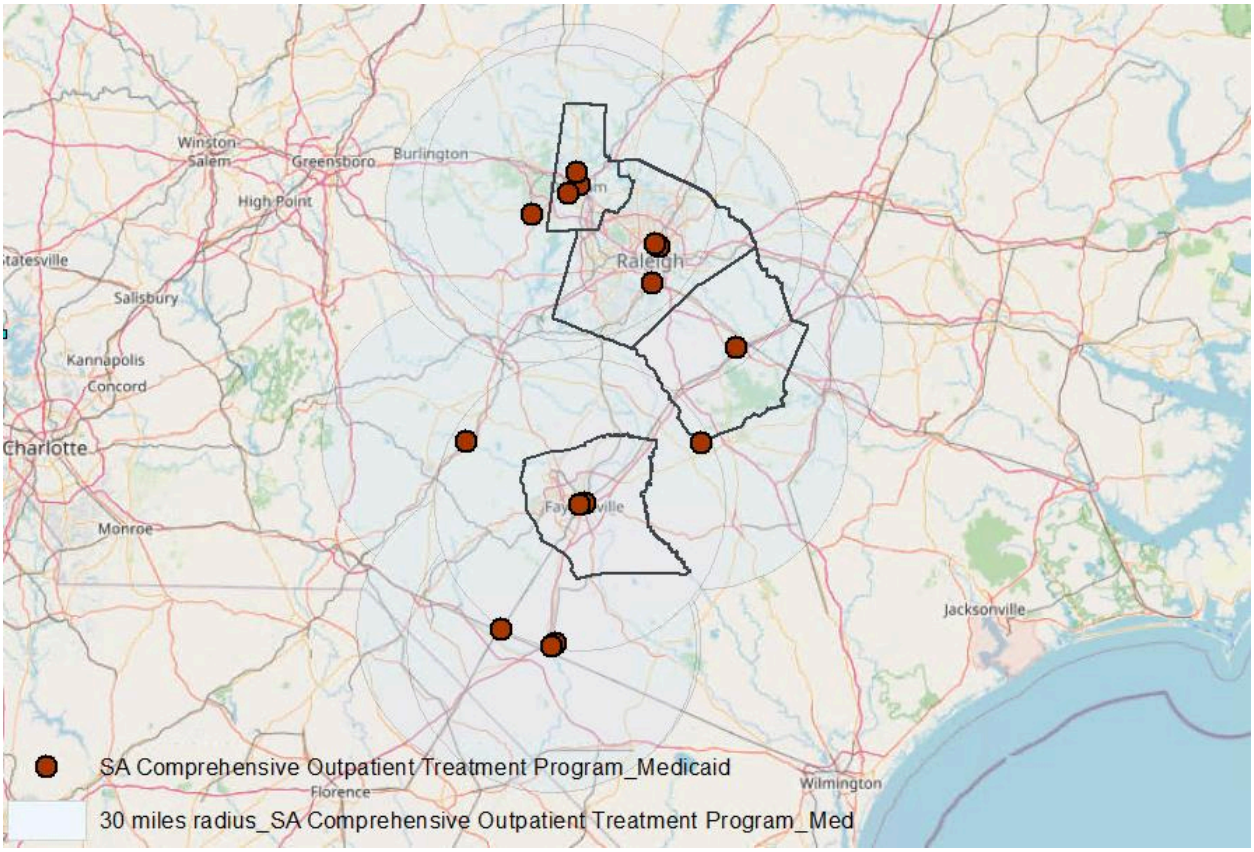
Wilmington
SA Intensive Outpatient Program_Medicaid
30 miles radius_SA Intensive Outpatient Program_Med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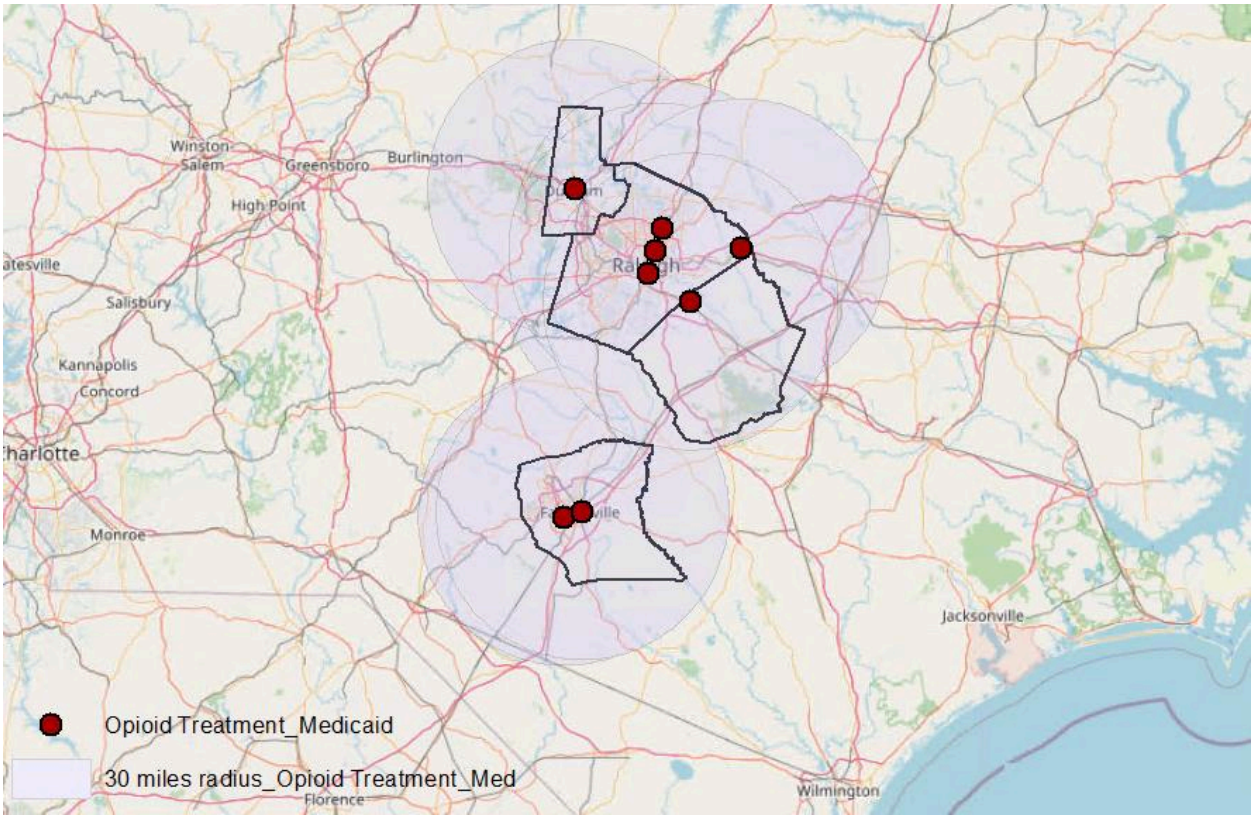
Monroe
Jacksonville
Wilmington
Florence
SA Comprehensive Outpatient Treatment Program_Medicaid
30 miles radius_SA Comprehensive Outpatient Treatment Program_Med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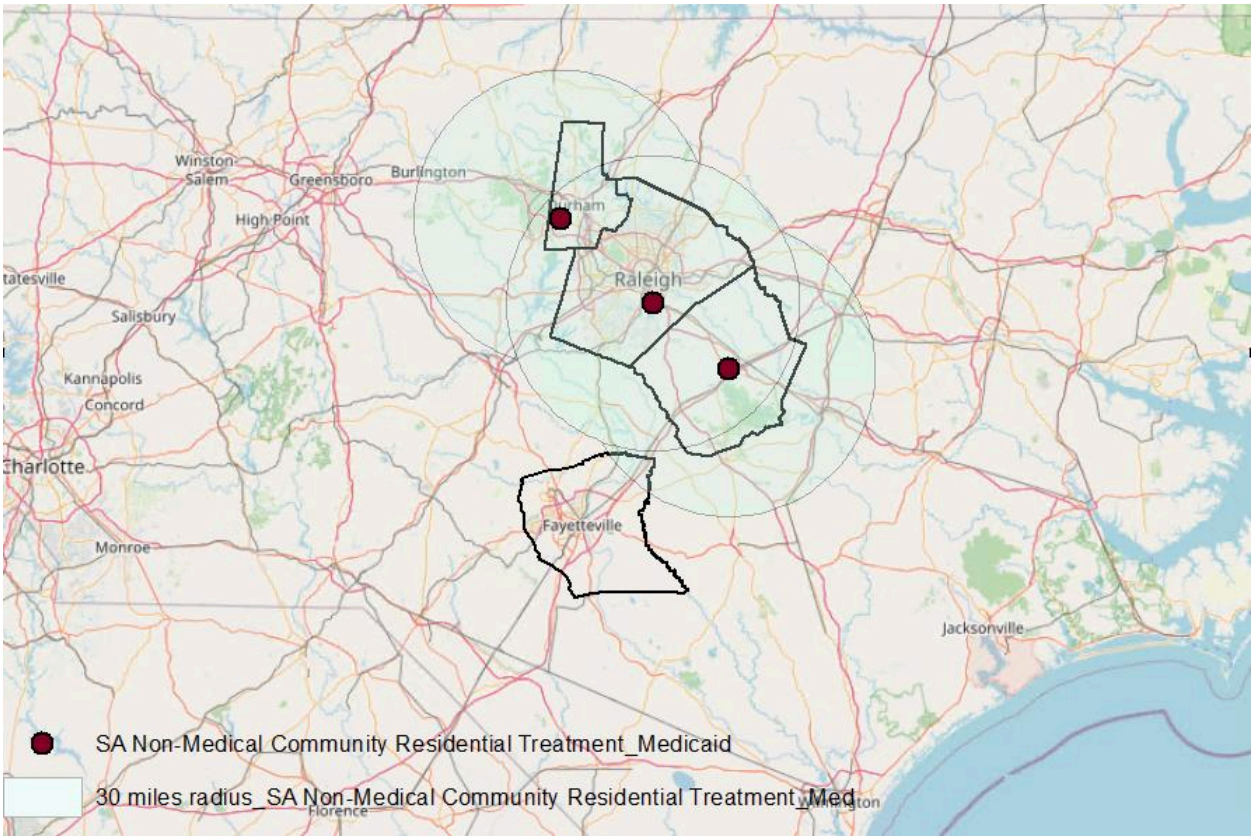
Florence
Opioid Treatment_Medicaid
30 miles radius_Opioid Treatment_Med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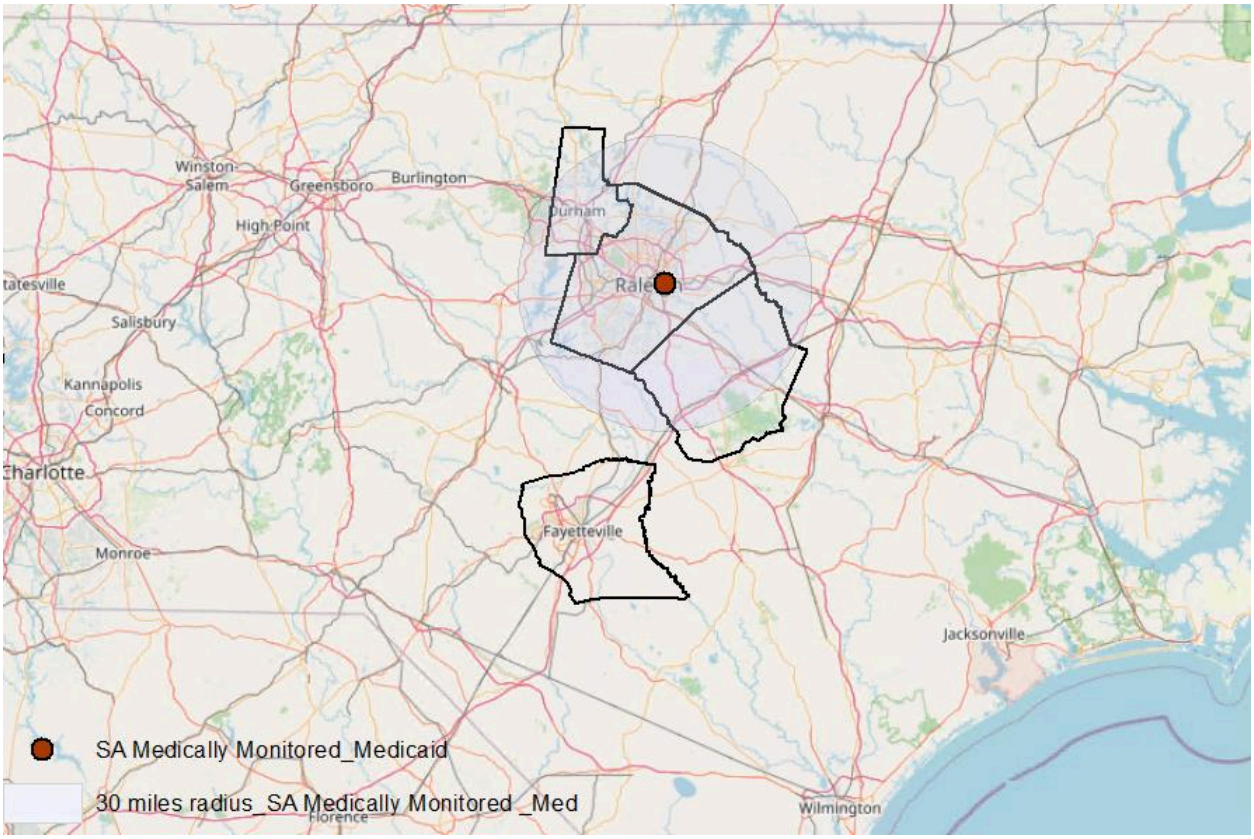
Fayetteville
Monroe
Jacksonville
SA Non-Medical_Community Residential Treatment_Medicaid
30 miles radius_SA Non-Medical Community Residential Treatment_Med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Charlotte
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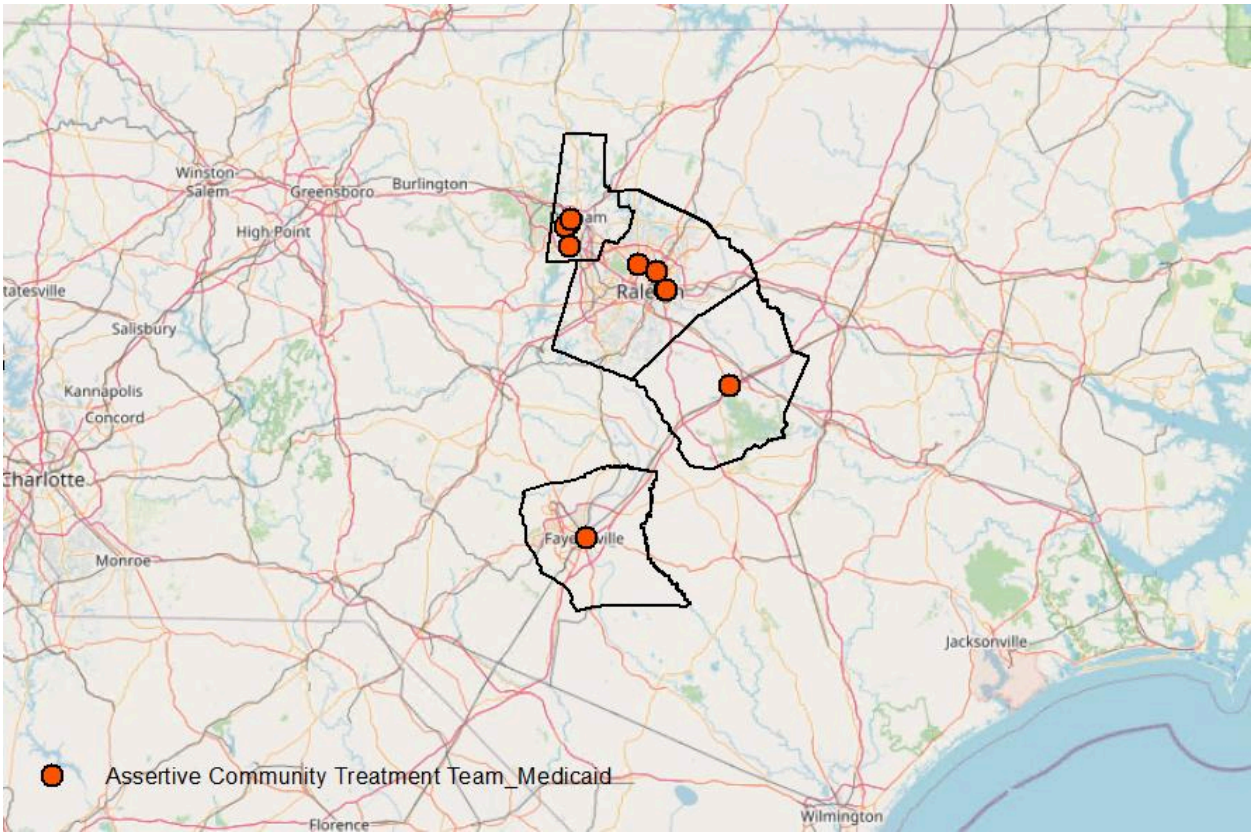
Monroe
Jacksonville
Wilmington
SA Medically Monitored_Medicaid
30 miles radius_SA Medically Monitored _Med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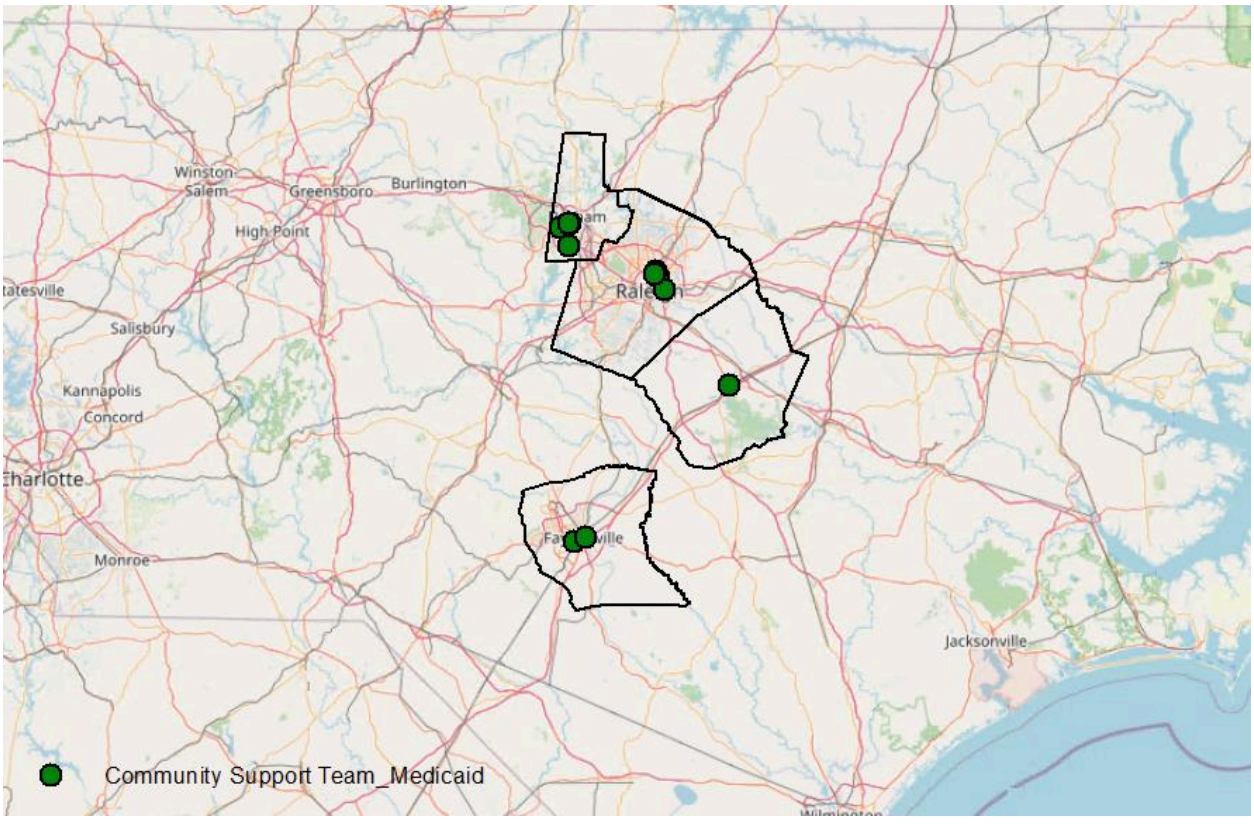
Wilmington
Florence
Assertive Community Treatment Team_Medicaid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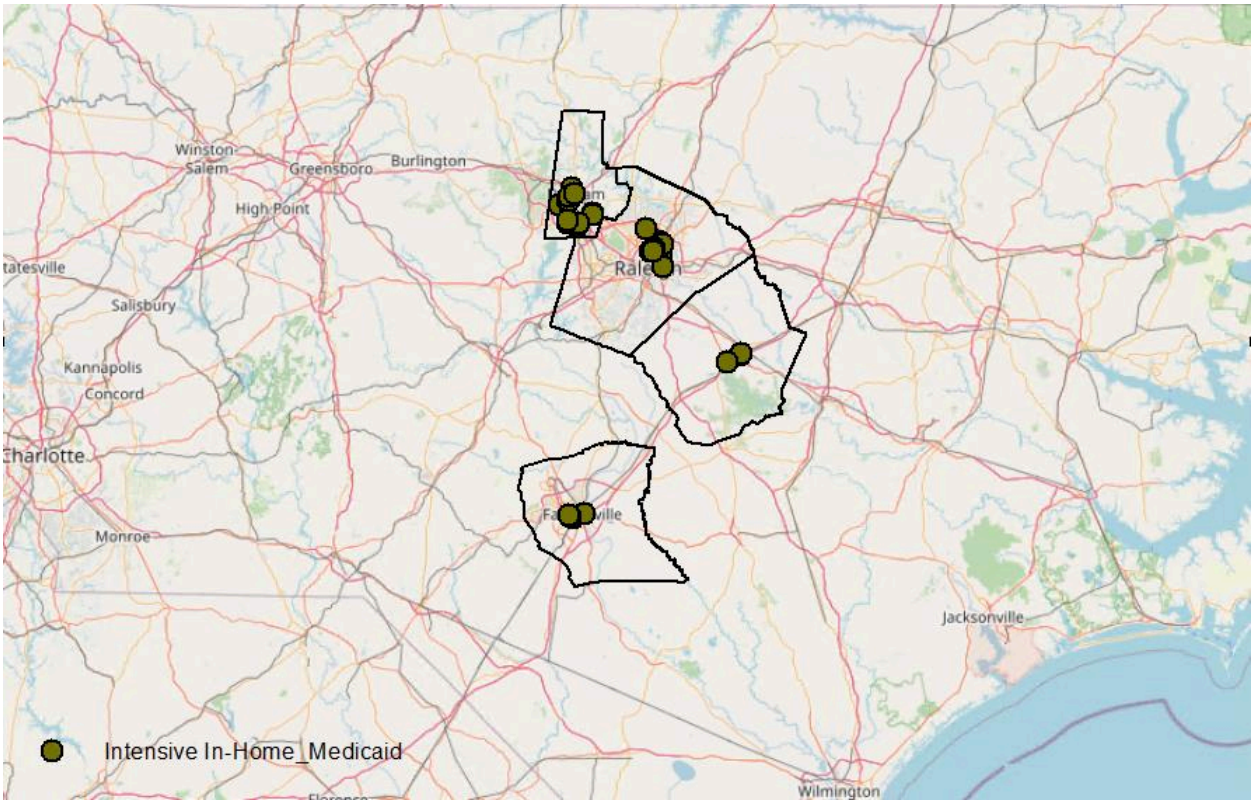
Jacksonville
Community Support Team_Medicaid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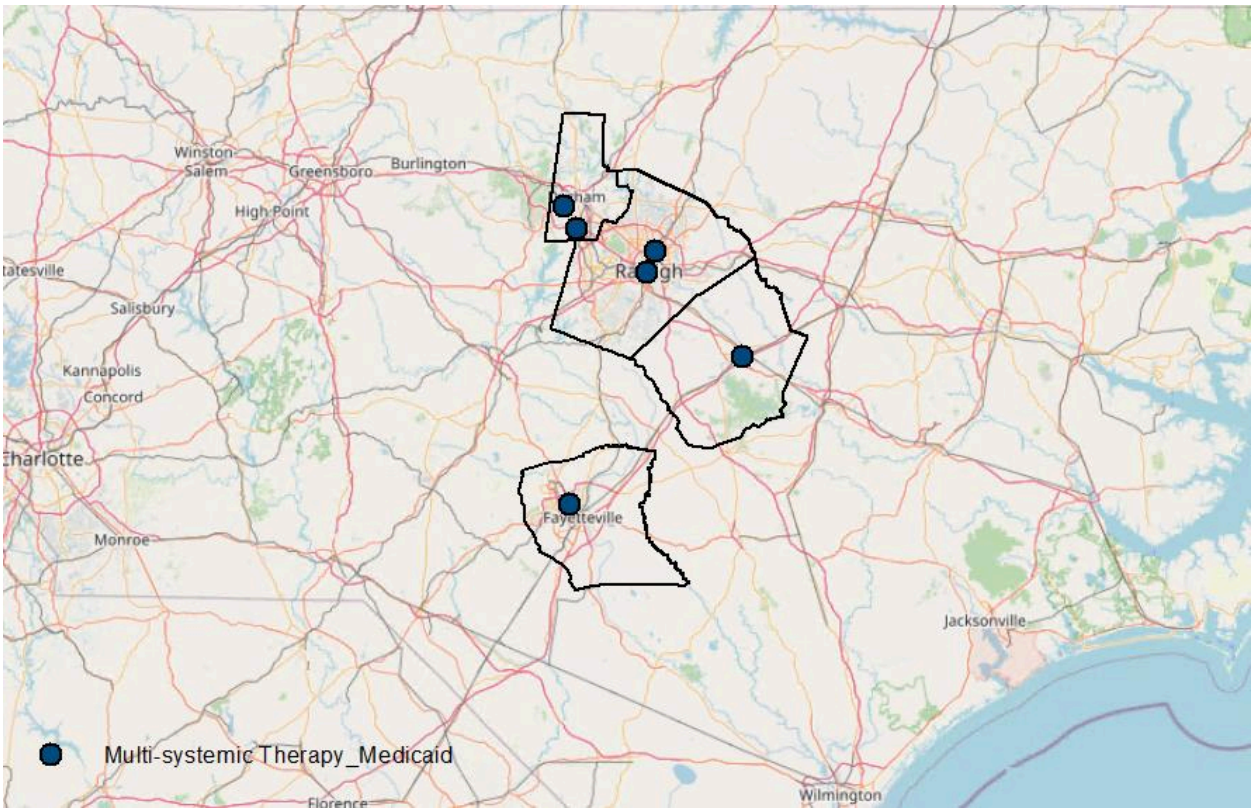
Wilmington
Intensive In-Home_Medicaid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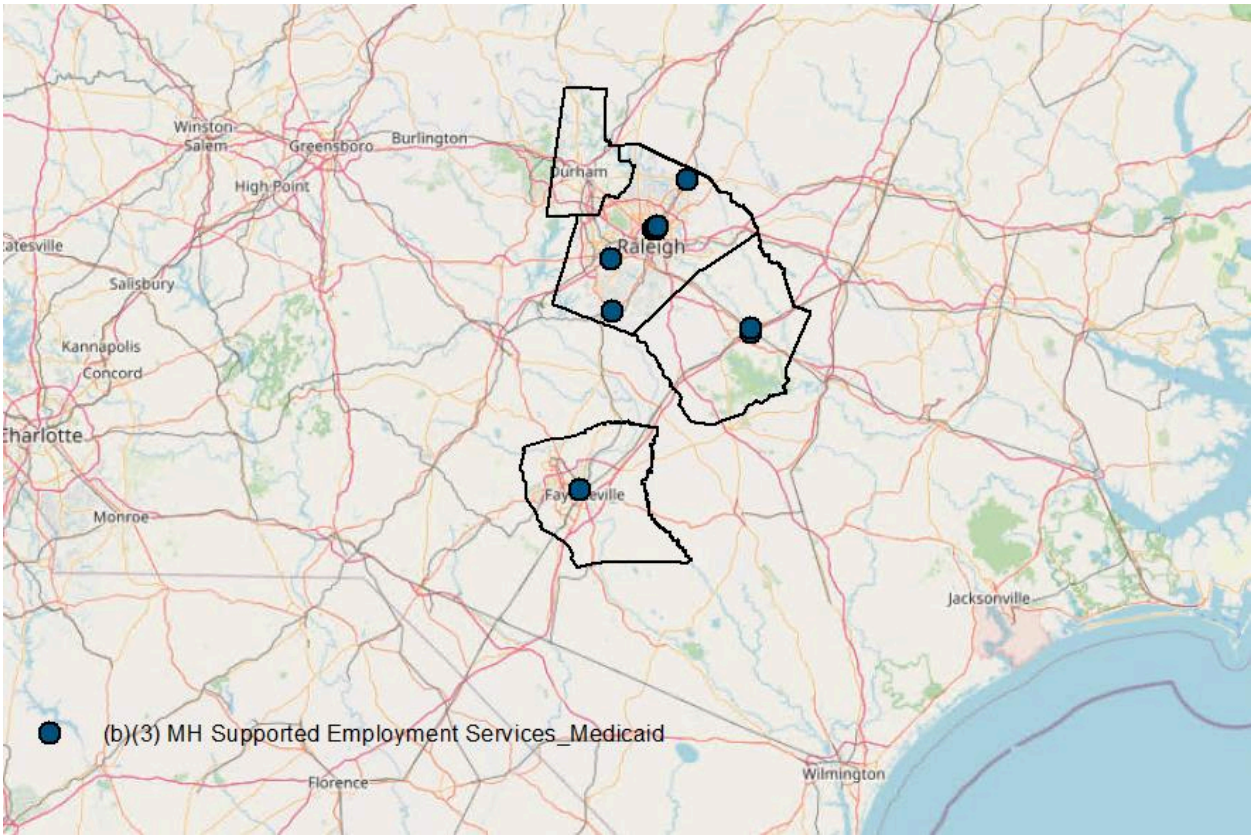
Wilmington
Multi-systemic Therapy_Medicaid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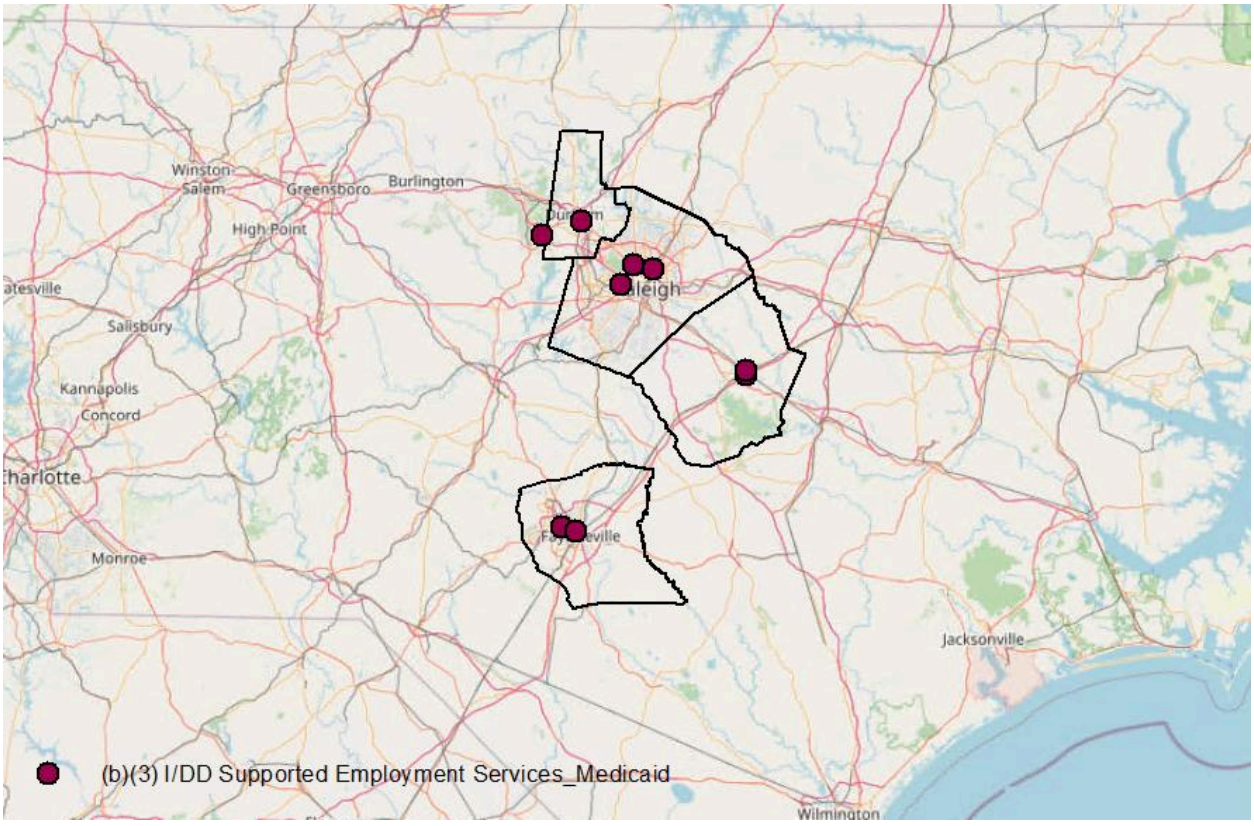
Florence
Wilmington
(b)(3) MH Supported Employment Services_Medicaid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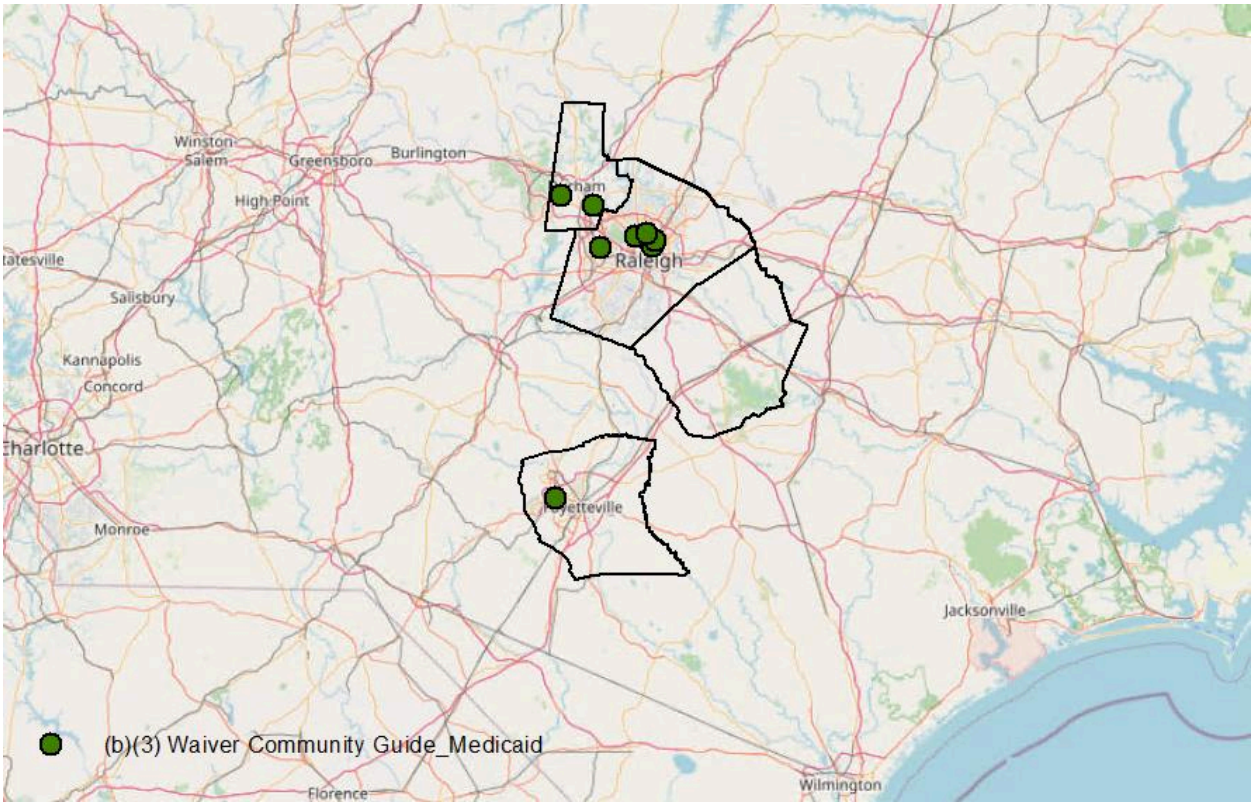
(b)(3) I/DD Supported Employment Services_Medicaid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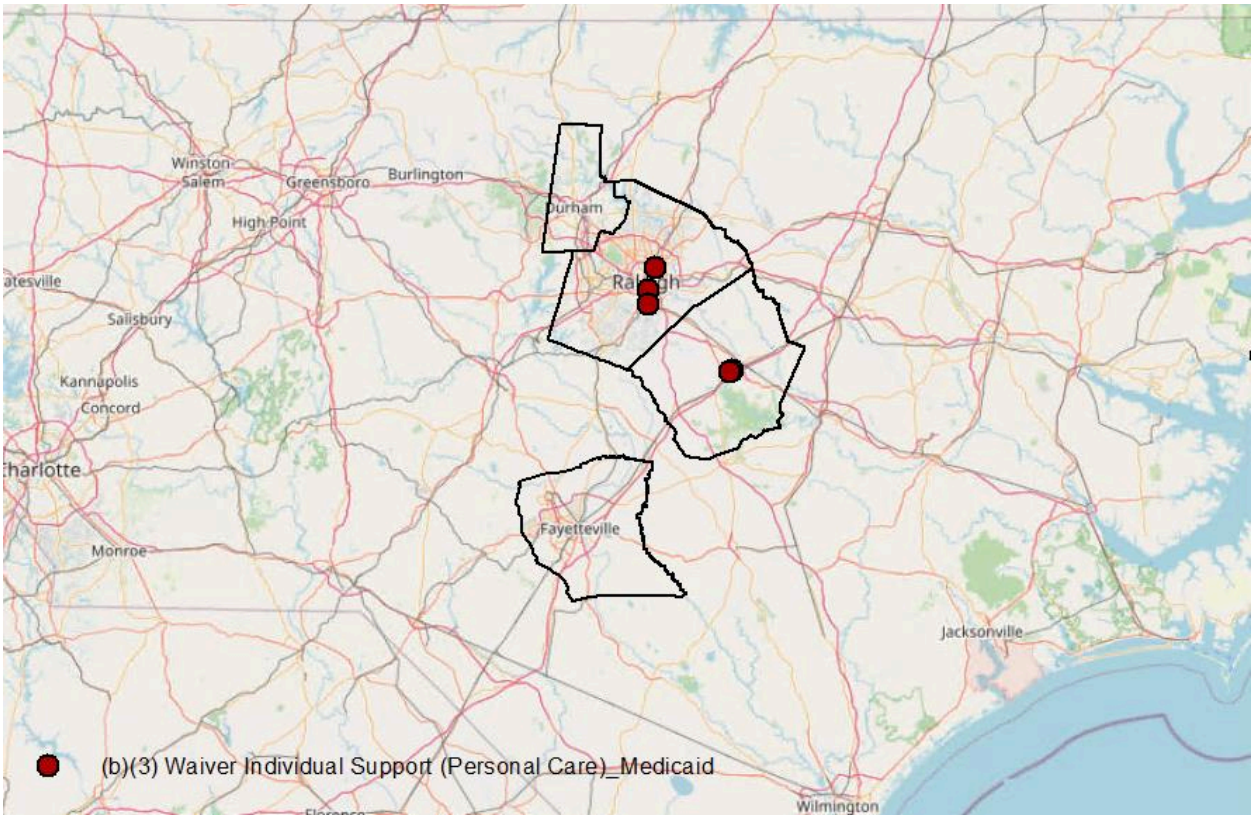
Jacksonville
Florence
Wilmington
(b)(3) Waiver Community Guide_Medicaid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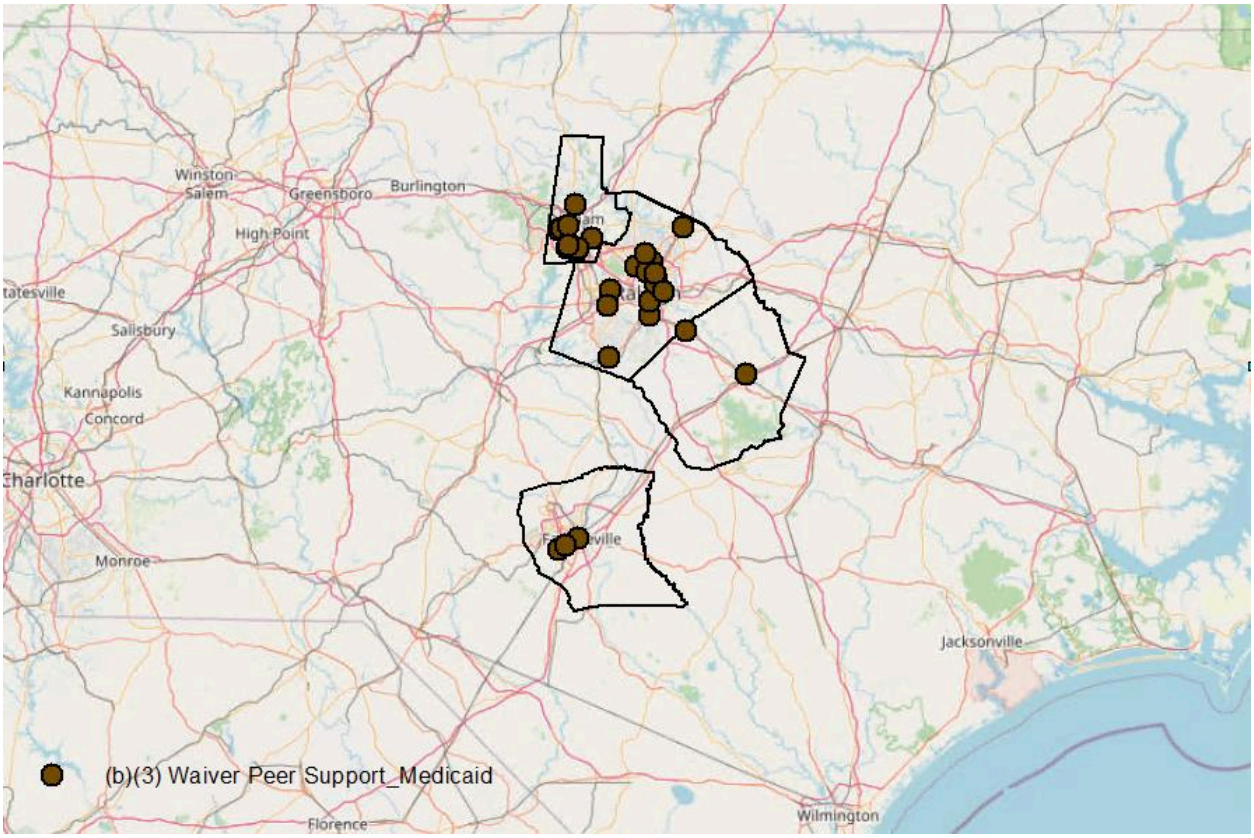
(b)(3) Waiver Individual Support (Personal Care)_Medicaid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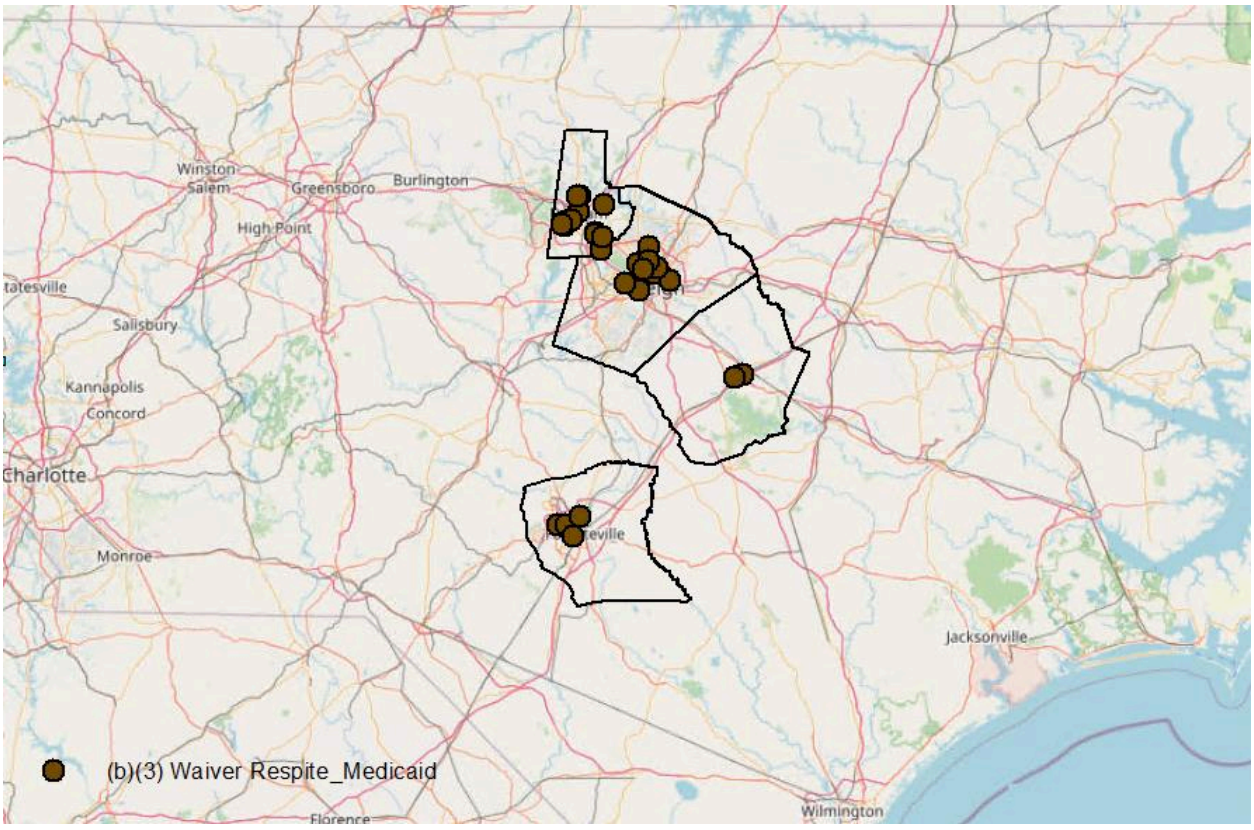
Florence
(b)(3) Waiver Peer Support_Medicaid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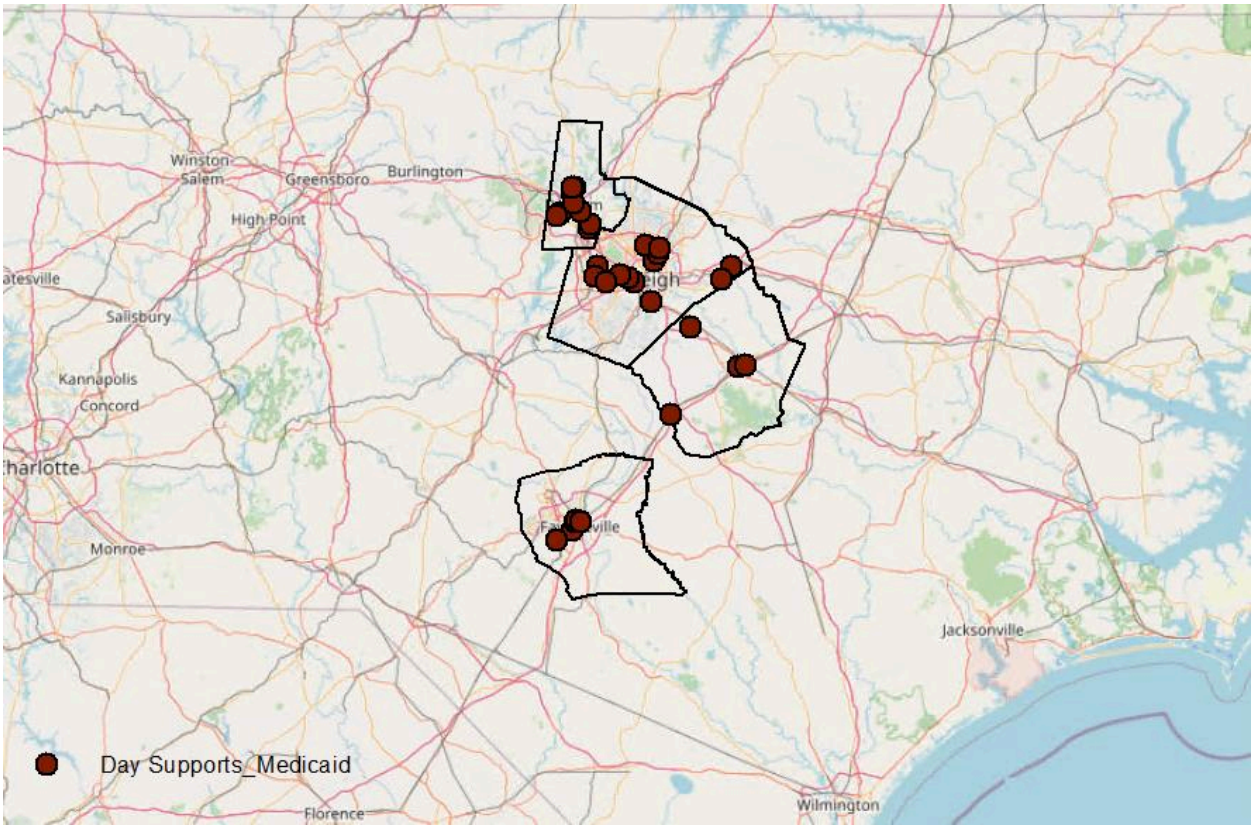
Florence
(b)(3) Waiver Respite_Medicaid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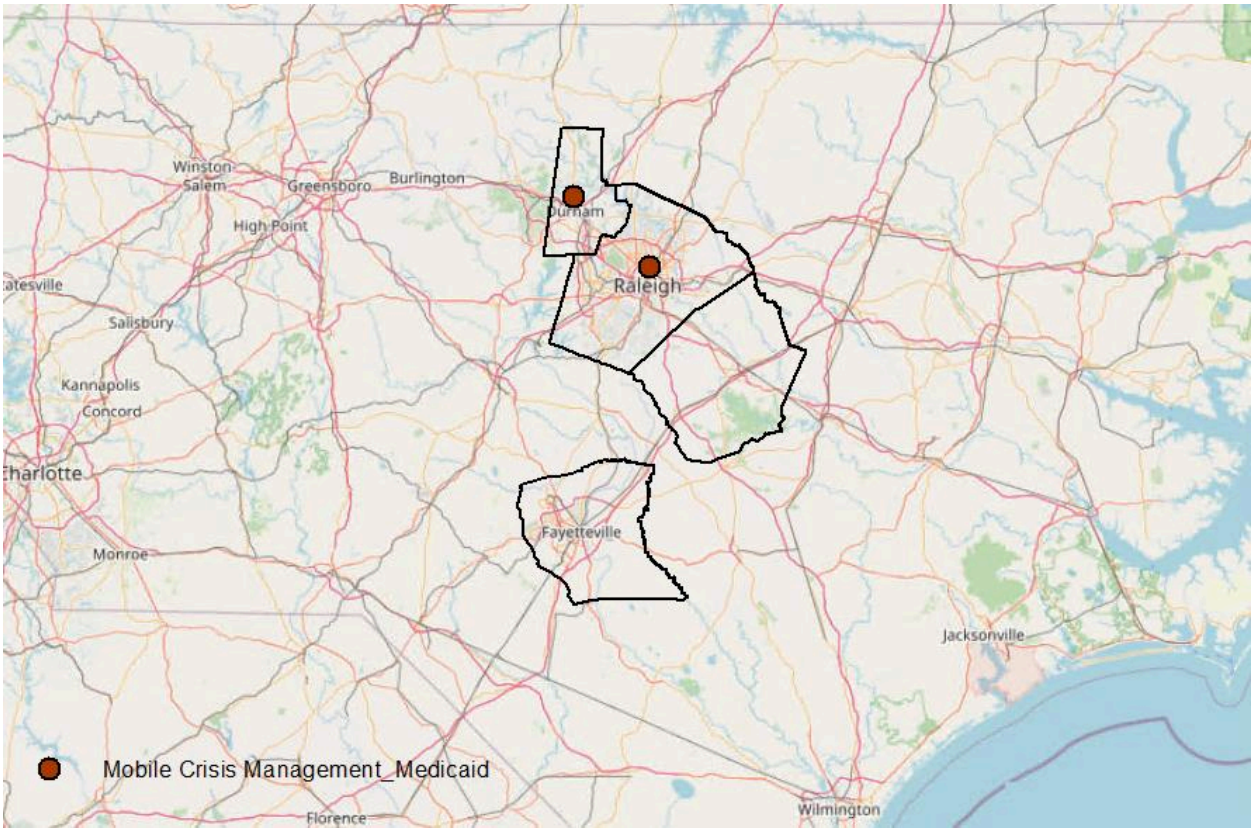
Wilmington
Florence
Day Supports_Medicaid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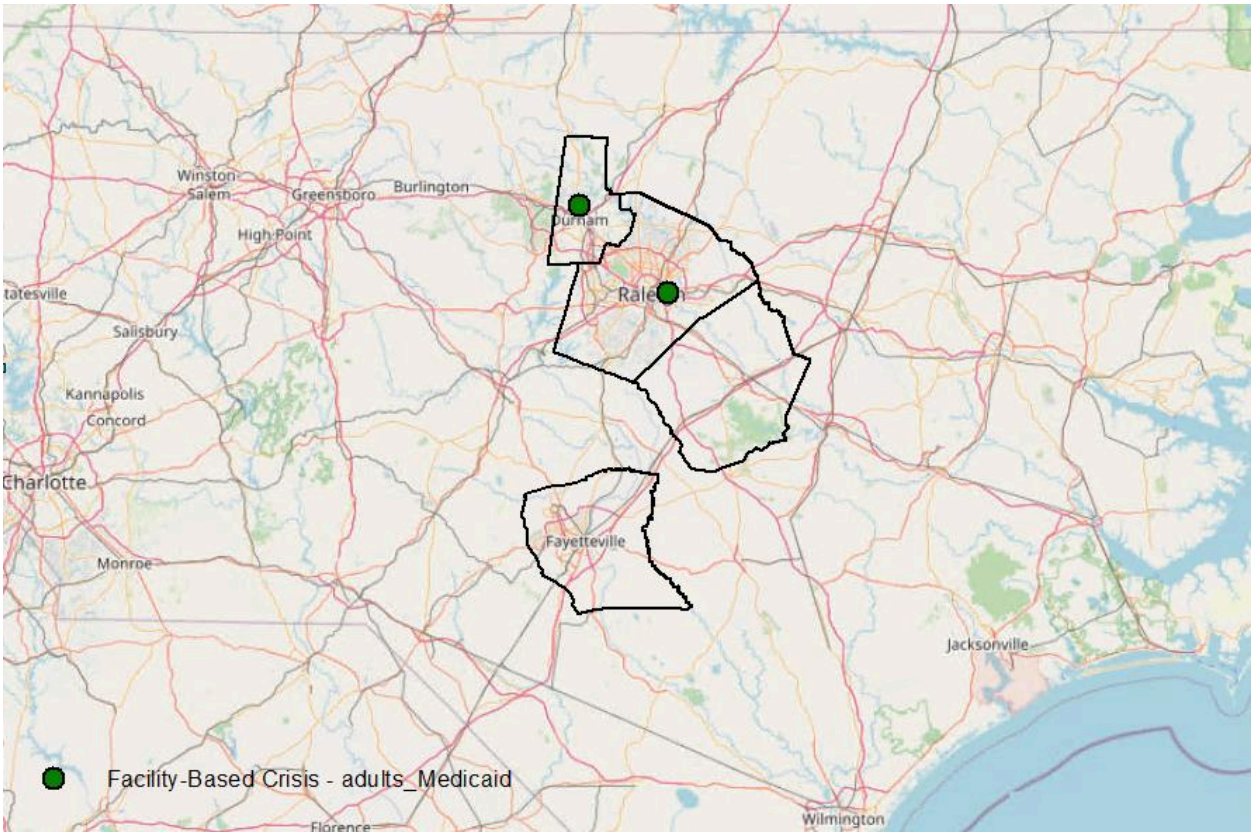
Jacksonville
Wilmington
Florence
Mobile Crisis Management_Medicaid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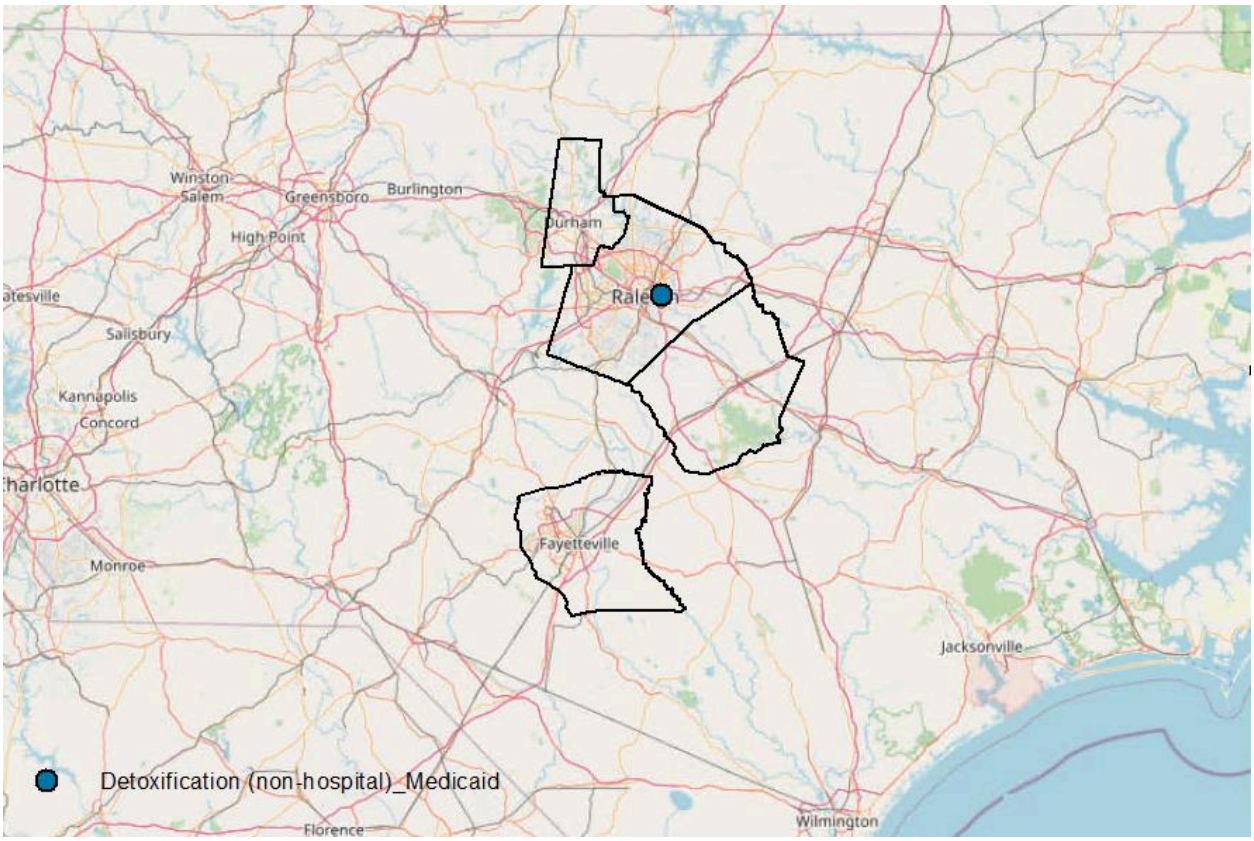
Fayetteville
Monroe
Jacksonville
Wilmington
Florence
Facility-Based Crisis - adults_Medicaid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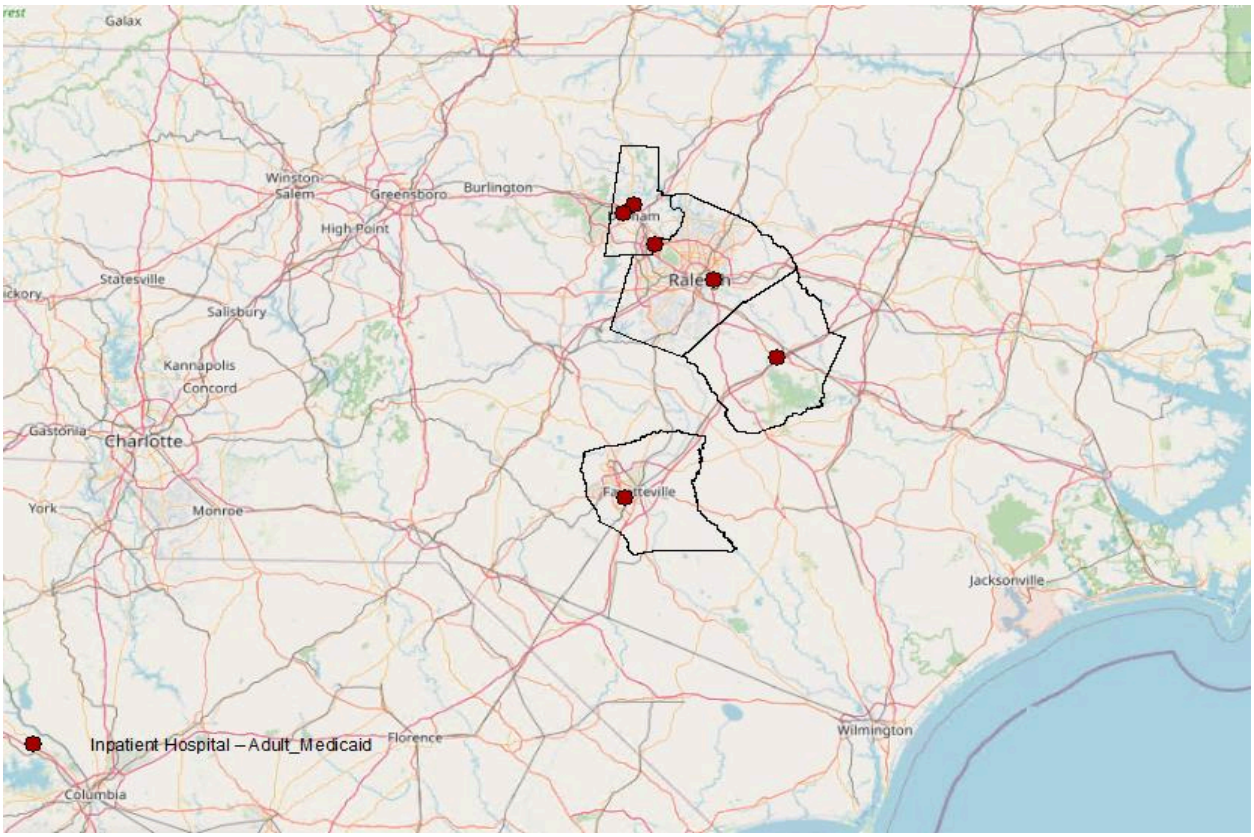
Fayetteville
Monroe
Jacksonville
Wilmington
Florence
Detoxification (non-hospital)_Medicaid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Greensboro
Burlington
High Point
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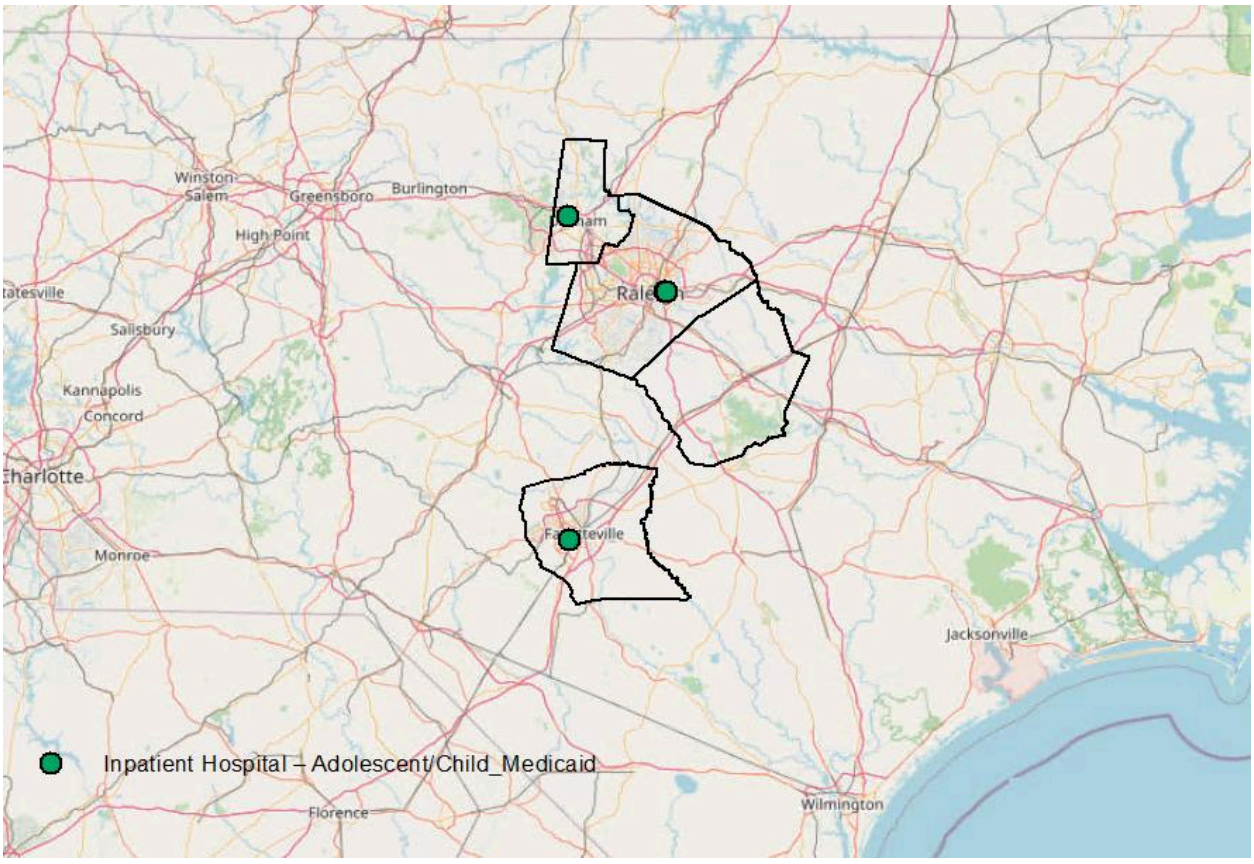
Concord
Gastonia
Charlotte
York
Monroe
Jacksonville
Florence
Wilmington
Columbia
Inpatient Hospital – Adult_Medicaid


Winston-Salem
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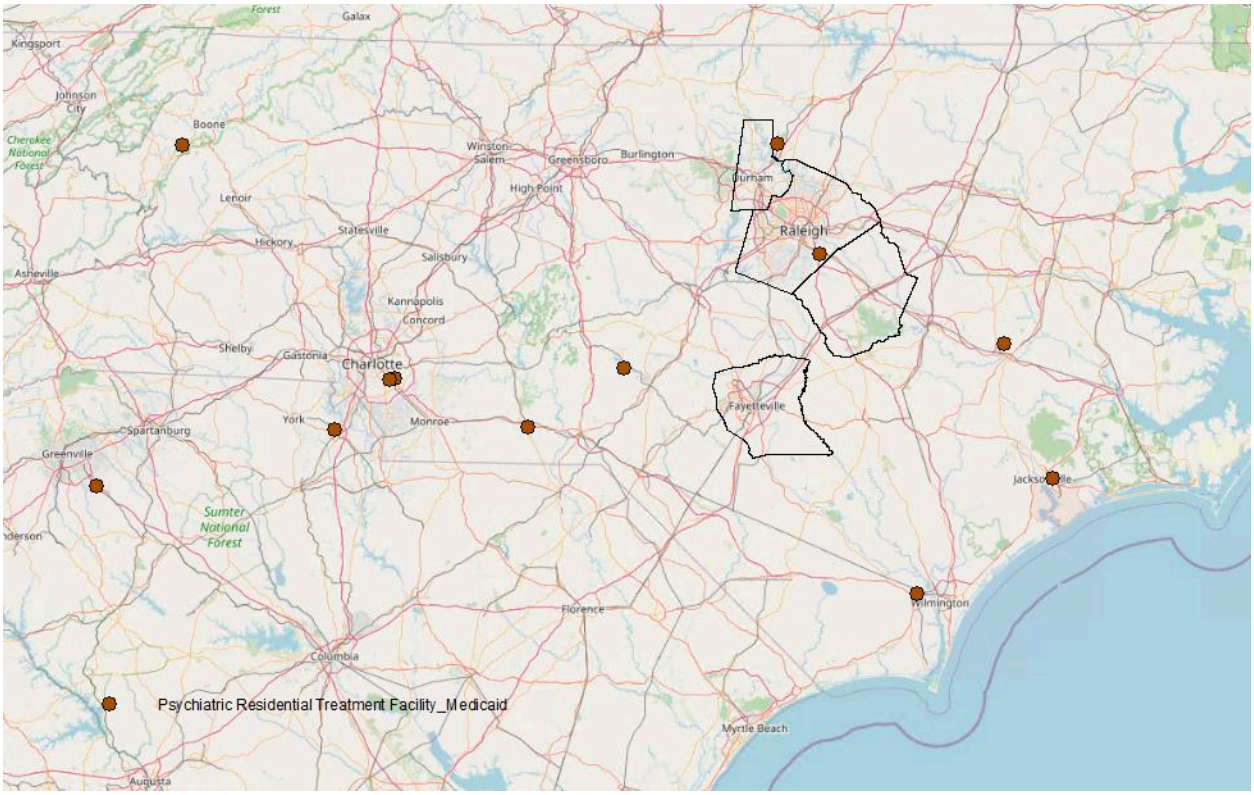
Jacksonville
Florence
Wilmington
Inpatient Hospital – Adolescent/Child_Medicaid


Psychiatric Residential Treatment Facility_Medicaid
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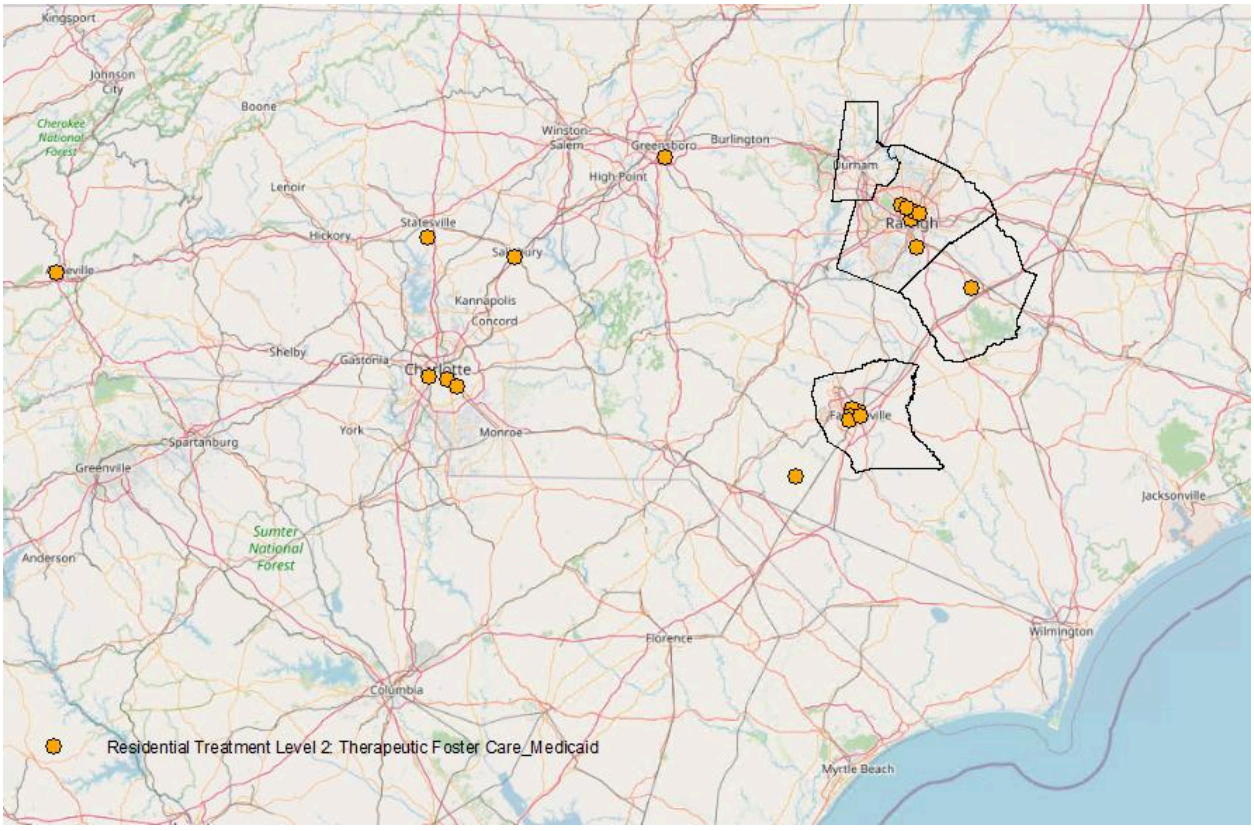
Charlotte
Fayetteville
Wilmington
Jacksonville
Myrtle Beach
Florence
Columbia
Augusta
Greenville
Spartanburg
Asheville
Boone
Lenoir
Hickory
Statesville
Salisbury
Kannapolis
Concord
Shelby
Gastonia
York
Monroe
Winston-Salem
Greensboro
Burlington
High Point
Sumter National Forest
Cherokee National Forest


Residential Treatment Level 2: Therapeutic Foster Care_Medicaid
Durham
Jacksonville
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Myrtle Beach
Florence
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Anderson
Greenville
Spartanburg
Asheville
Boone
Lenoir
Hickory
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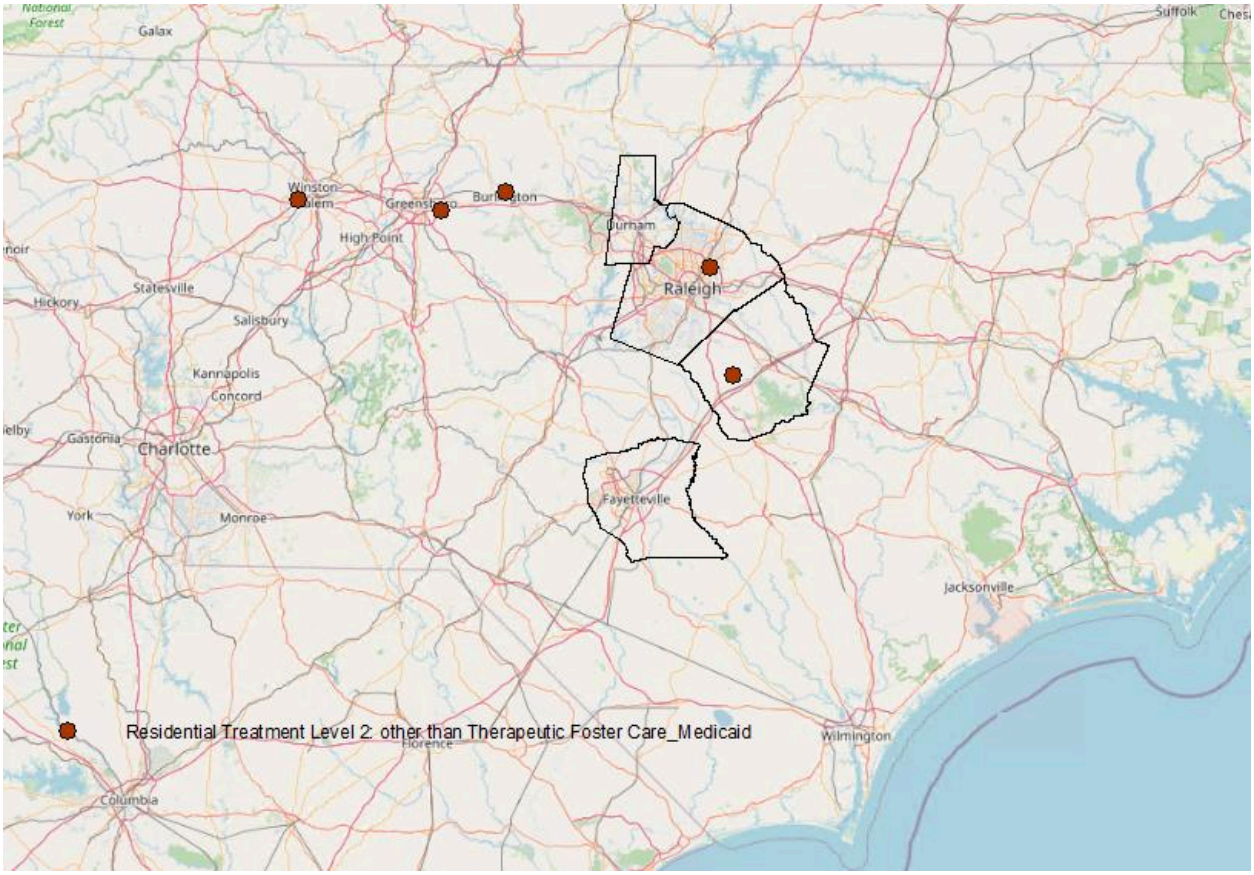
Greensboro
Burlington
High Point
Sumter National Forest
Cherokee National Forest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Greensboro
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Statesville
Hickory
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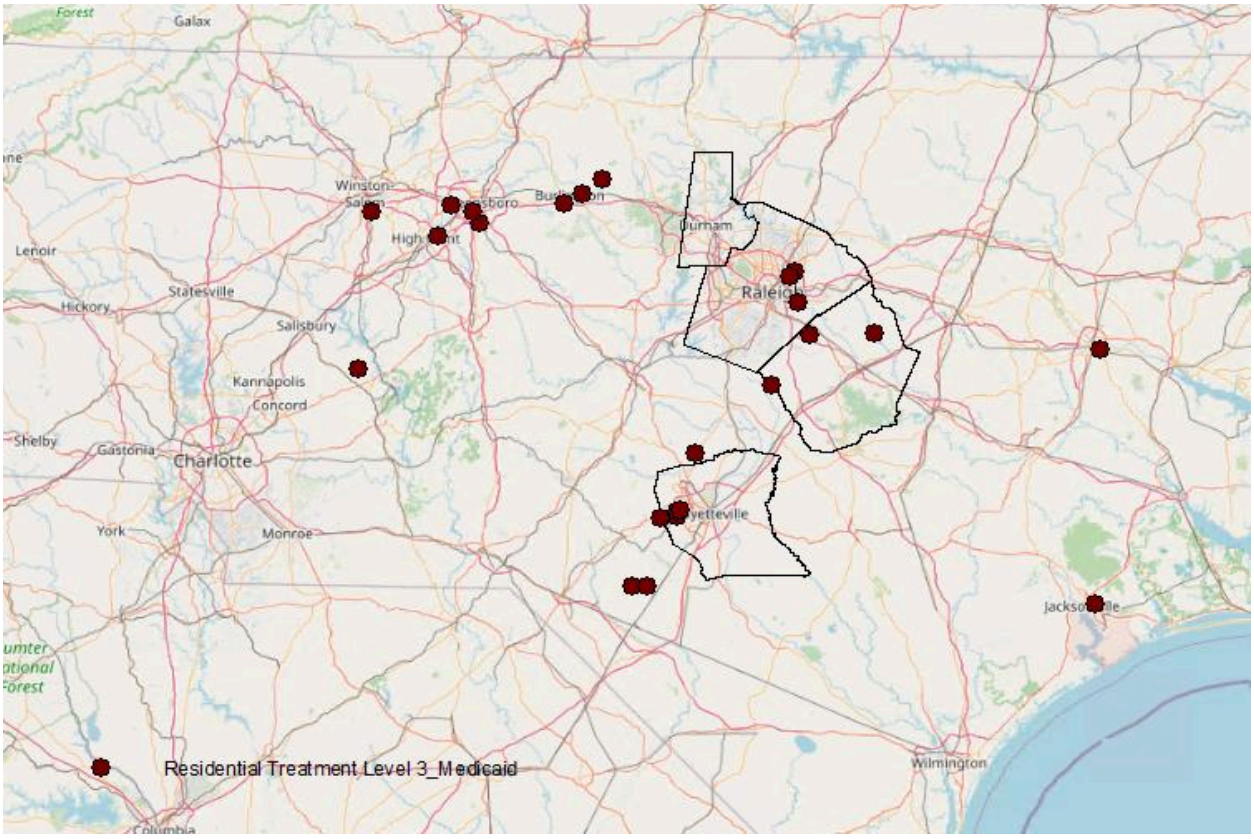
Florence
Columbia
Residential Treatment Level 2: other than Therapeutic Foster Care_Medicaid


Galax
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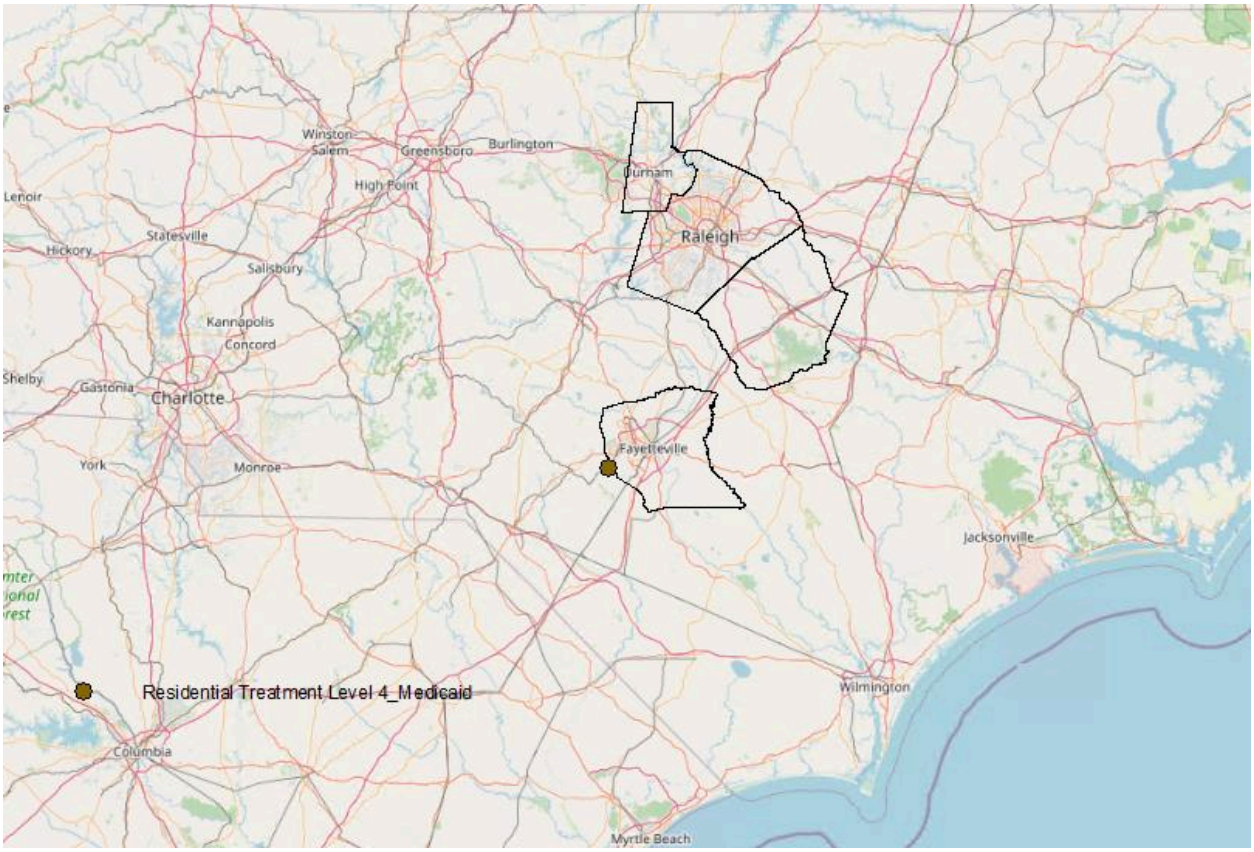
Raleigh
Wilmington
Residential Treatment Level 3_Medicaid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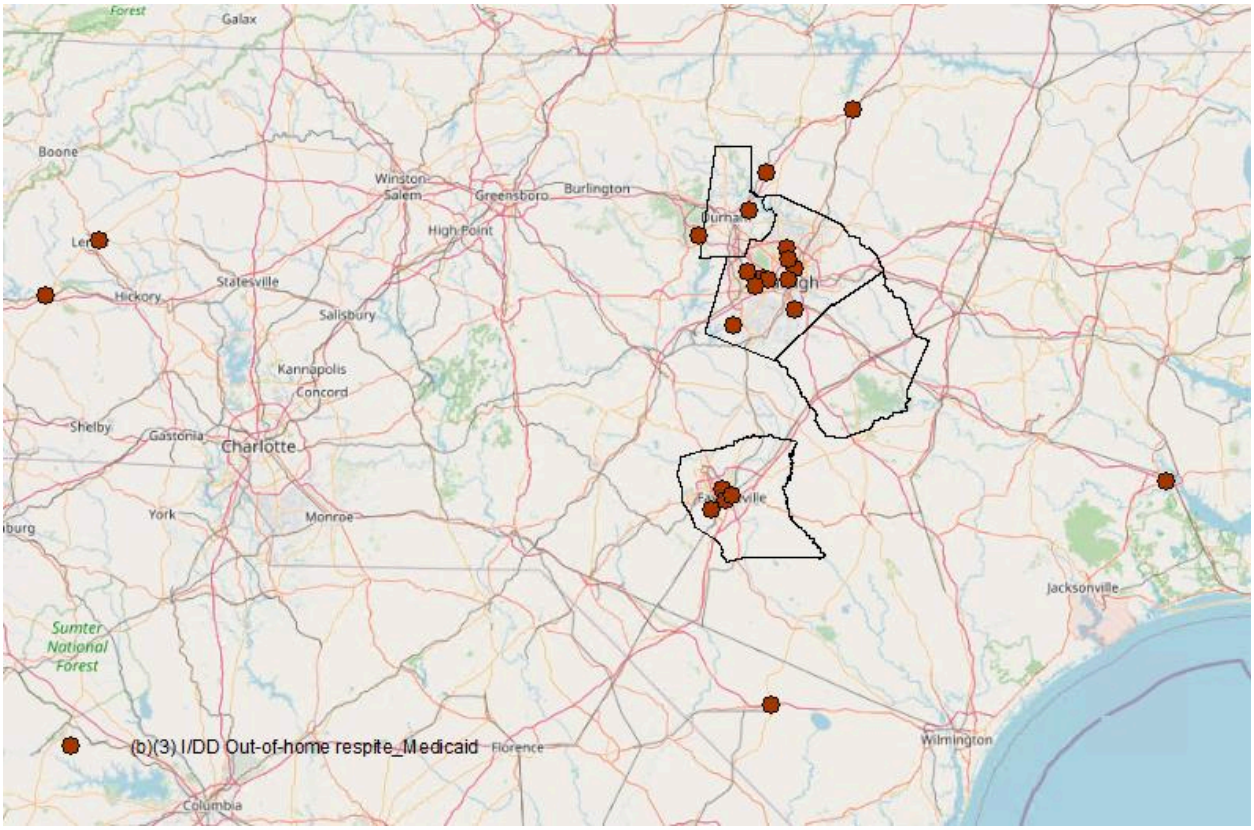
Jacksonville
Residential Treatment Level 4_Medicaid
Wilmington
Columbia
Myrtle Beach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Hickory
Salisbury
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Concord
Shelby
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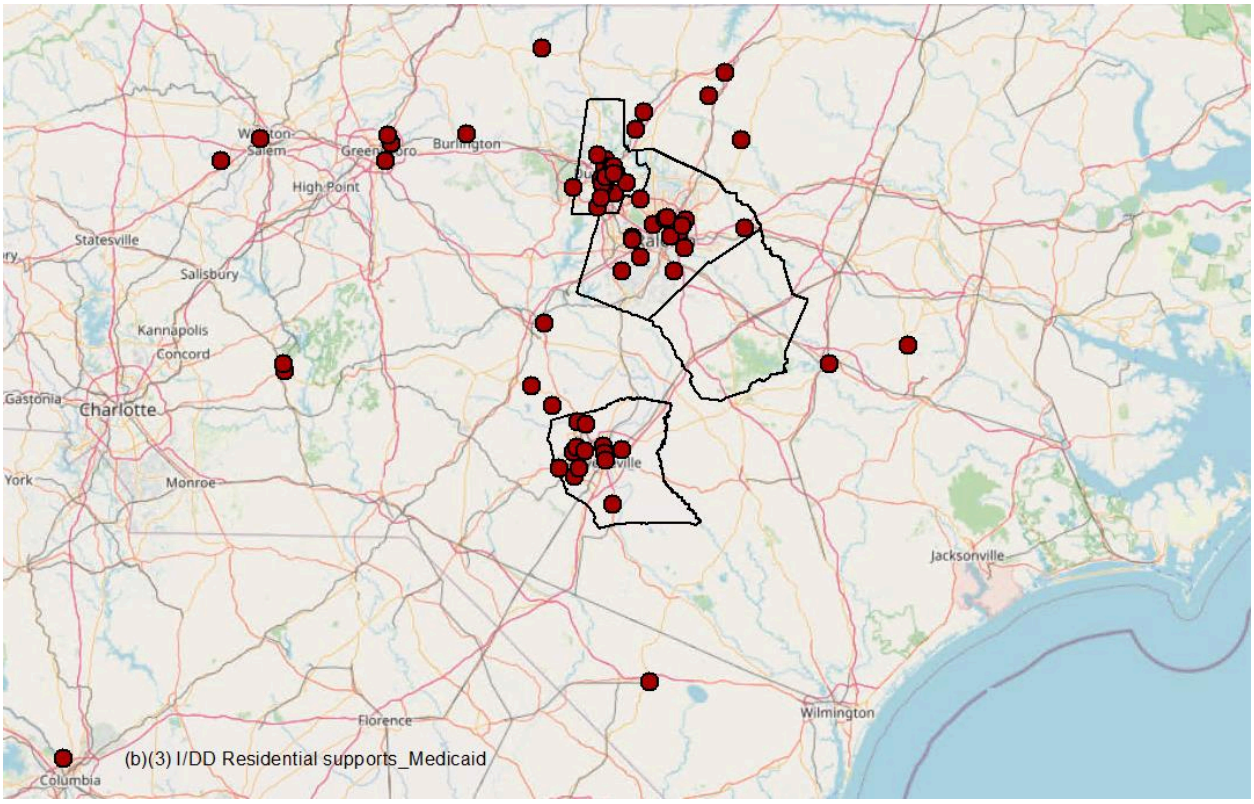
York
Monroe
Sumter National Forest
Jacksonville
(b)(3) I/DD Out-of-home respite_Medicaid
Florence
Wilmington
Columbia


Statesville
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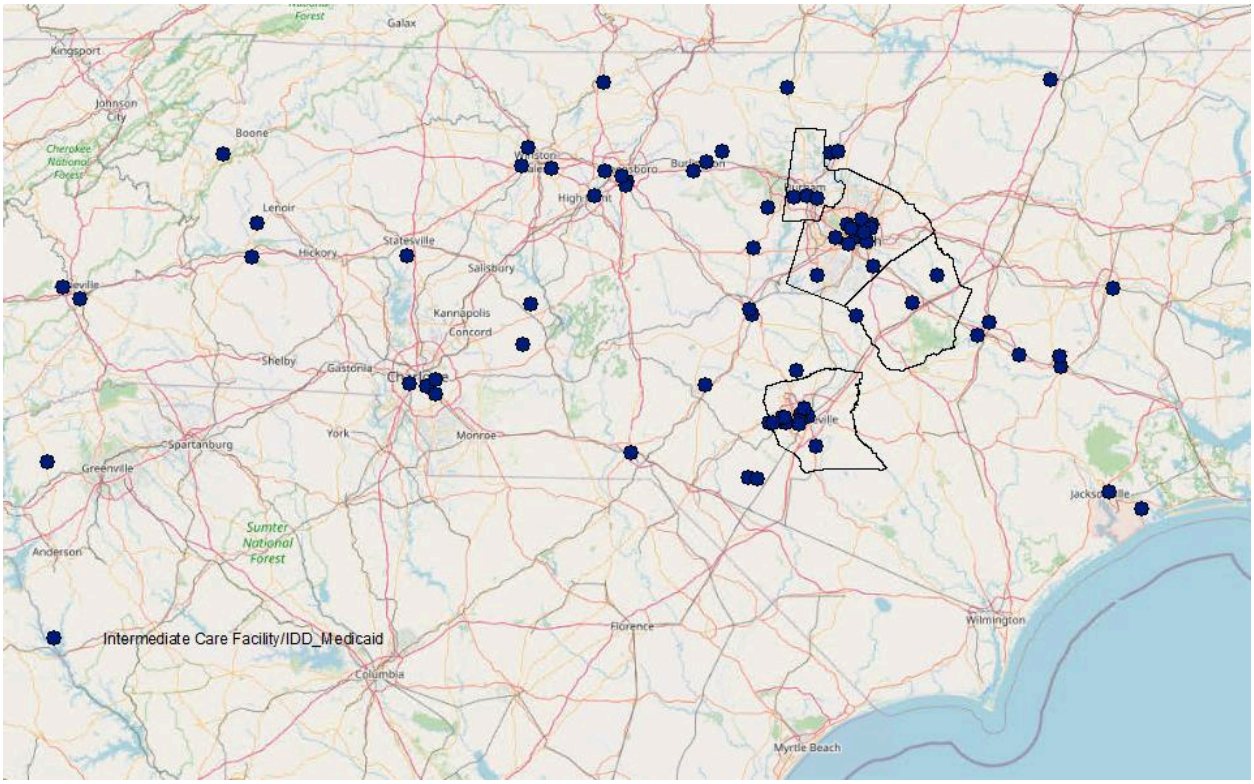
High Point
Jacksonville
Florence
Wilmington
Columbia
(b)(3) I/DD Residential supports_Medicaid


Kingsport
Johnson City
Boone
Cherokee National Forest
Lenoir
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Concord
Shelby
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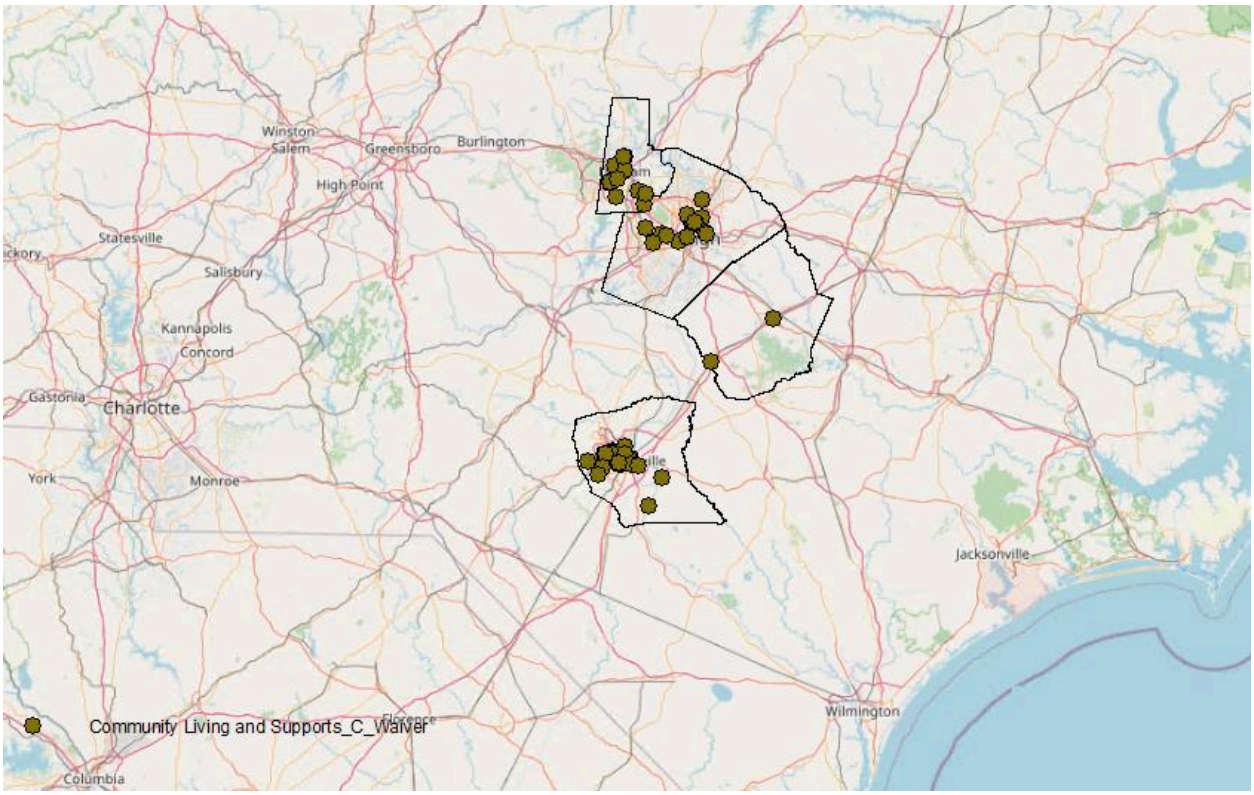
Myrtle Beach
Wilmington
Intermediate Care Facility/IDD_Medicaid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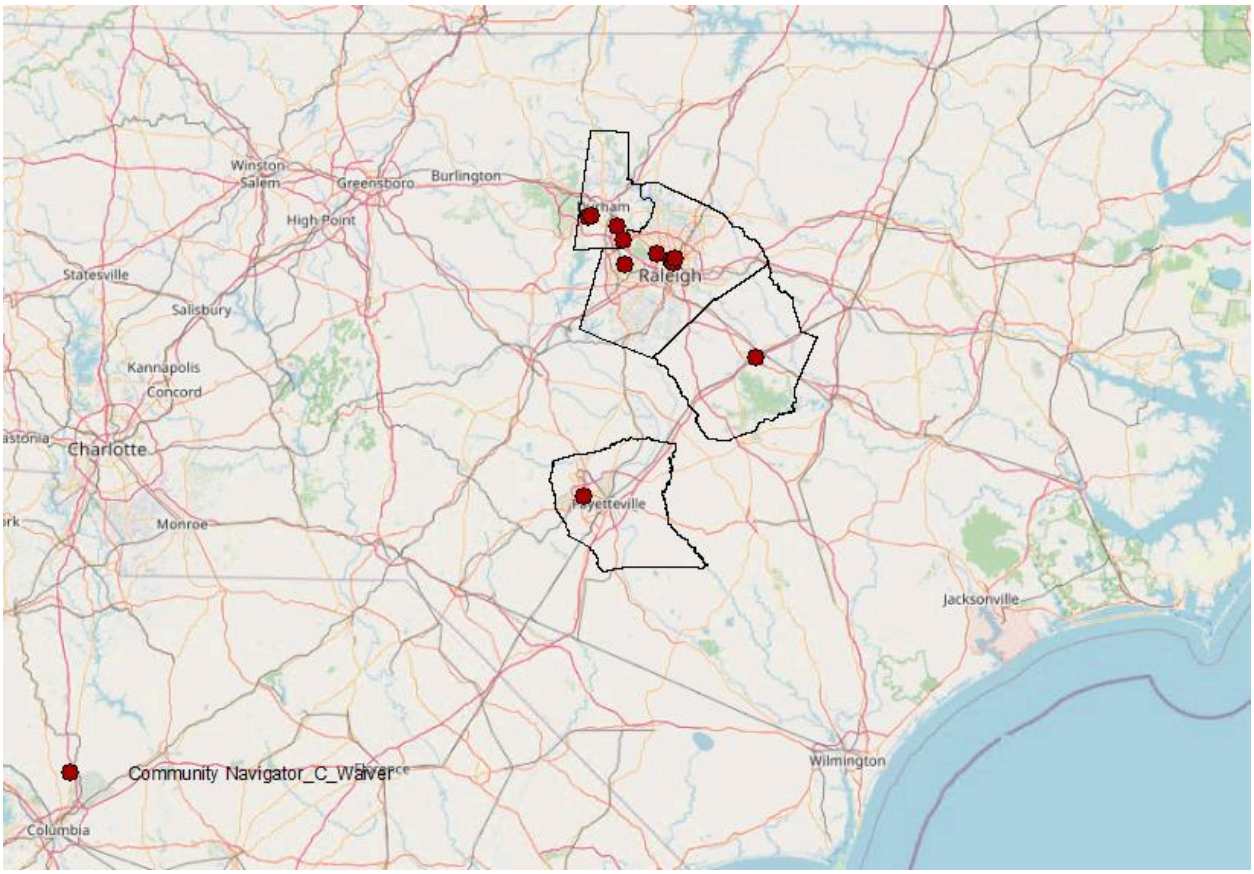
Jacksonville
Wilmington
Community Living and Supports_C_Waiver
Columbia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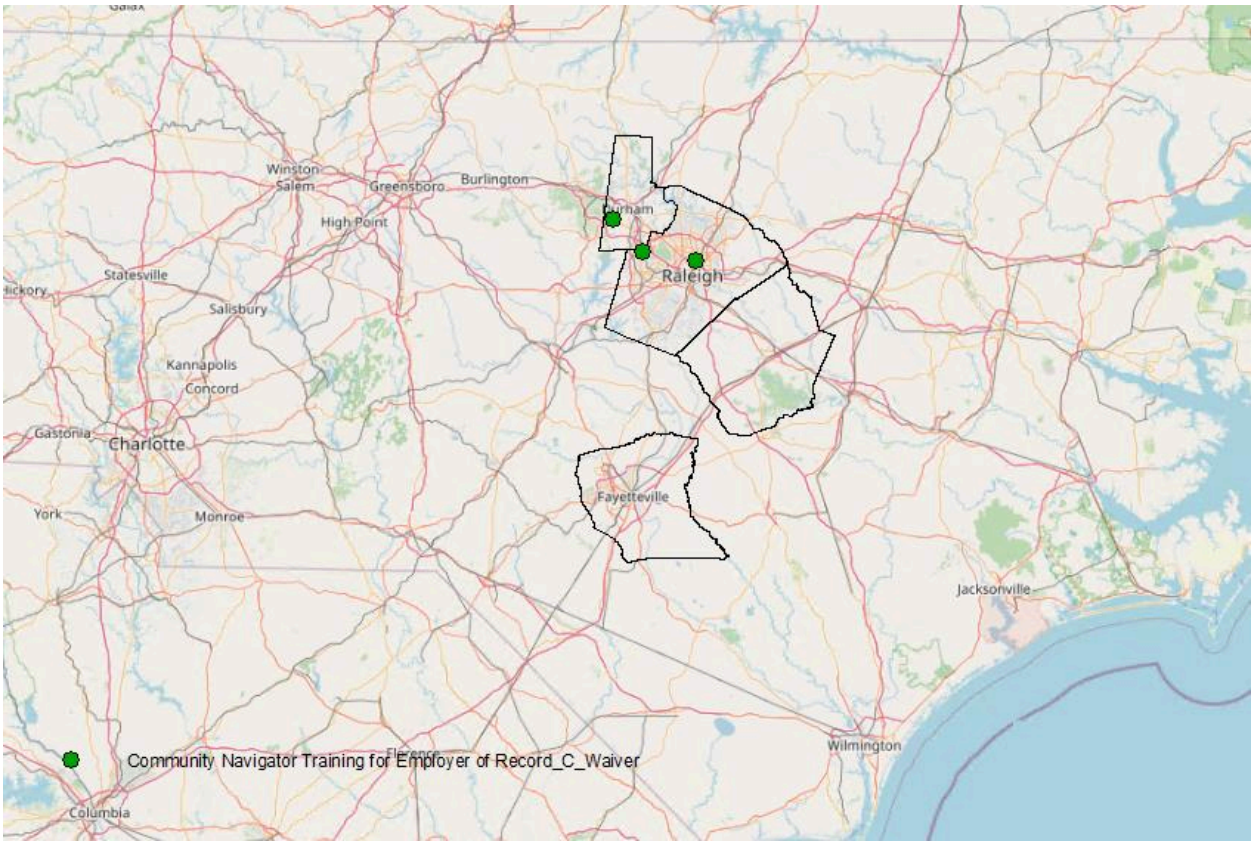
Monroe
Jacksonville
Wilmington
Community Navigator_C_Waiver
Columbia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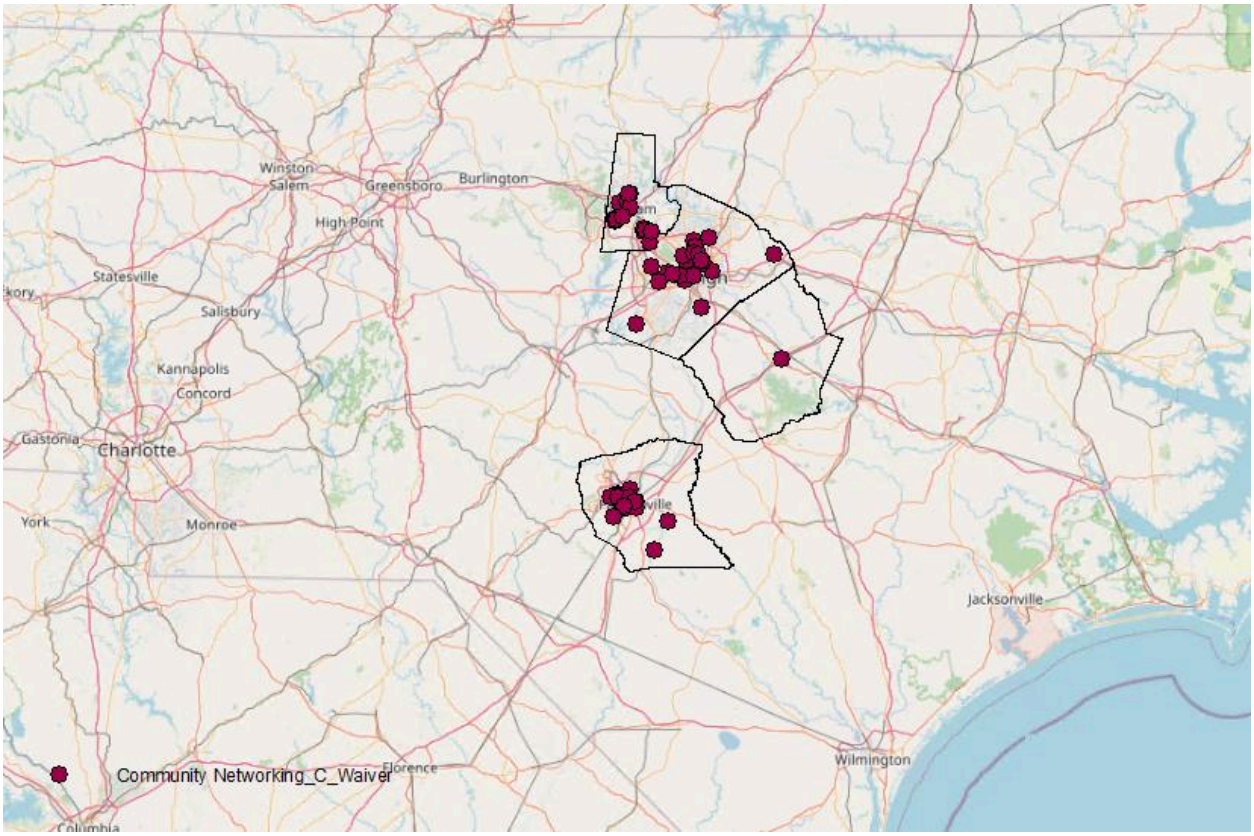
Community Navigator Training for Employer of Record_C_Waiver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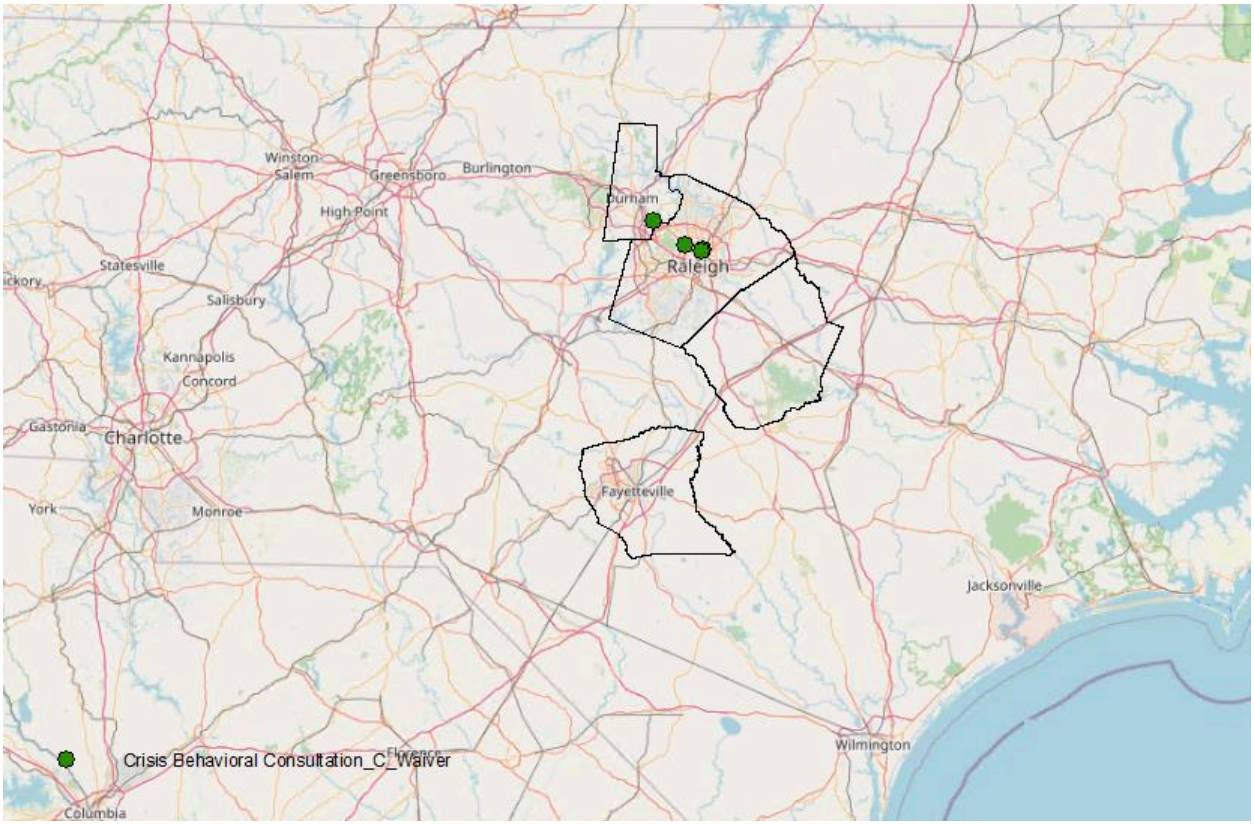
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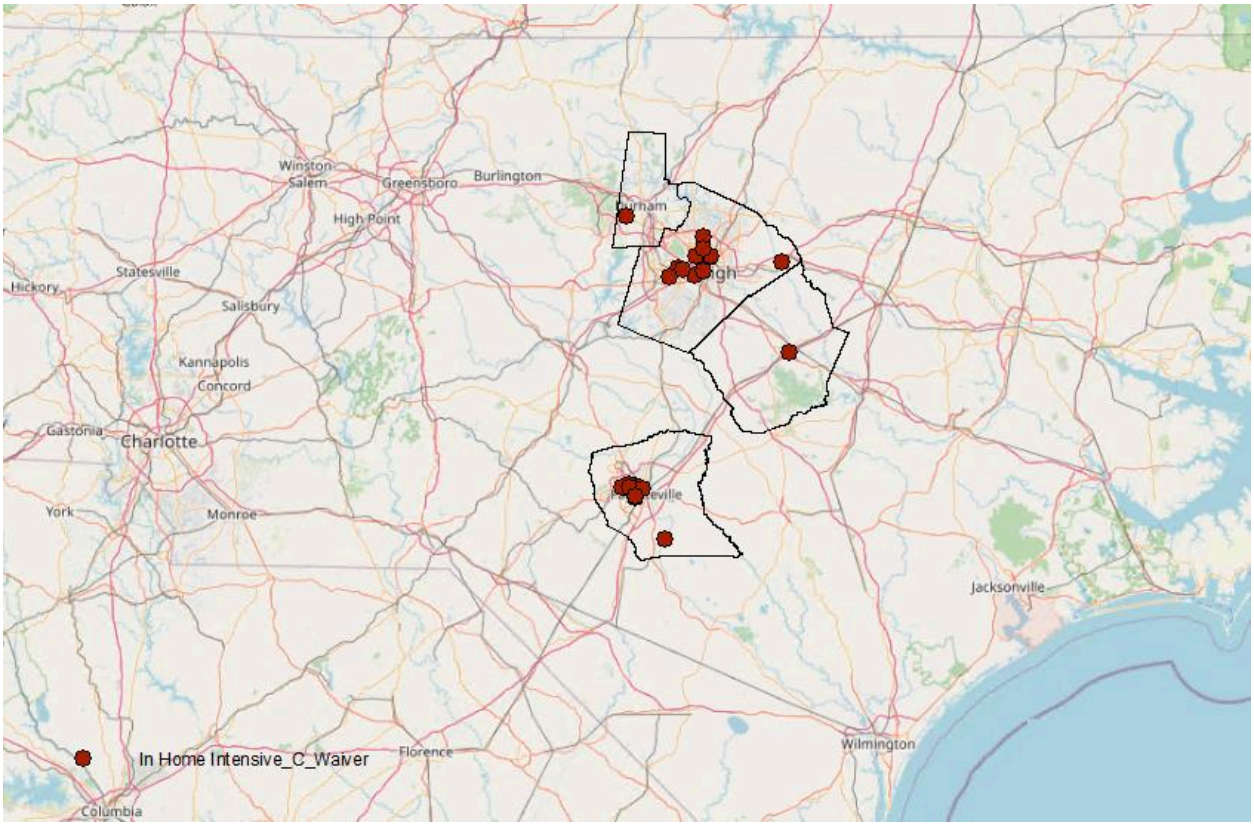
Crisis Behavioral Consultation_C_Waiver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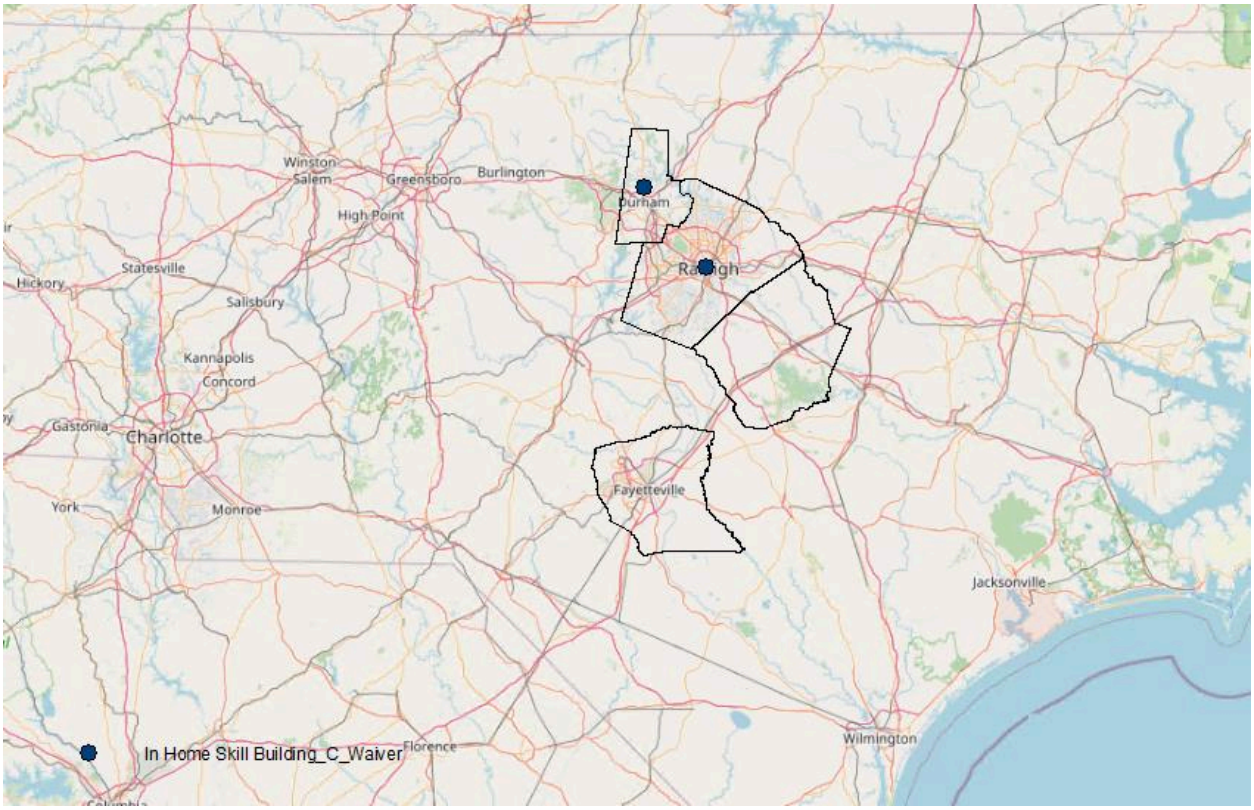
In Home Intensive_C_Waiver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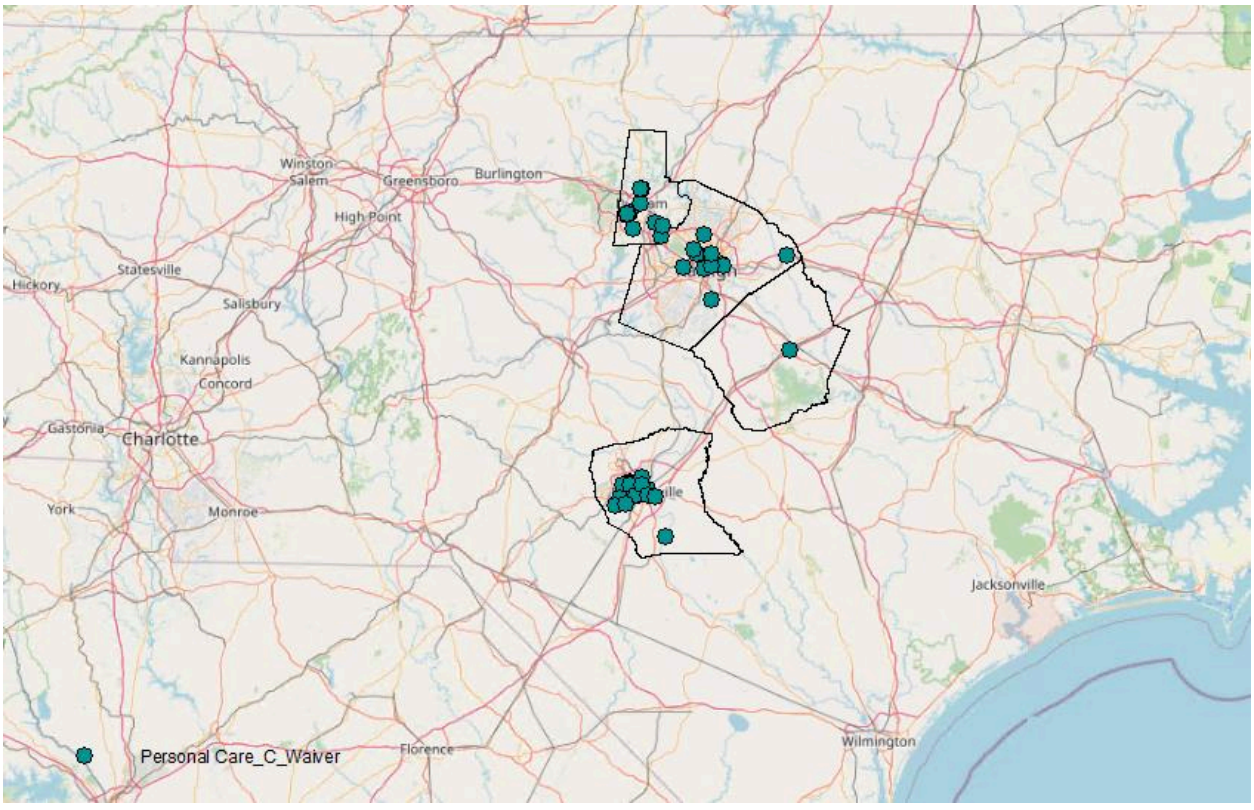
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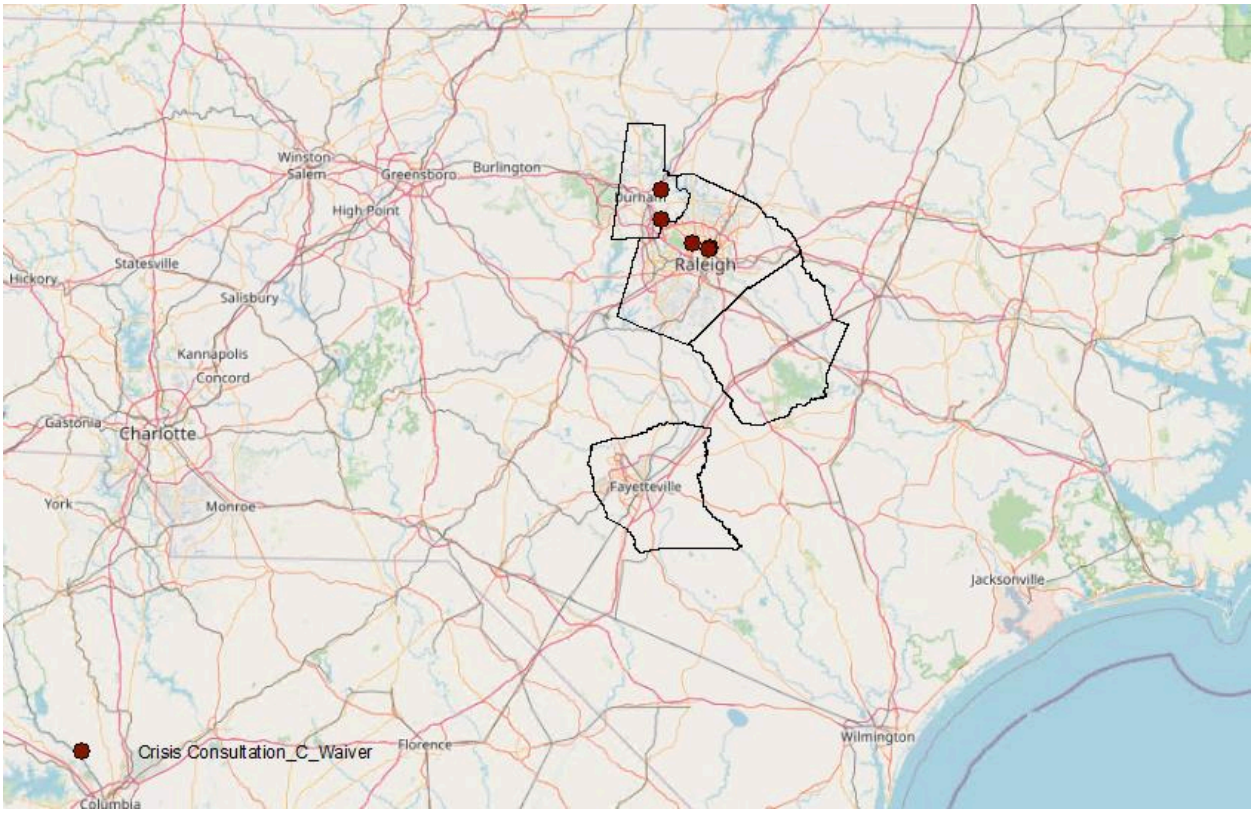
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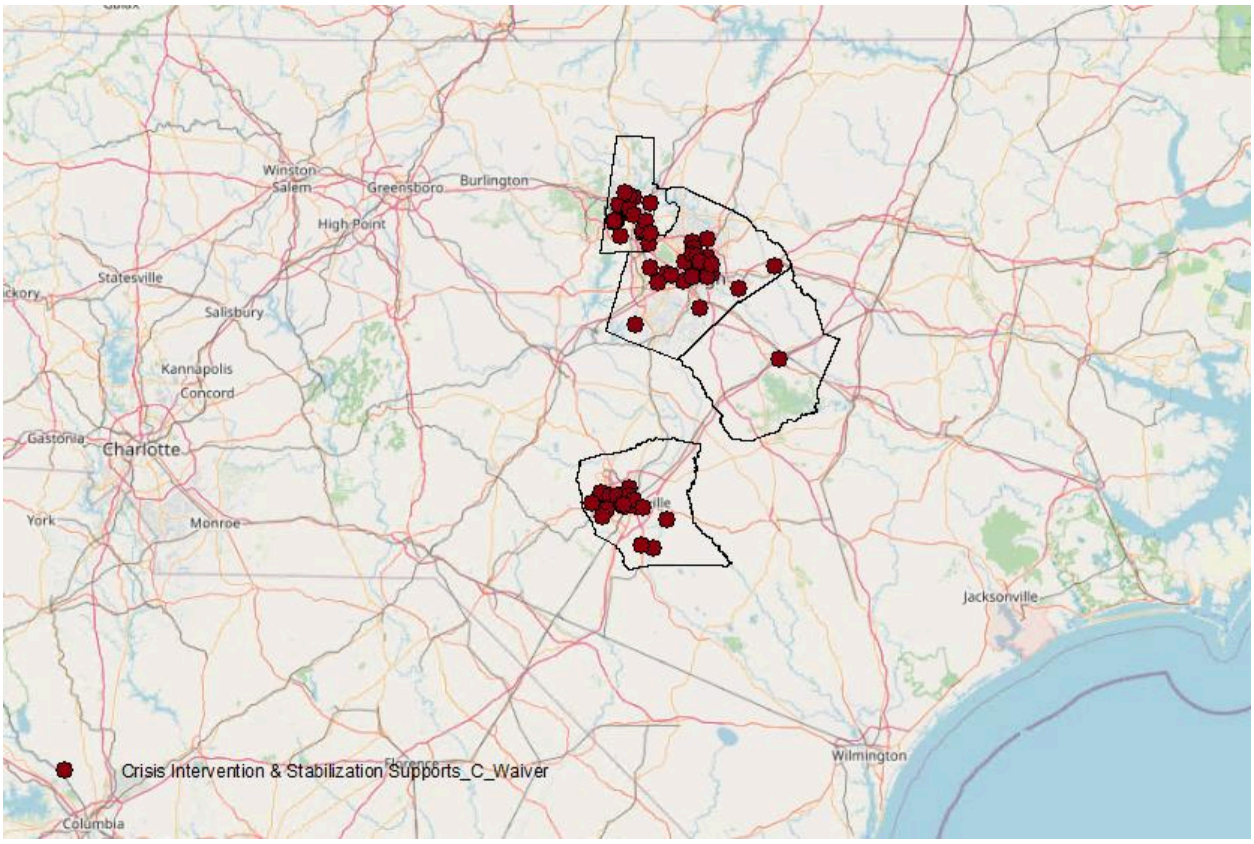
Crisis Consultation_C_Waiver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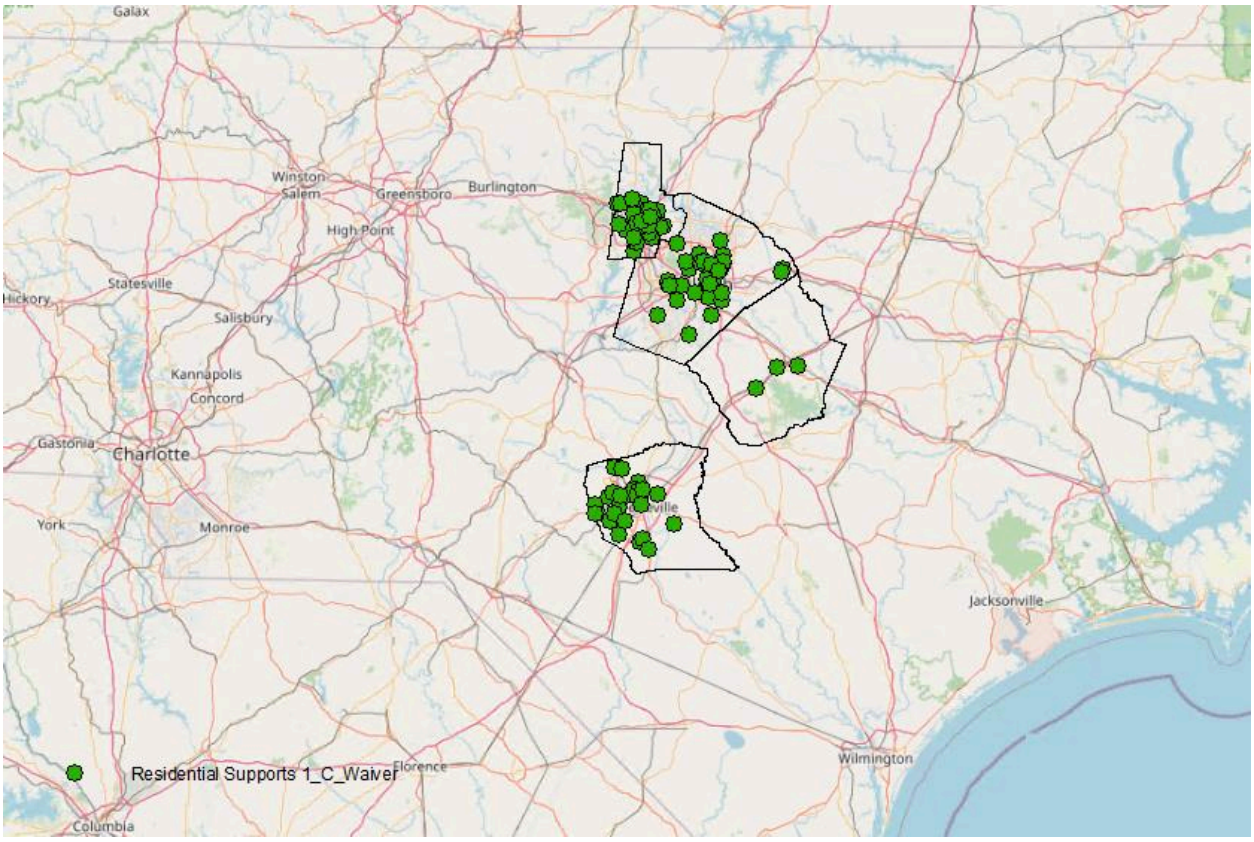
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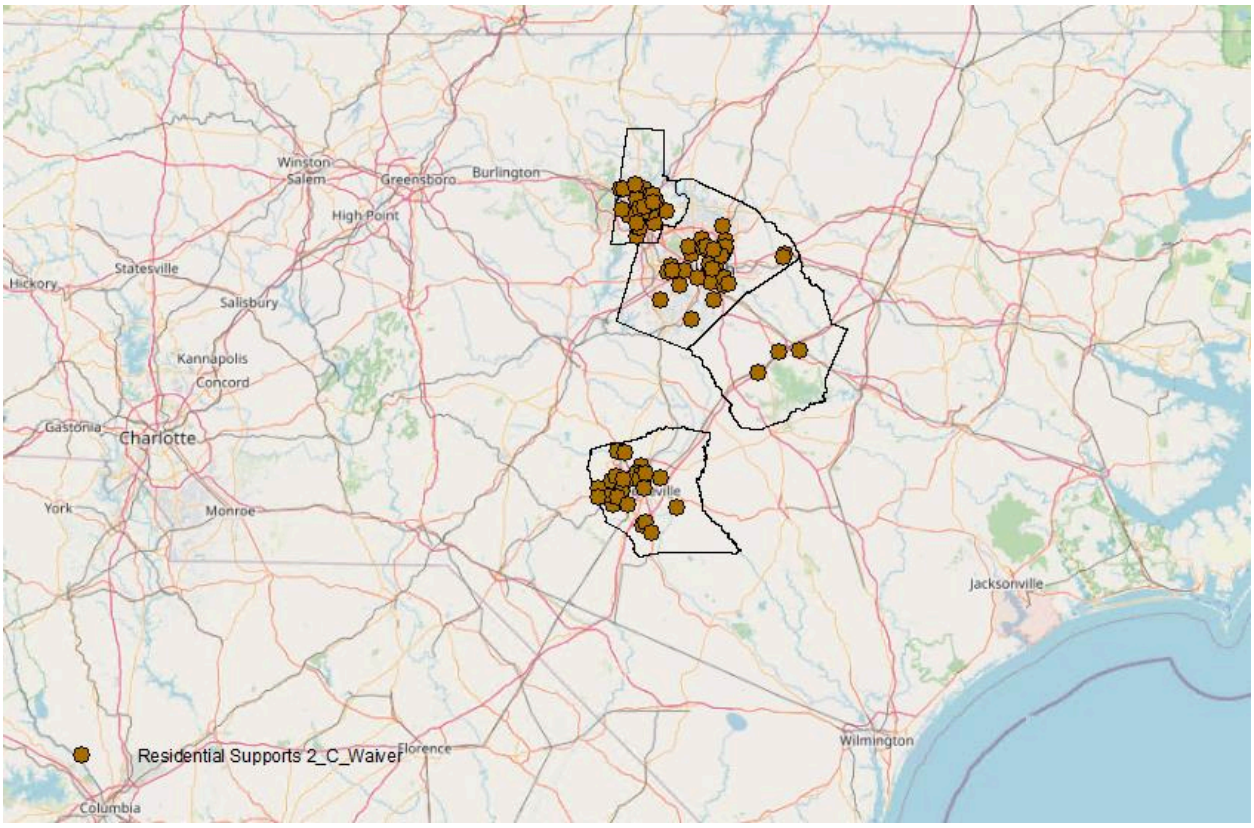
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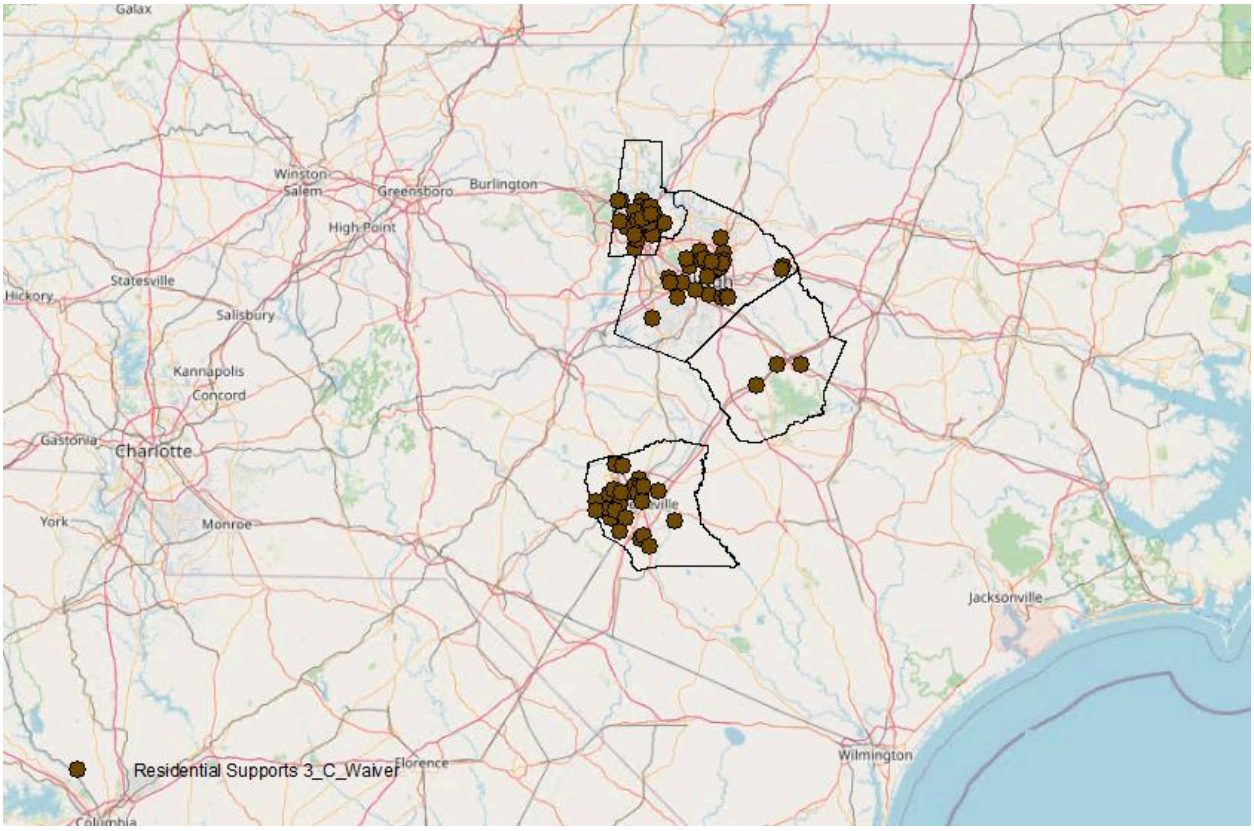
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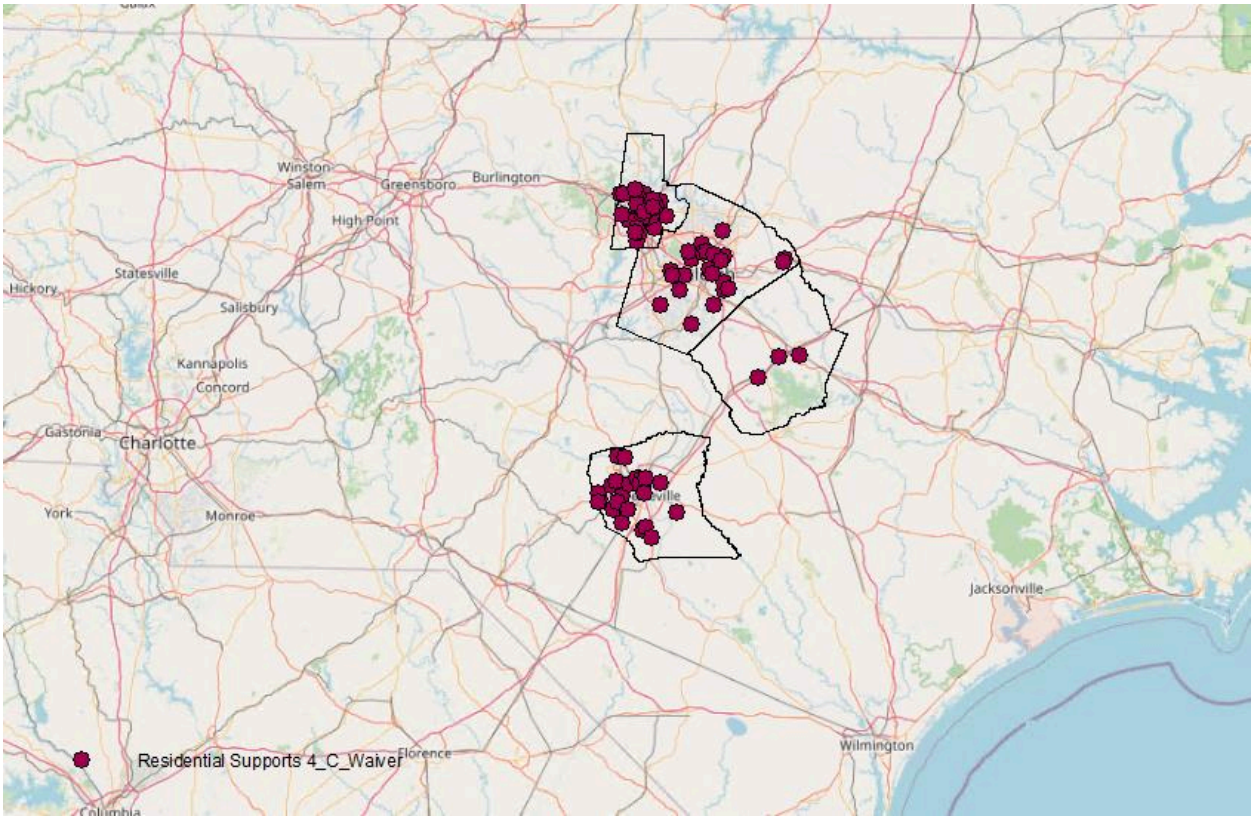
Residential Supports 3_C_Waiver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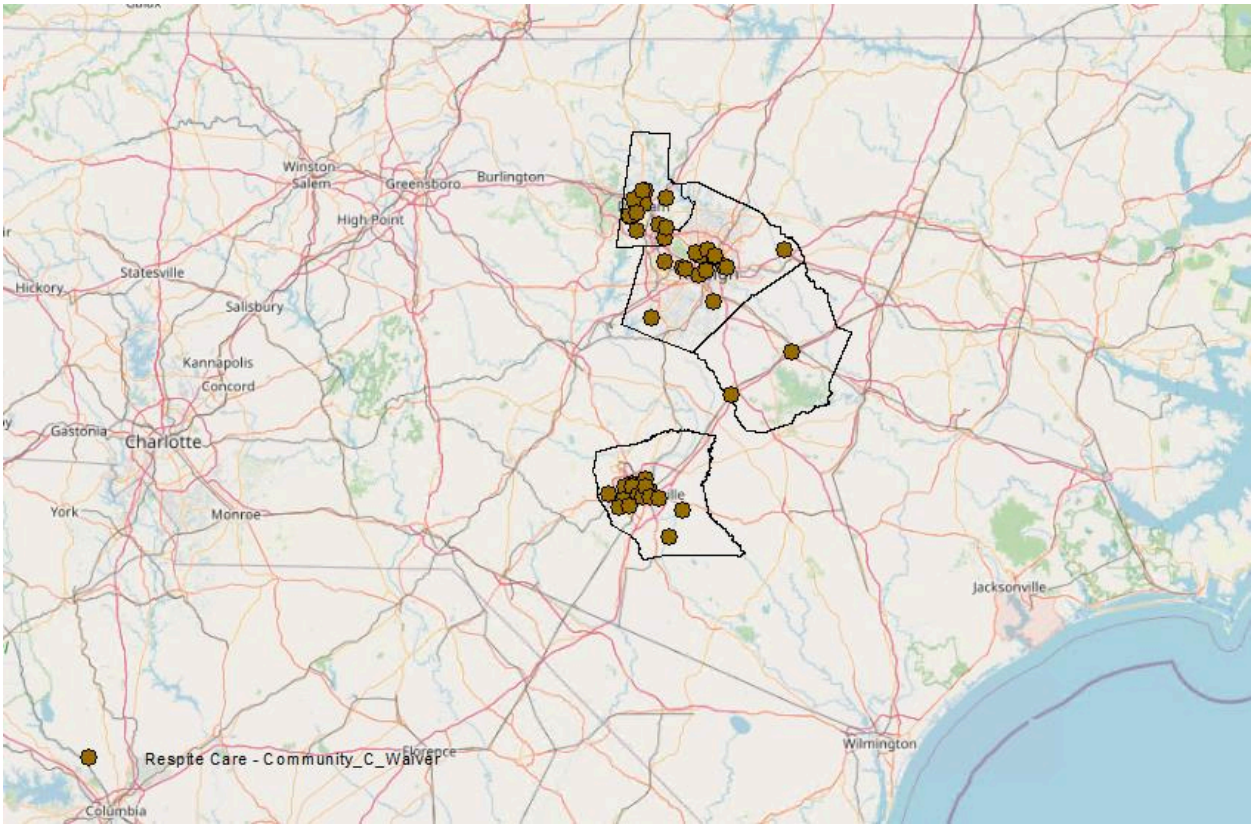
Residential Supports 4_C_Waiver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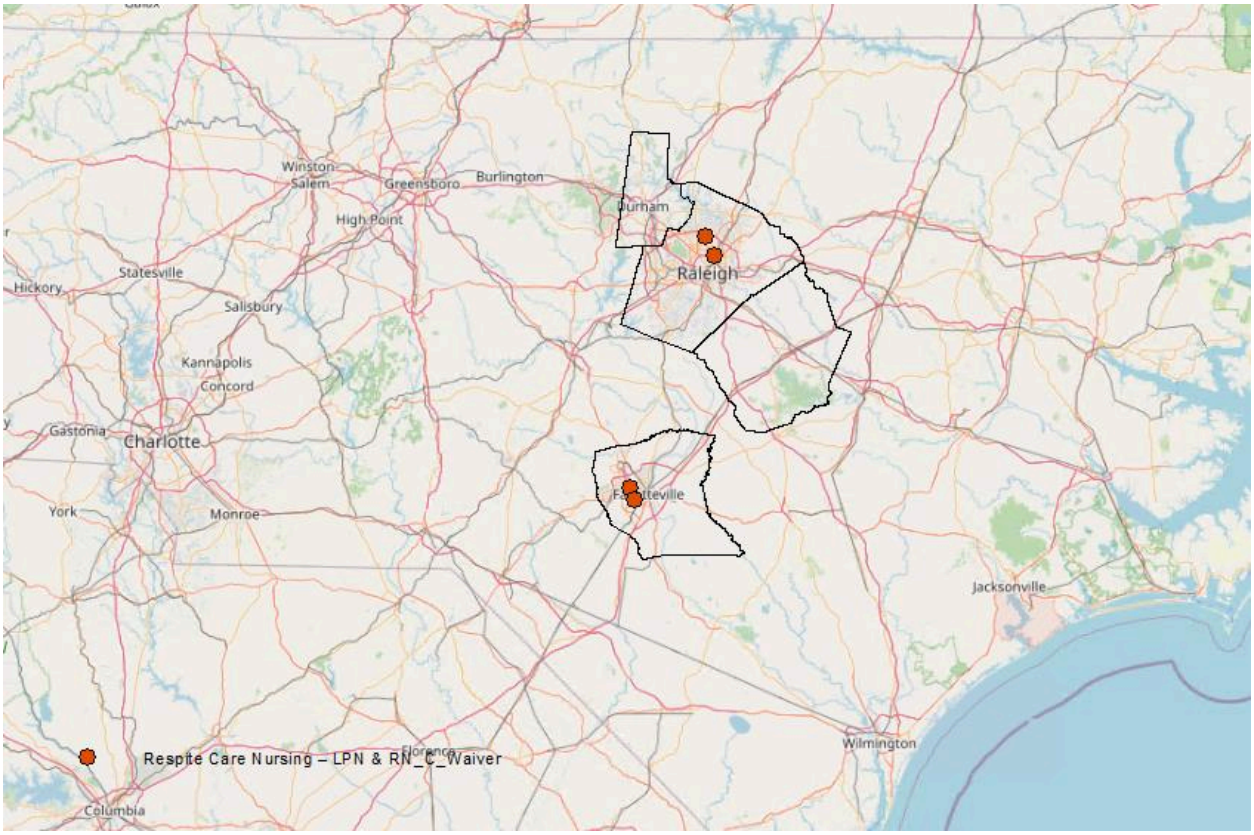
Respite Care - Community_C_Waiver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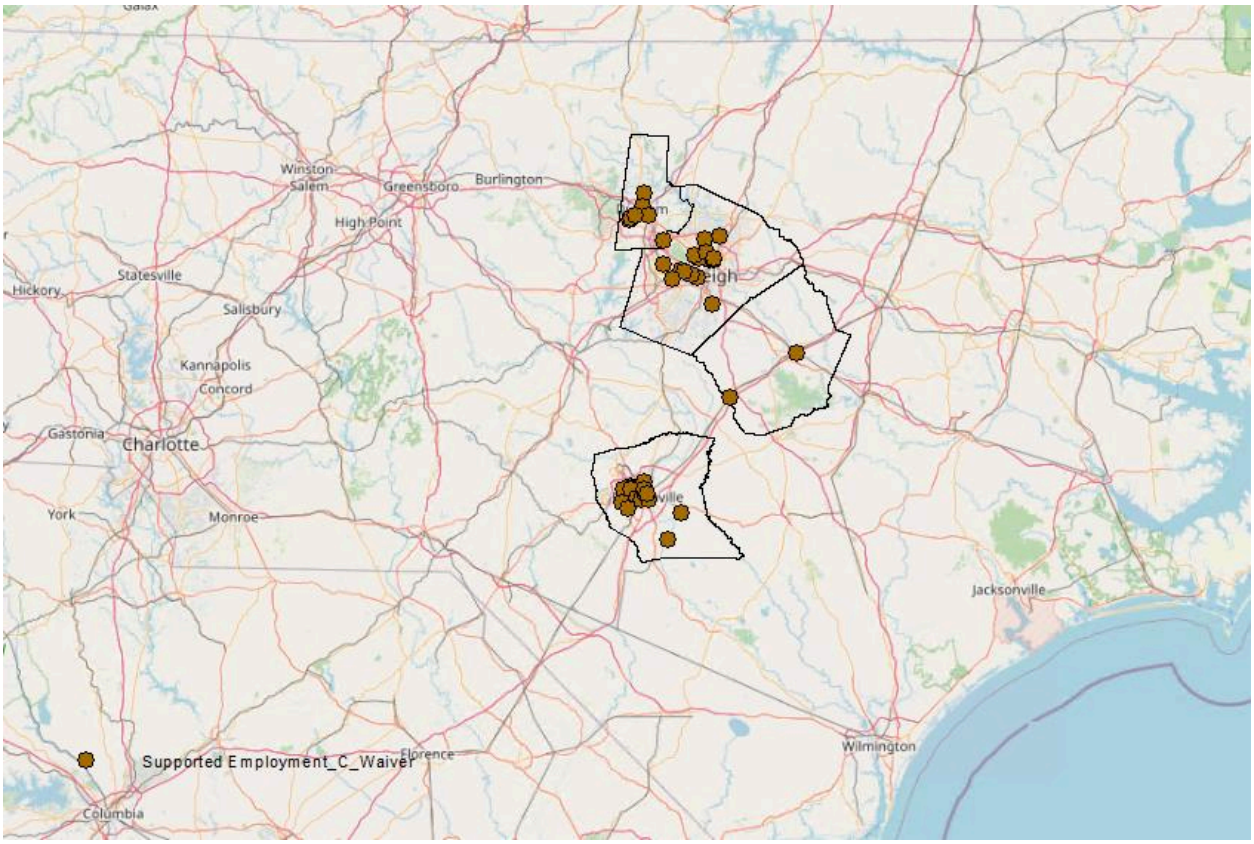
Respite Care Nursing – LPN & RN_C_Waiver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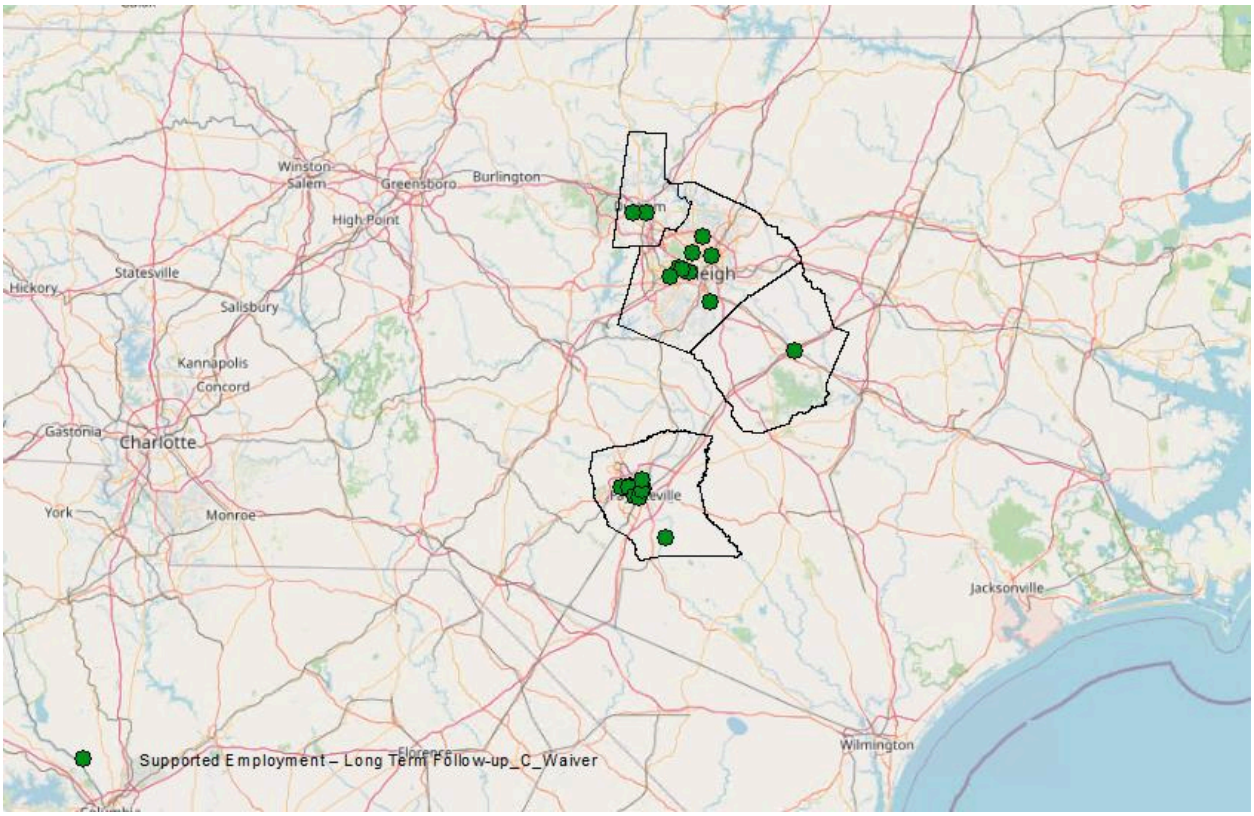
Supported Employment_C_Waiver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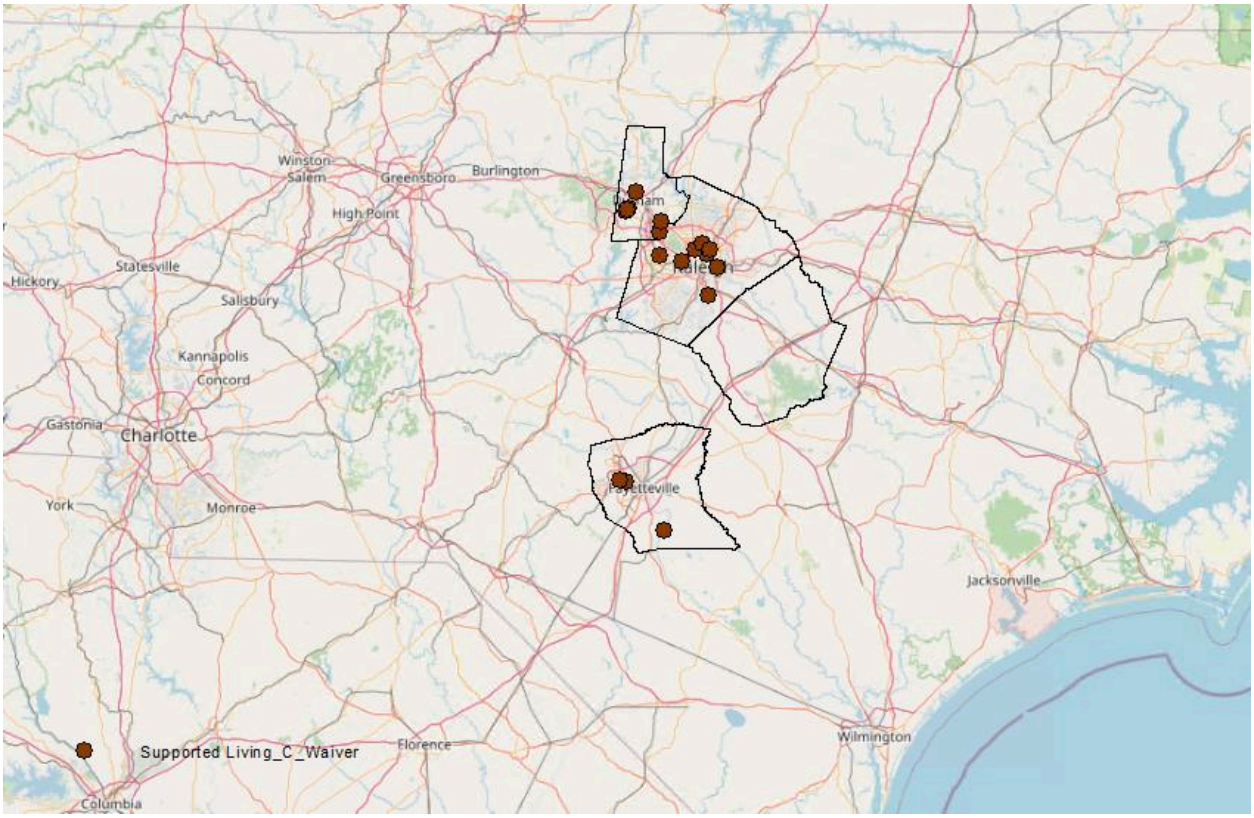
Supported Employment – Long Term Follow-up_C_Waiver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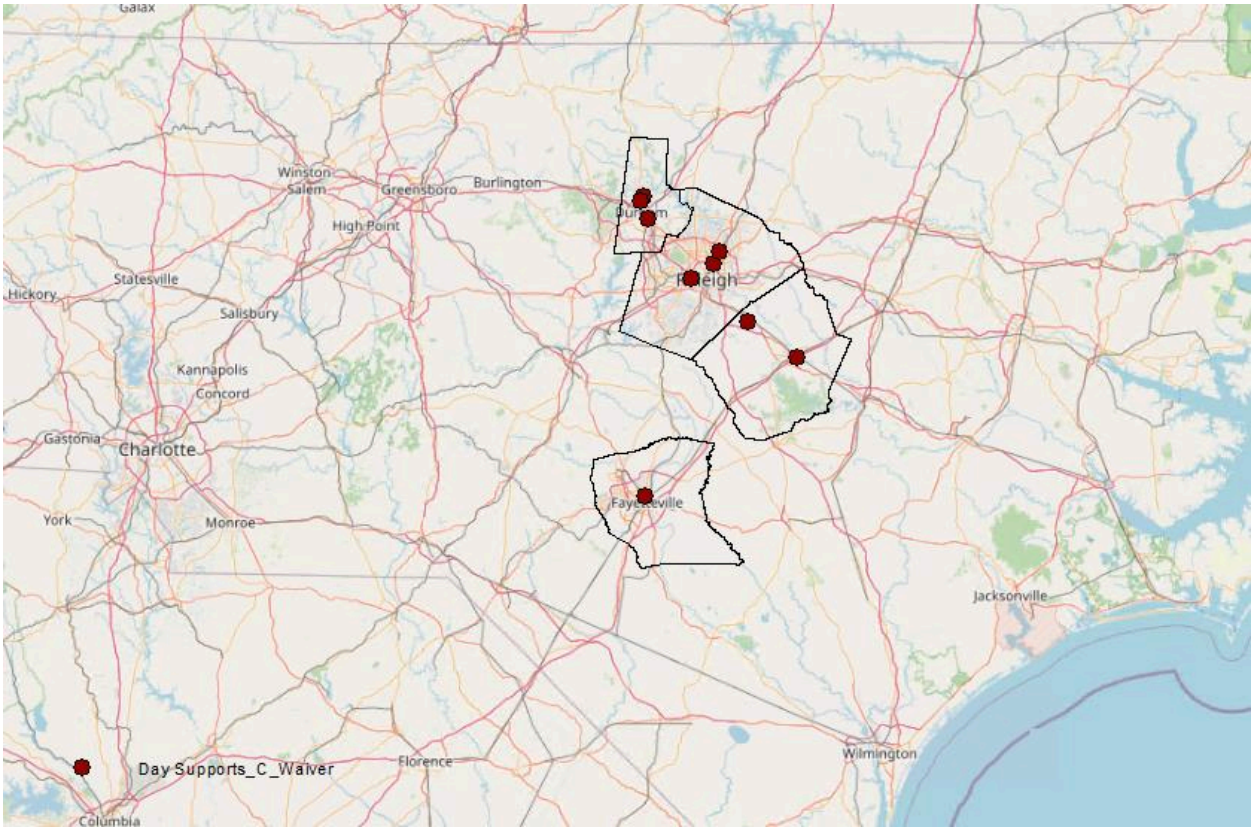
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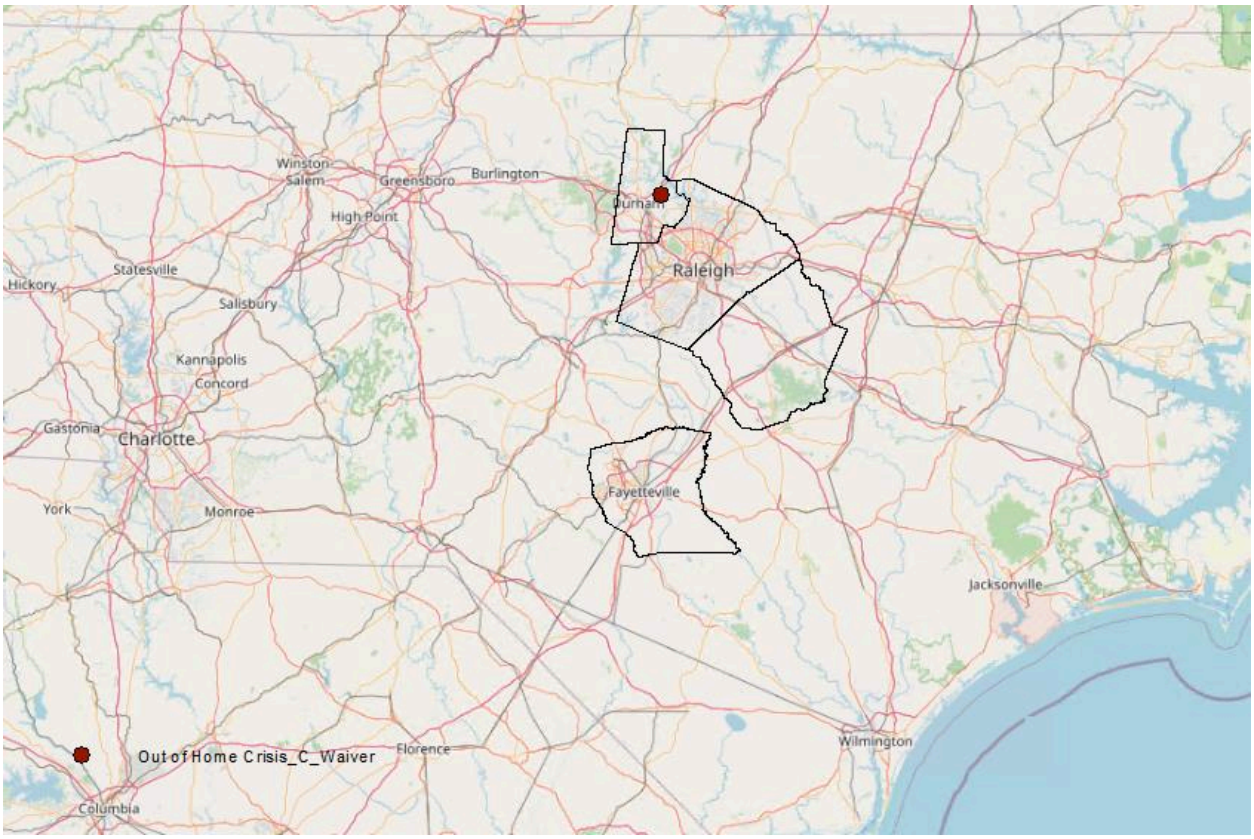
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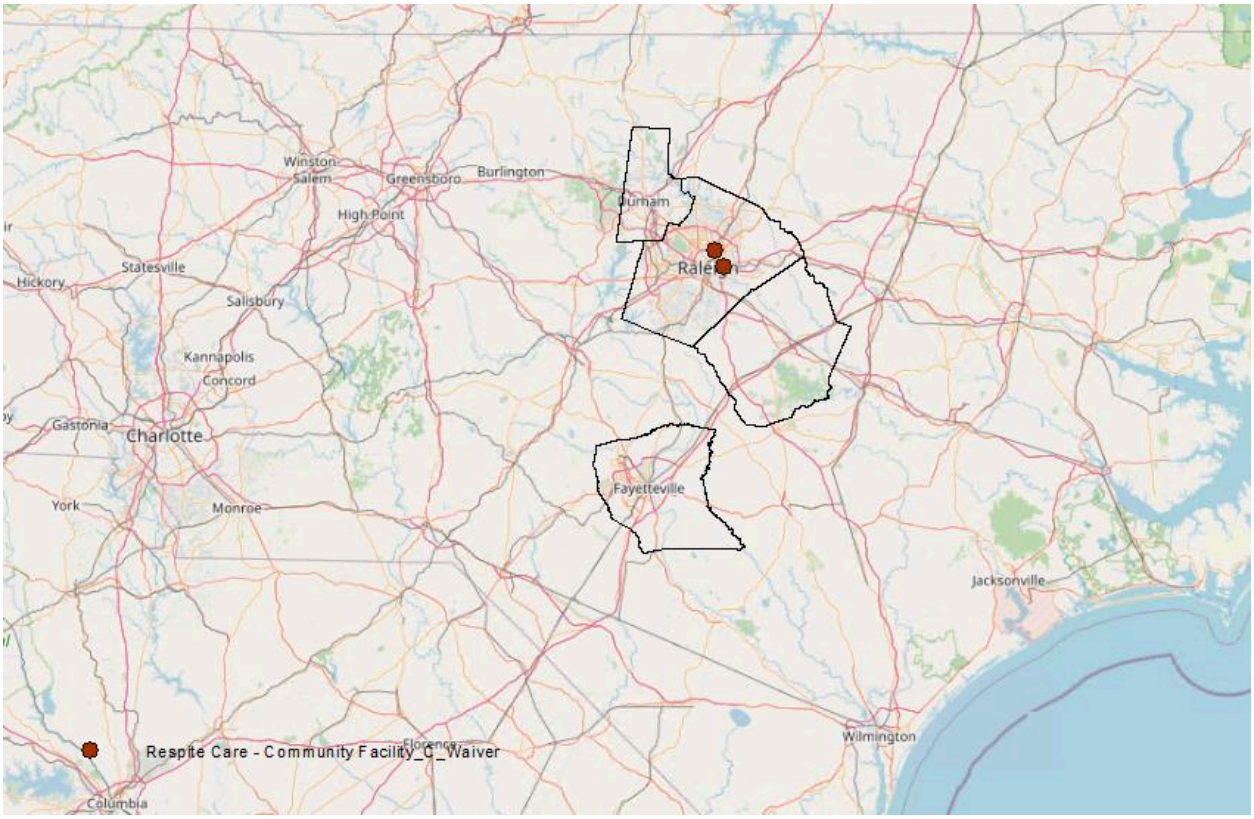
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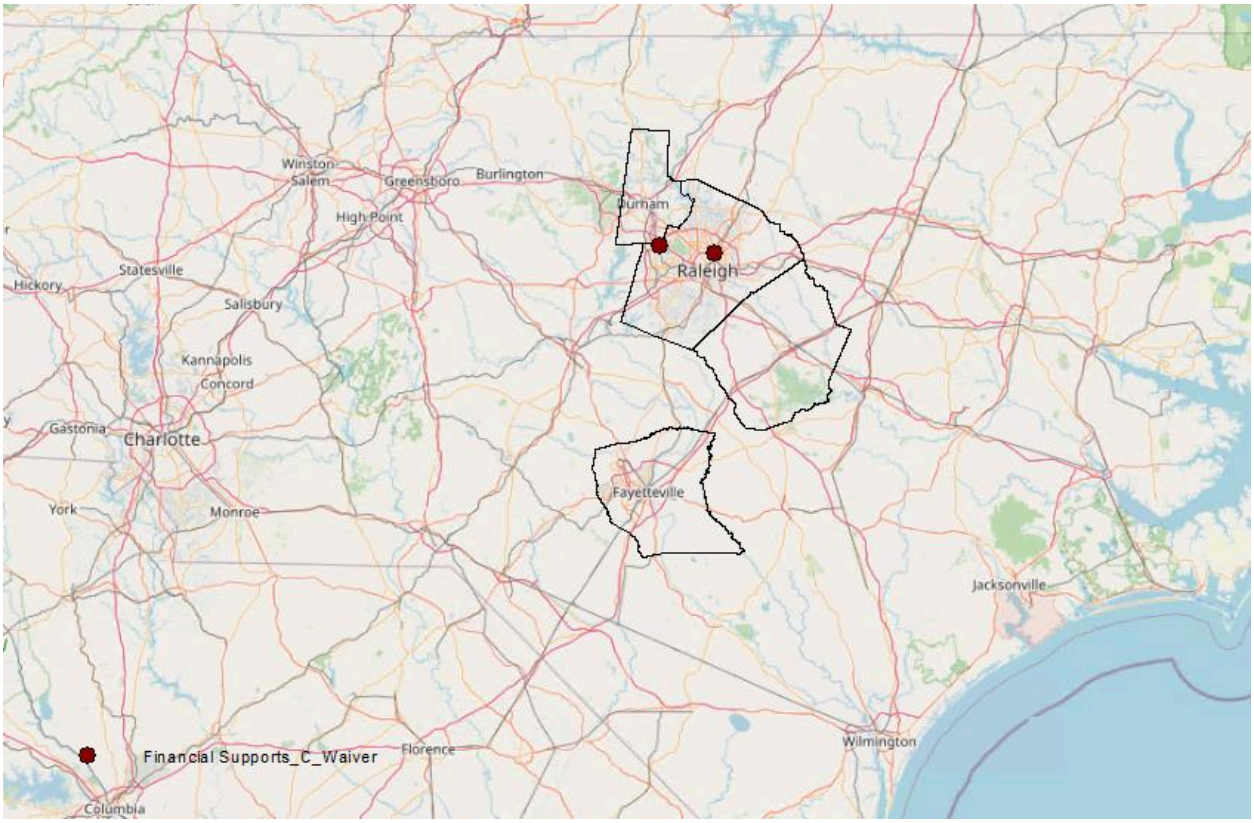
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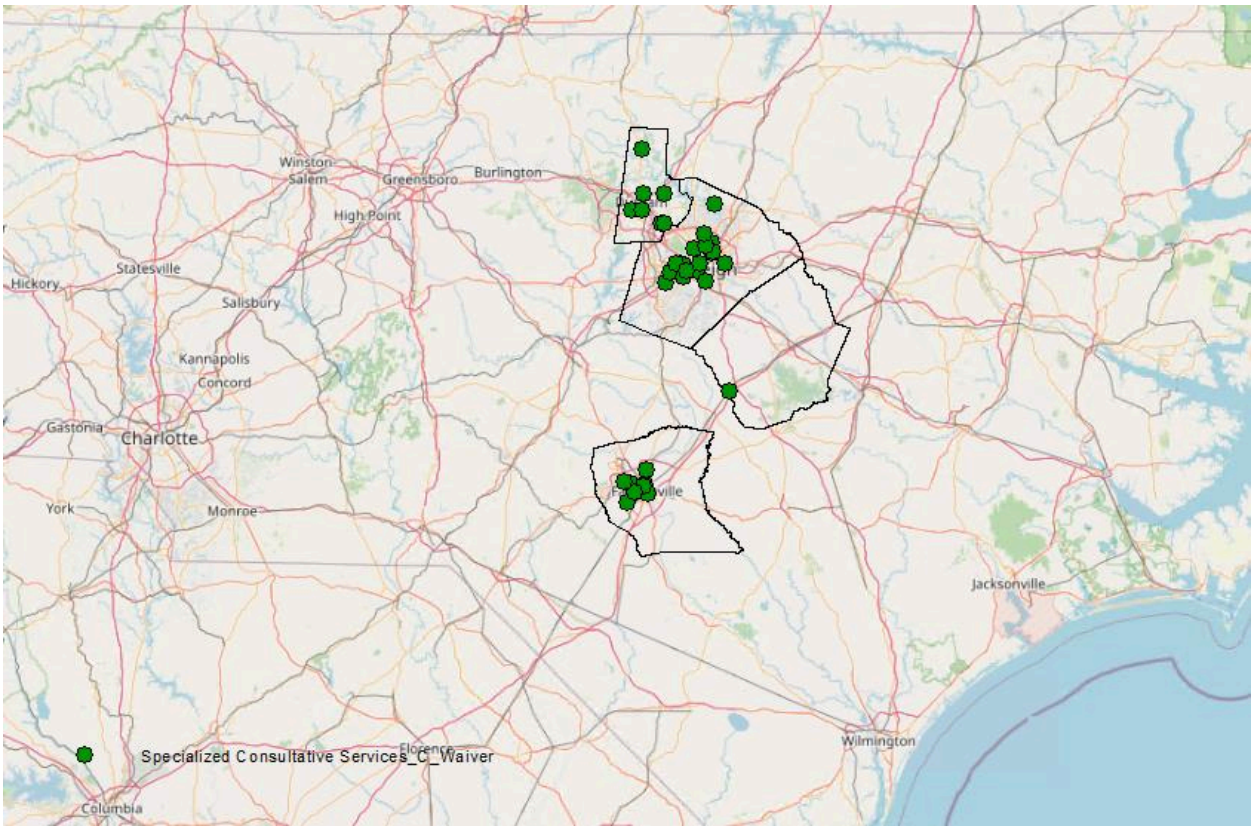
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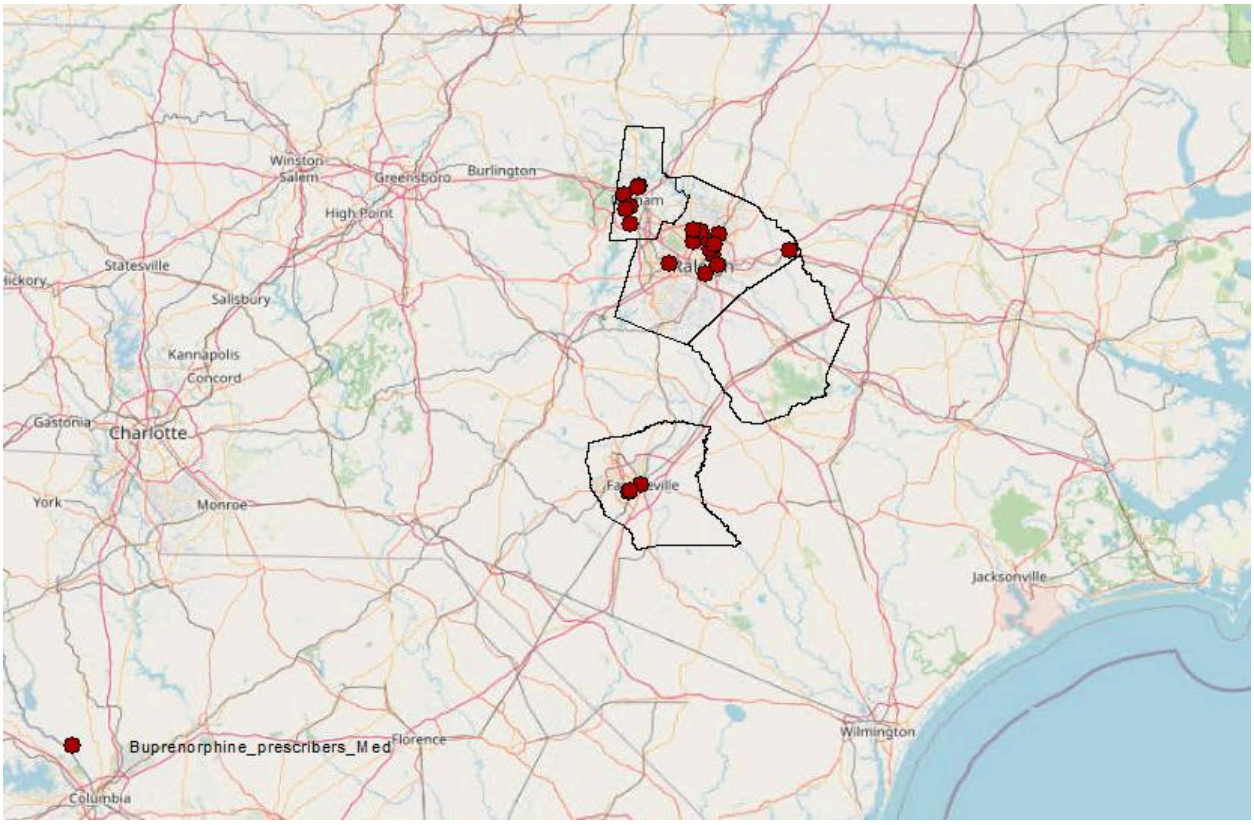
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2021 Maps

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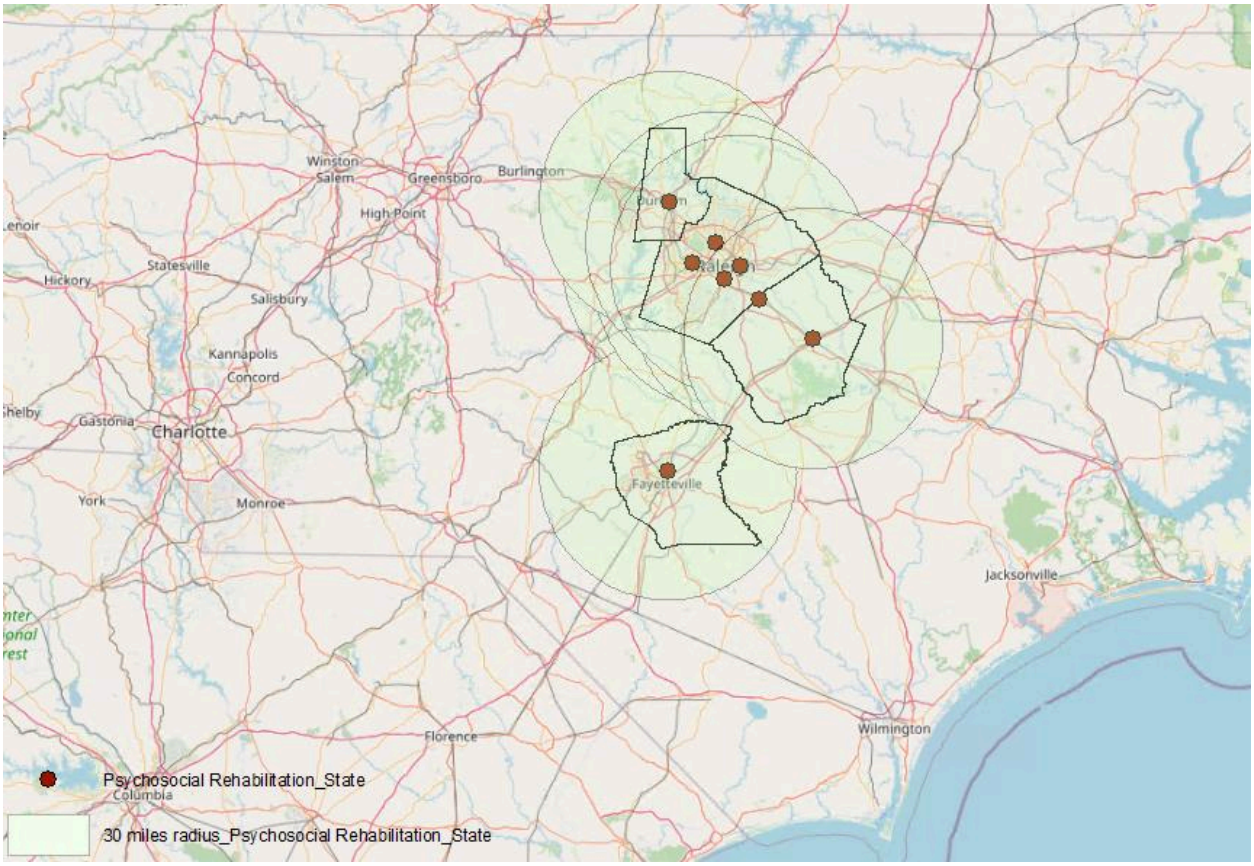
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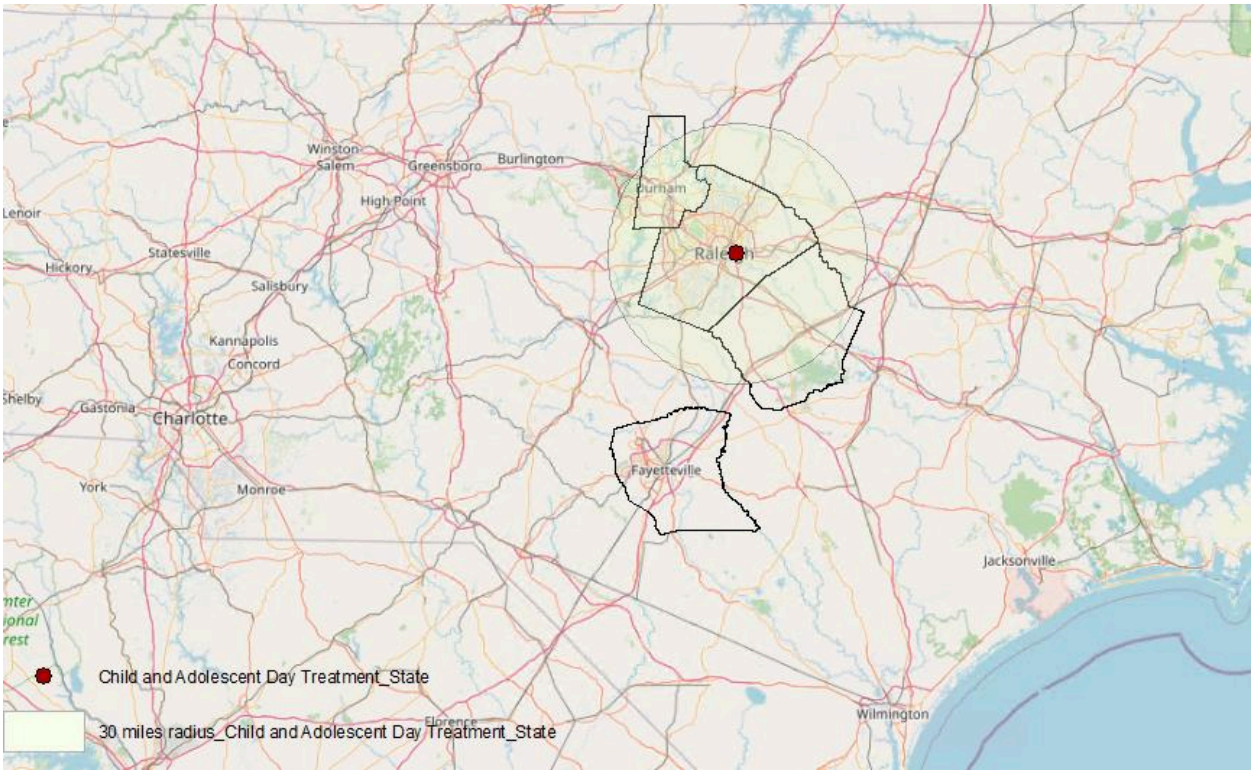
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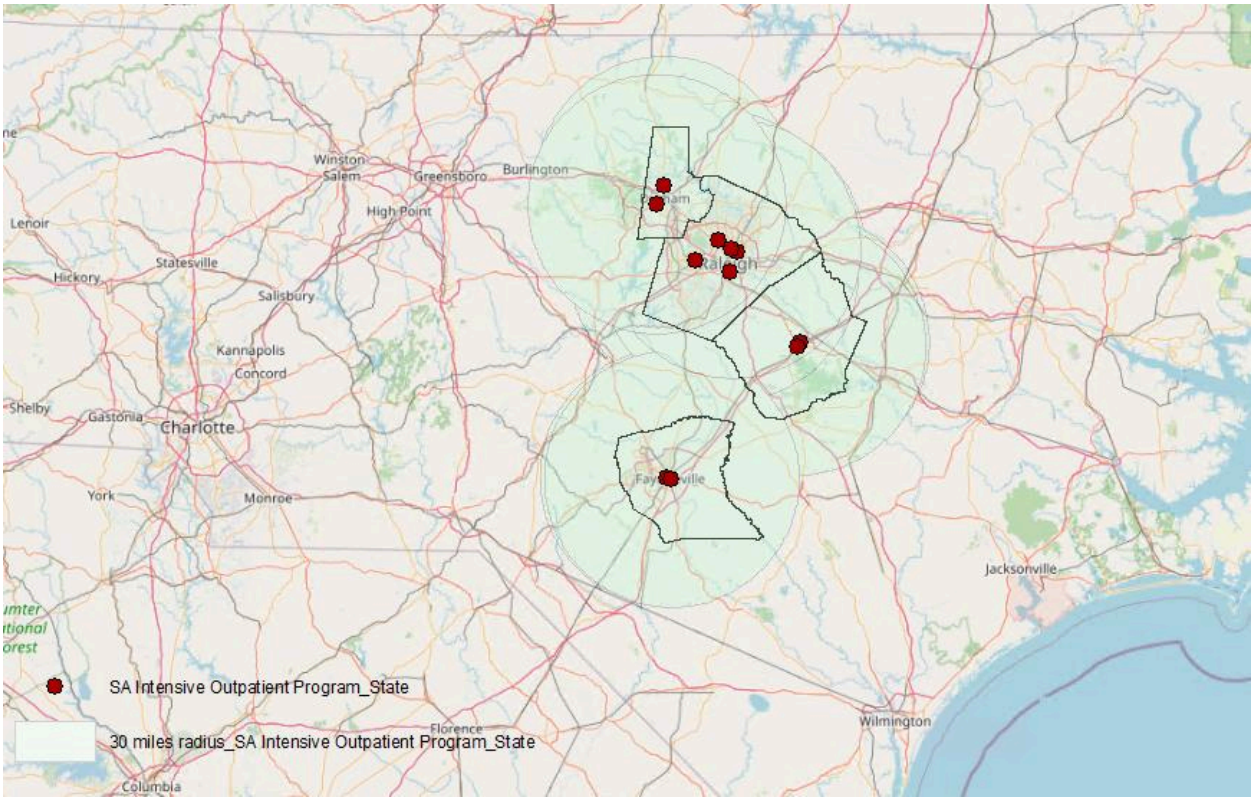
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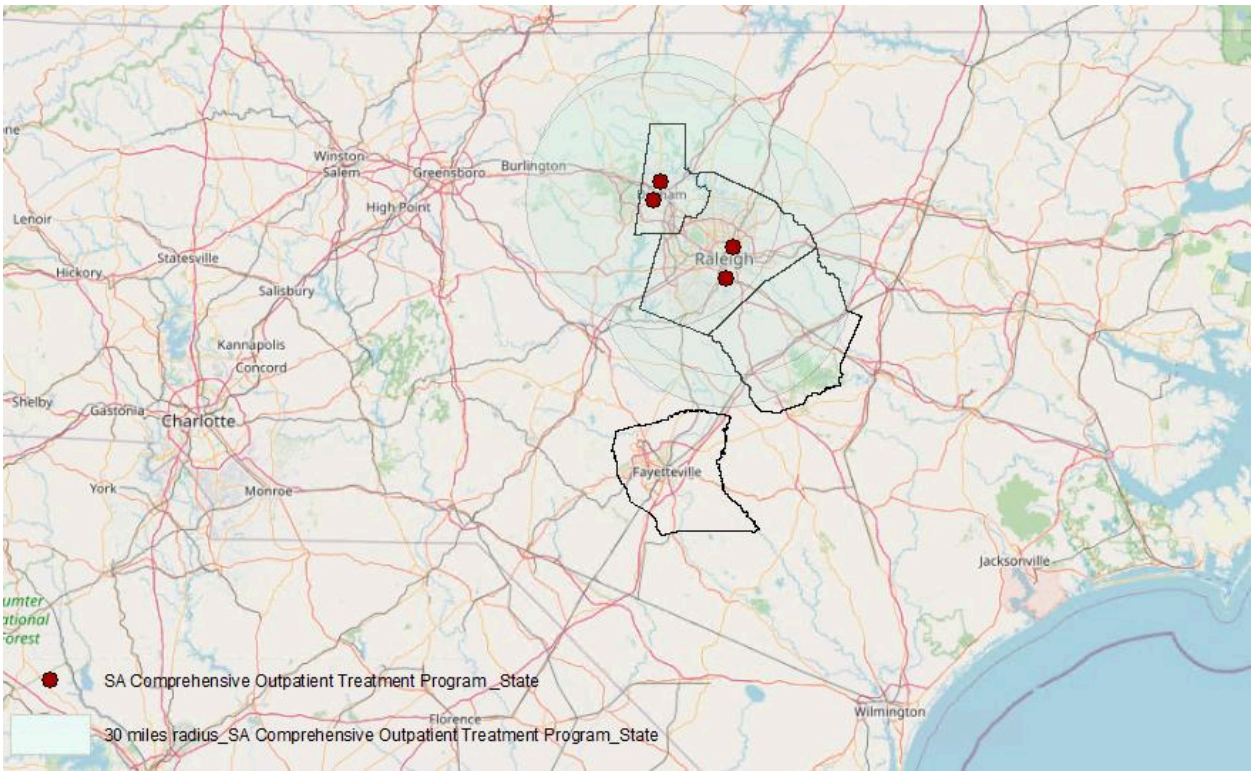
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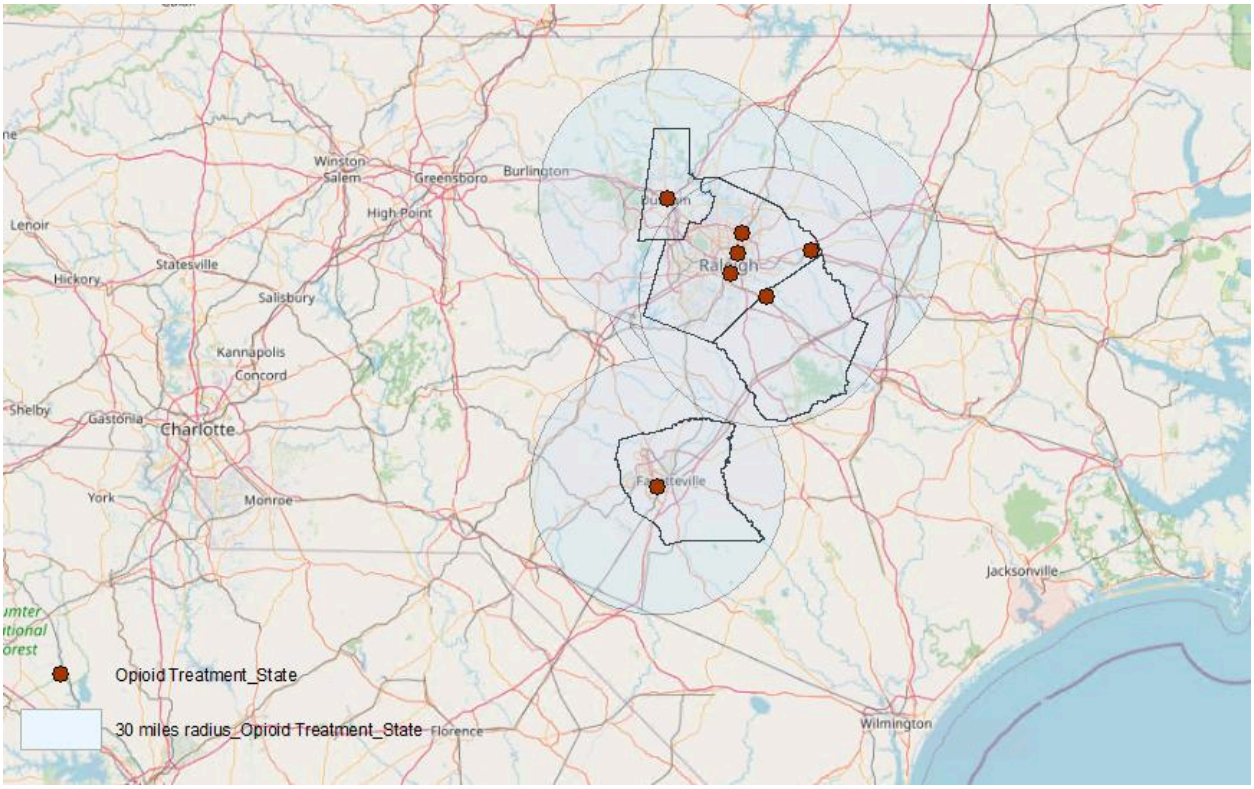
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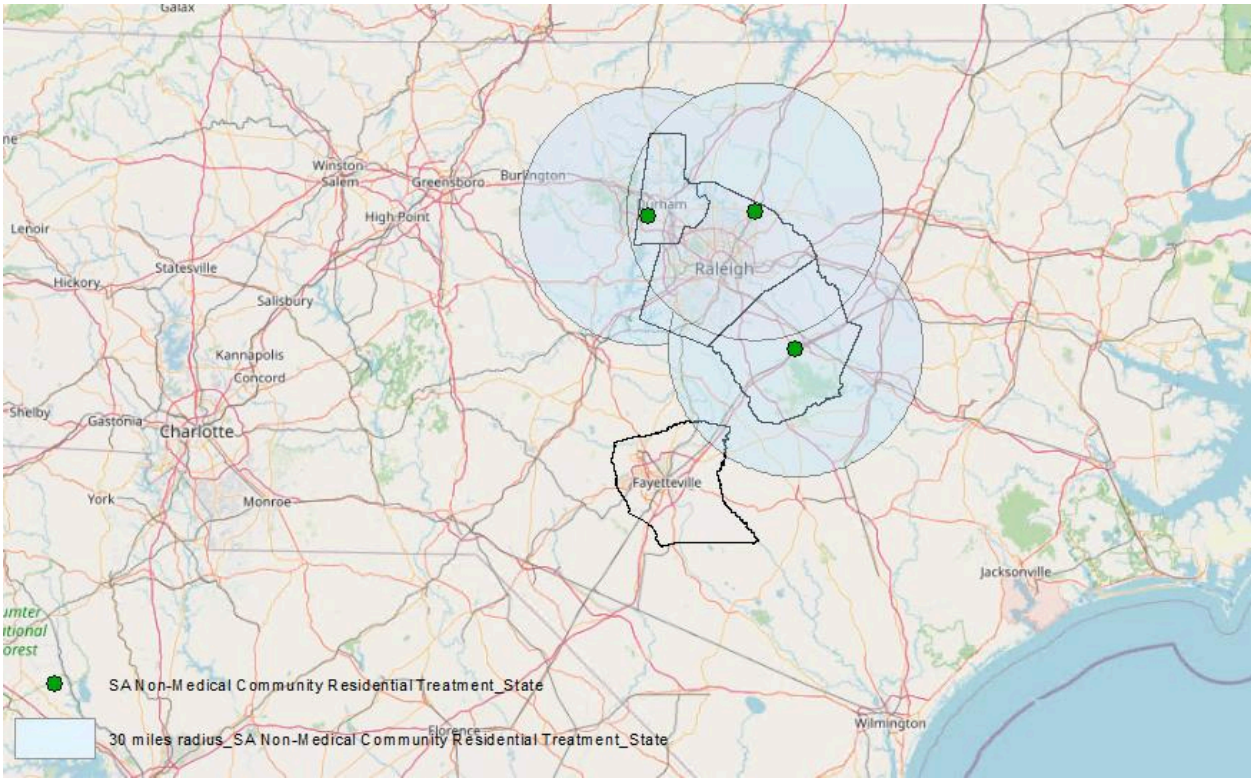
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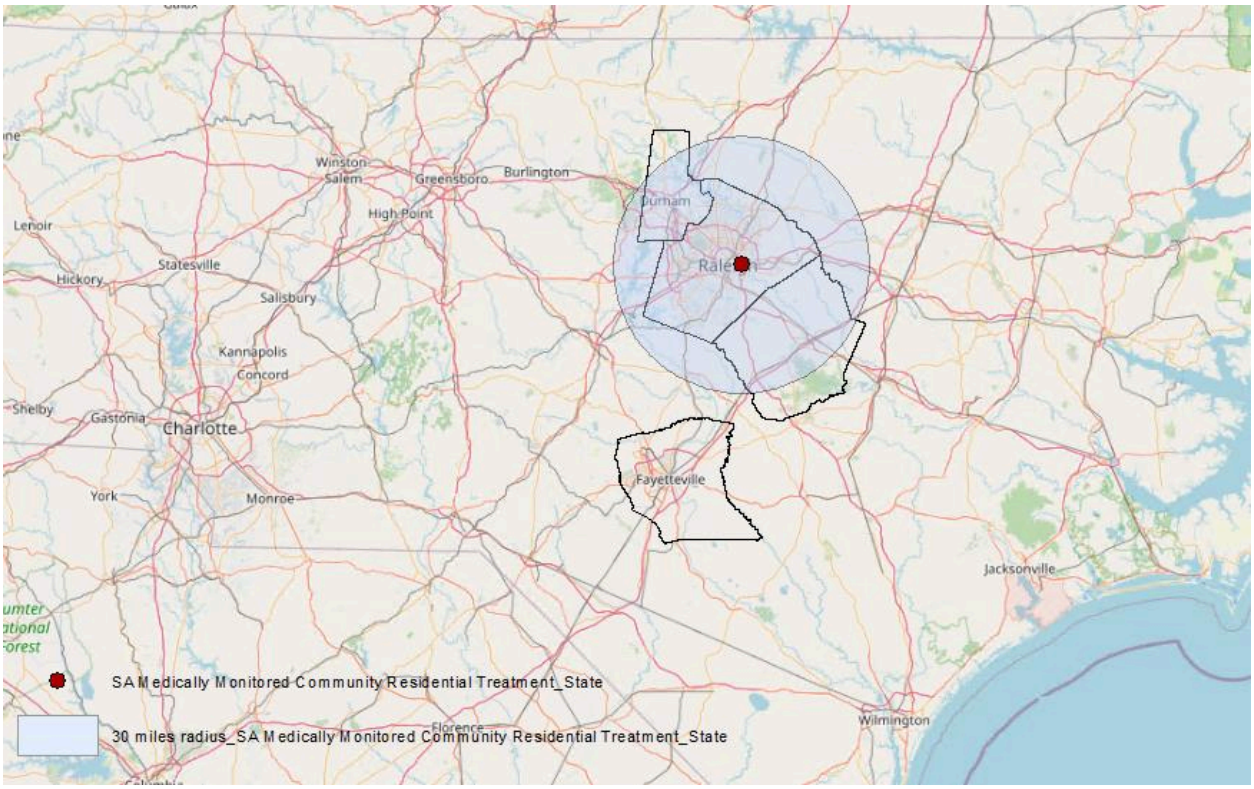
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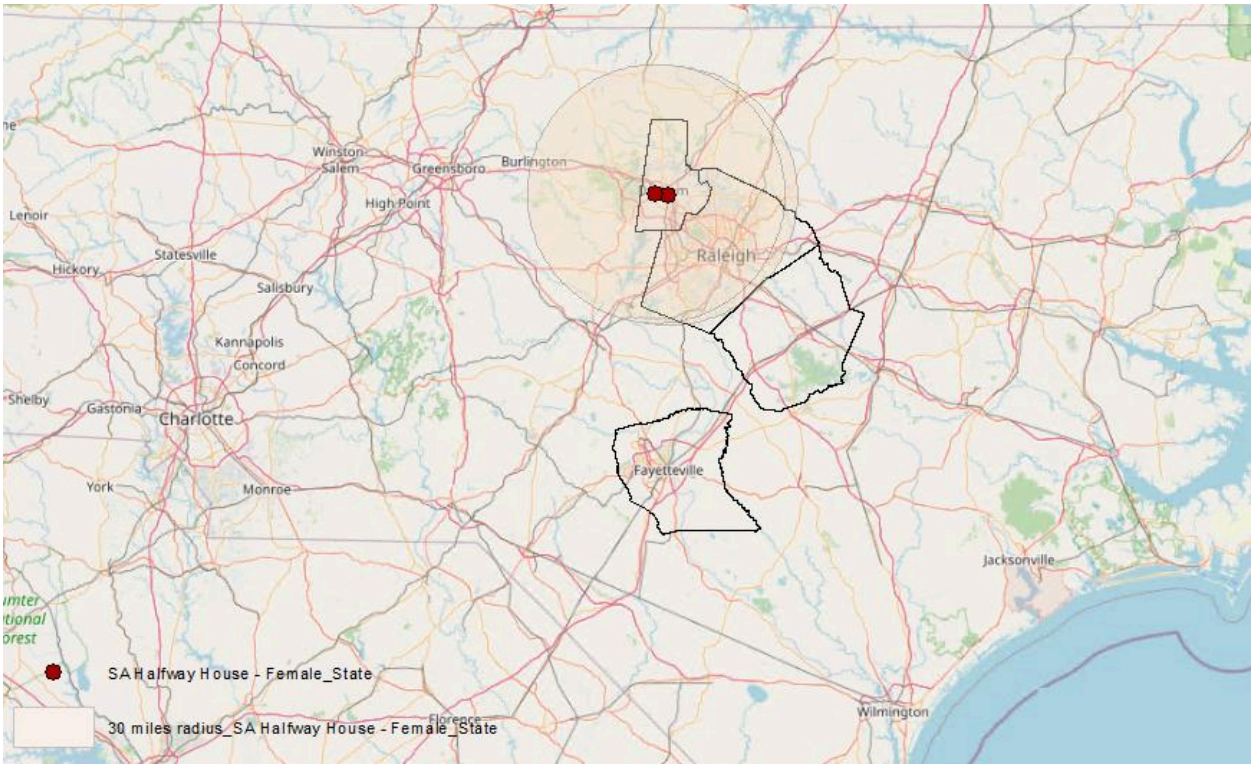
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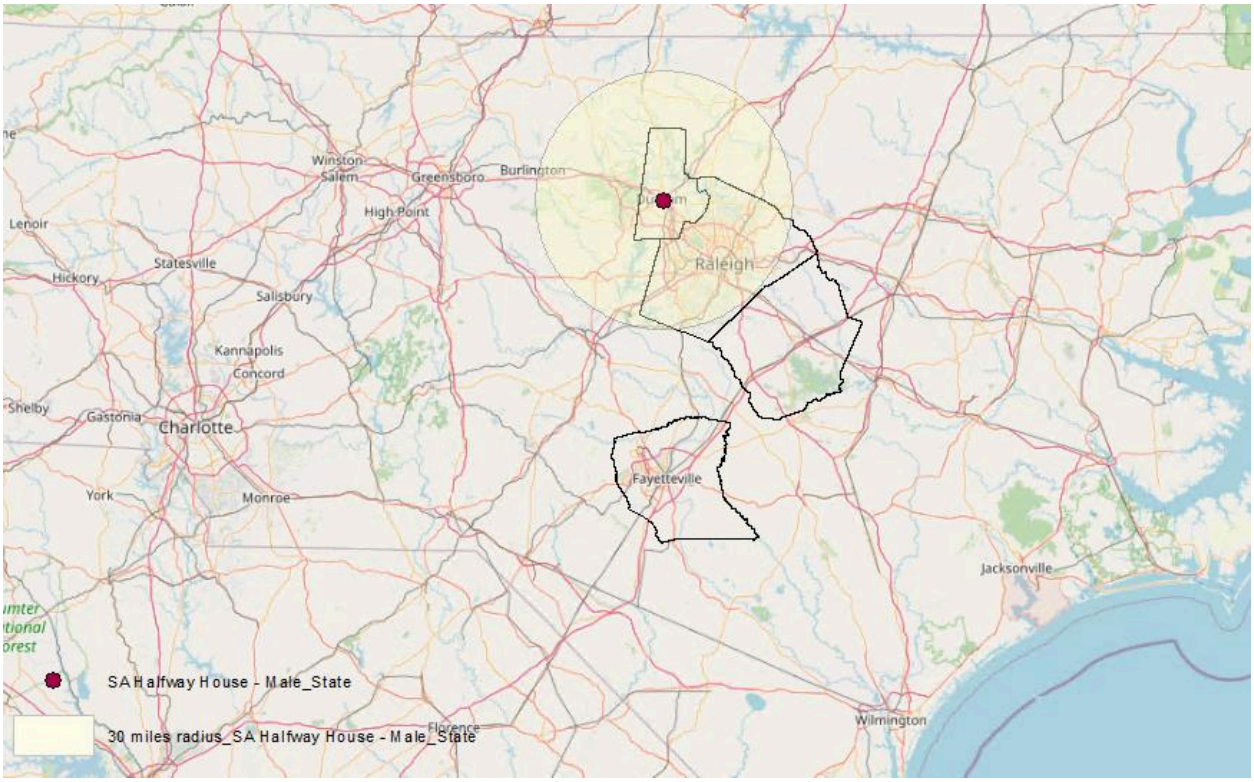
30 miles radius_SA Halfway House - Female_State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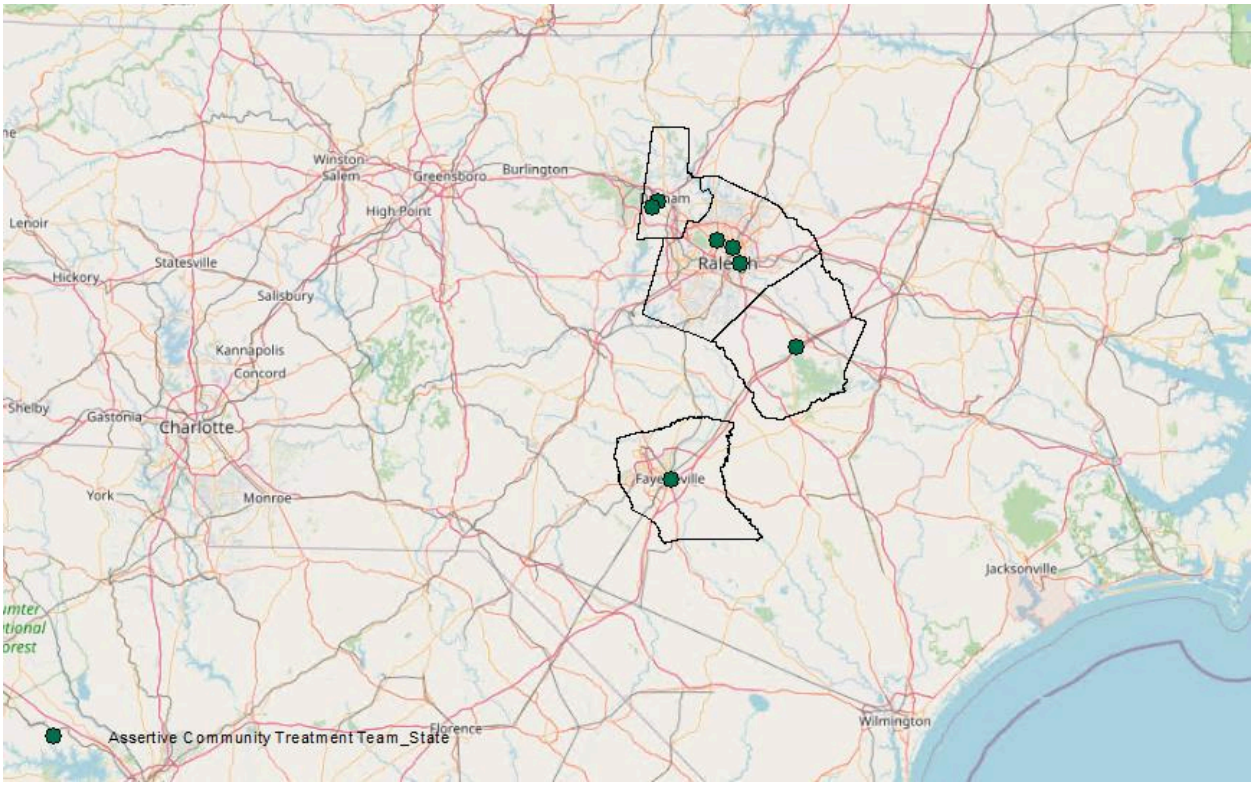
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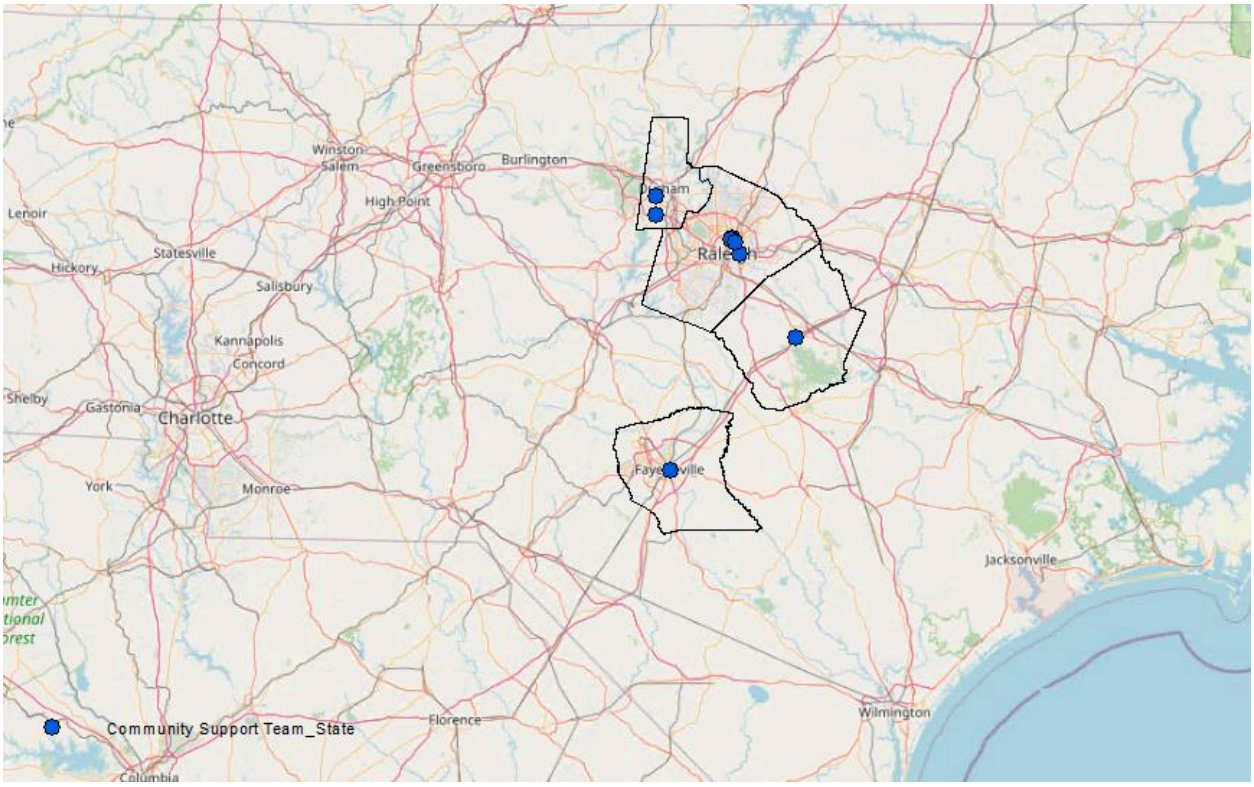
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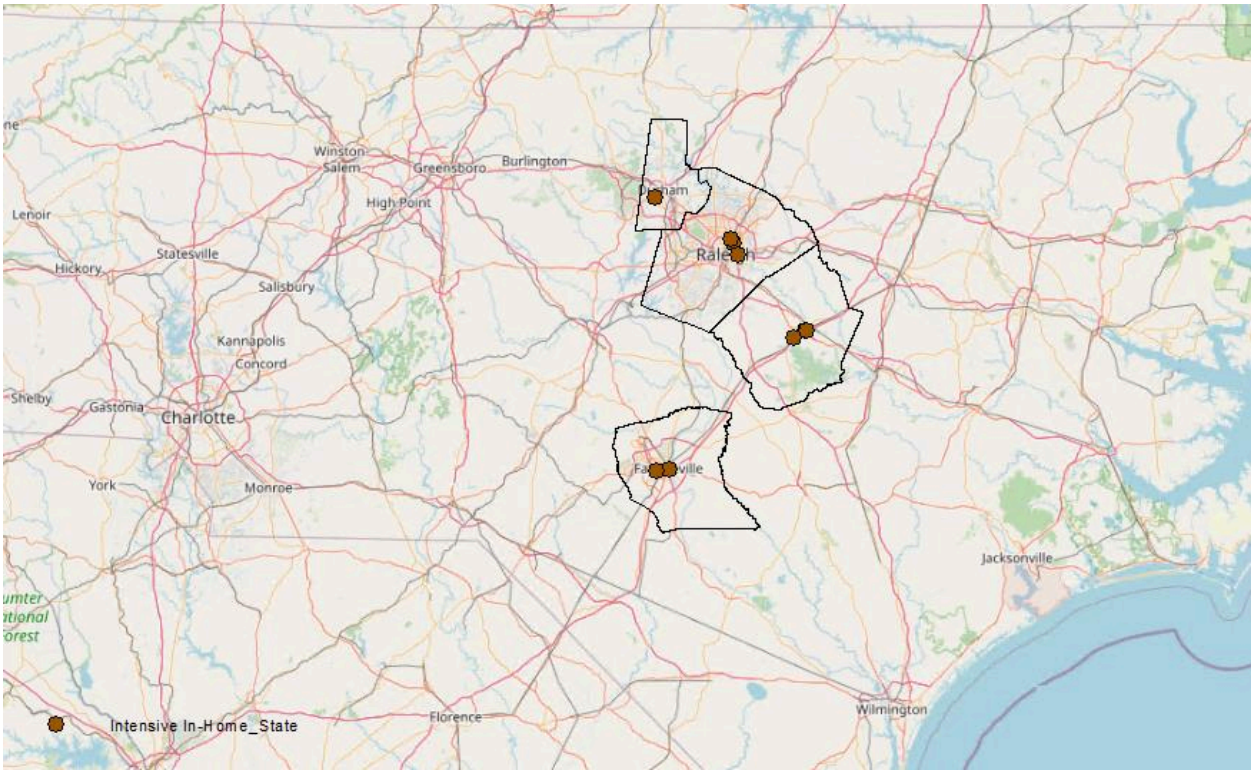
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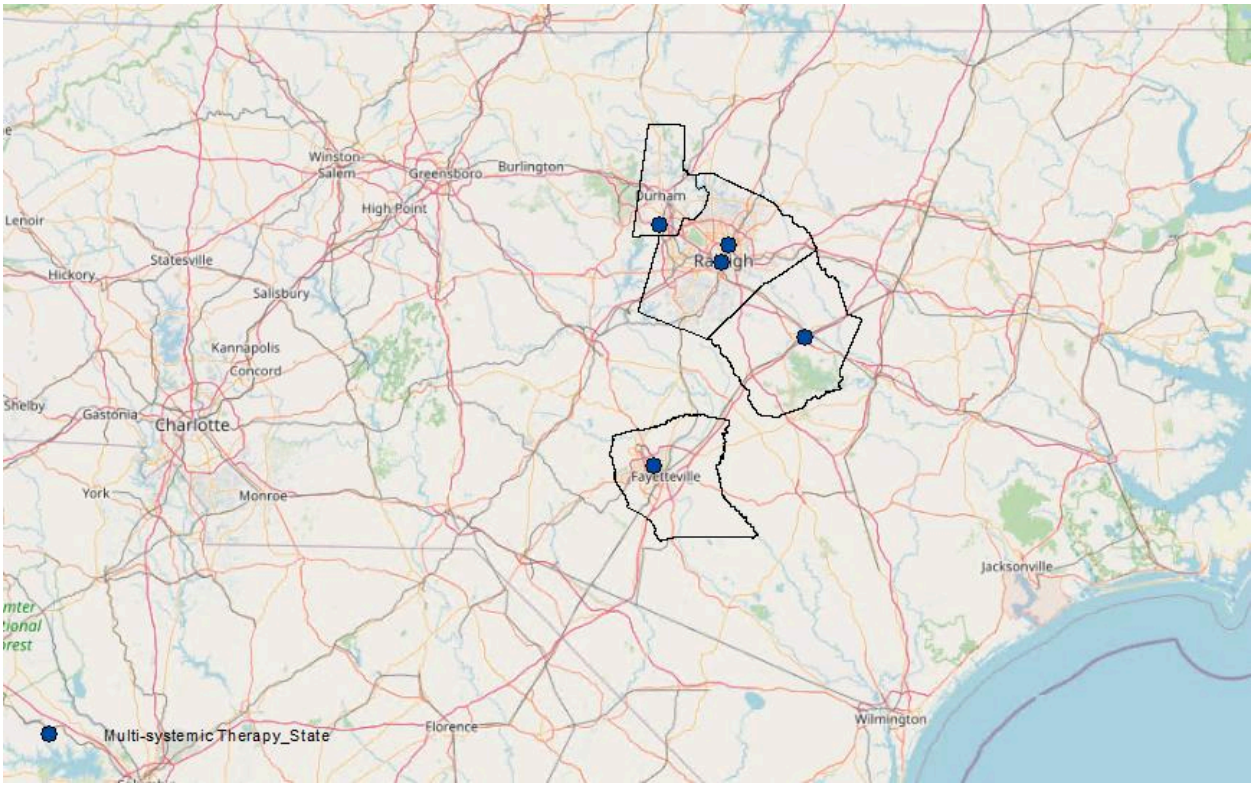
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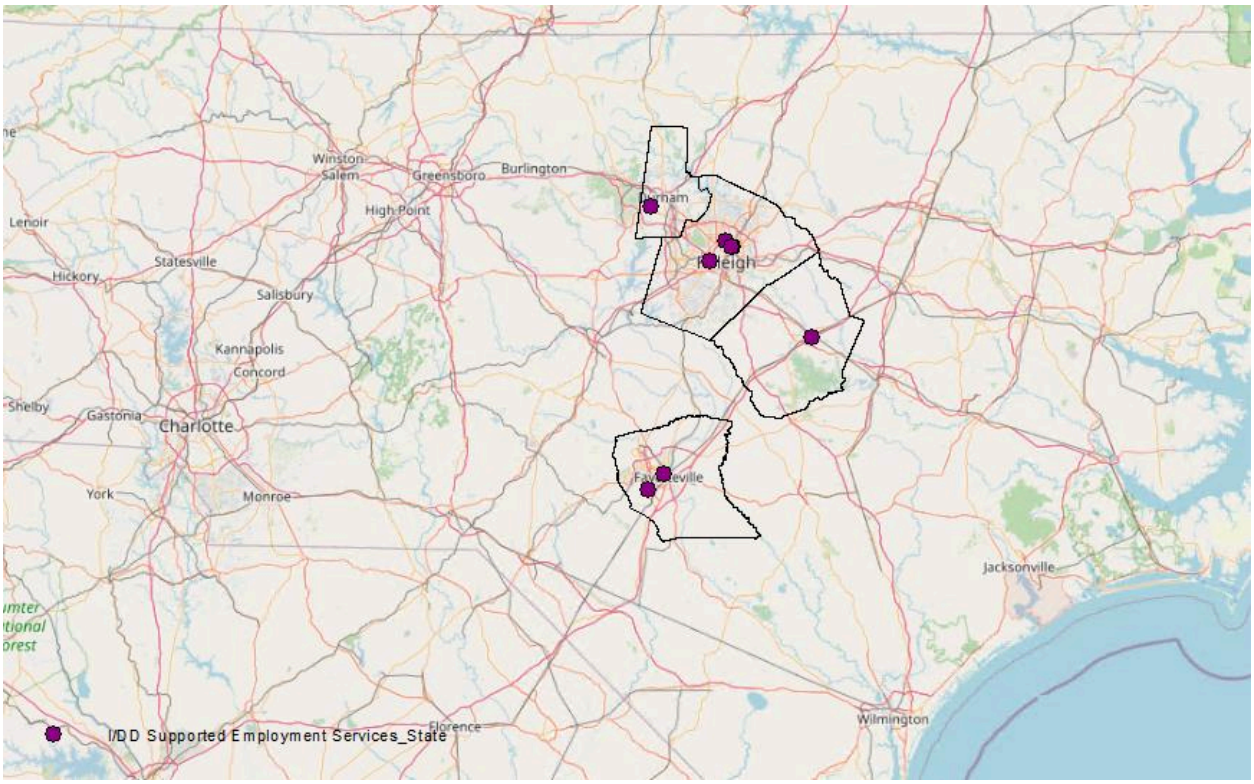
Multi-systemic Therapy_State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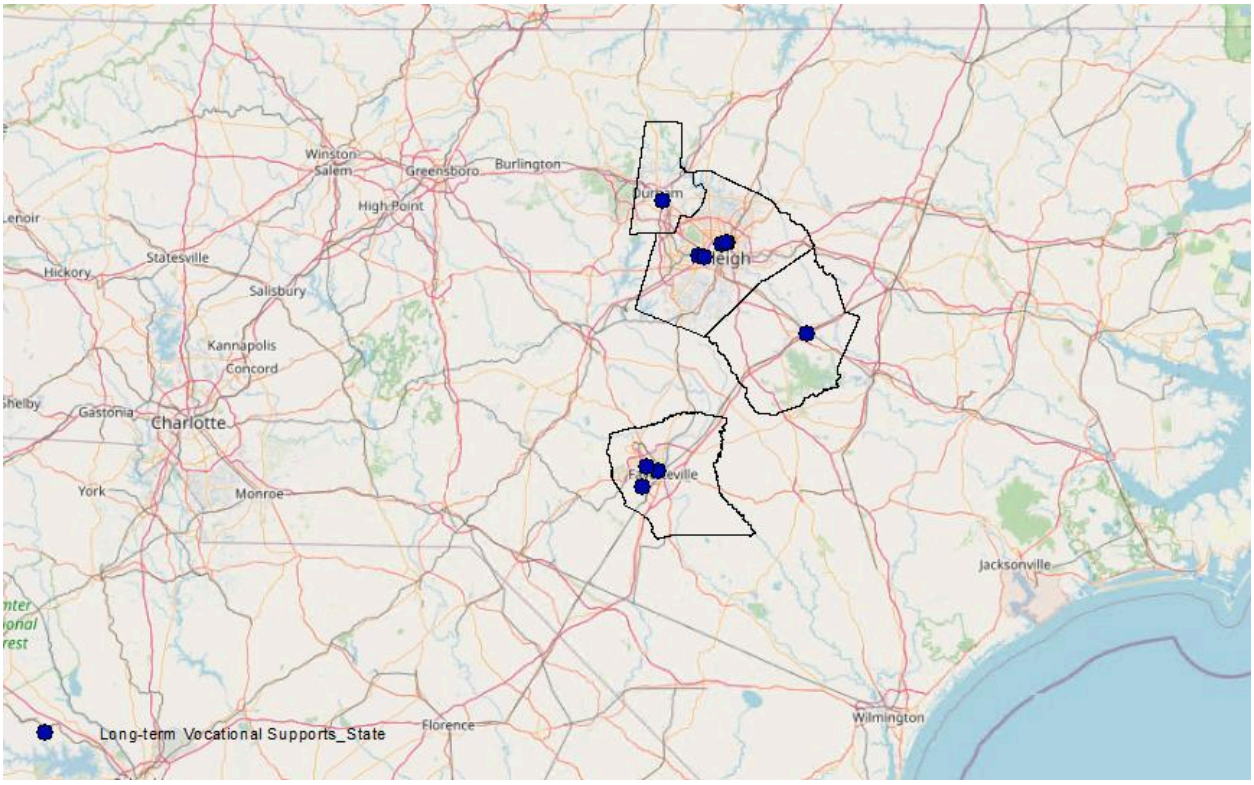
I/DD Supported Employment Services_State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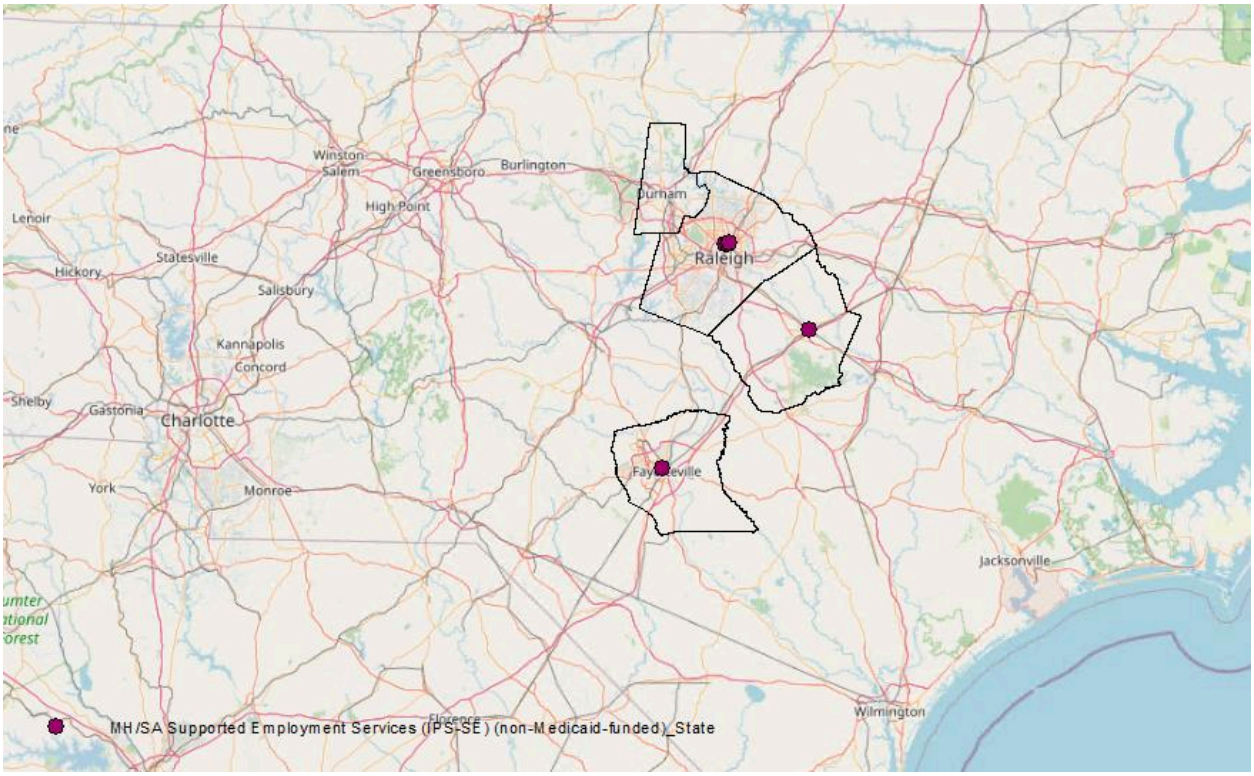
Long-term Vocational Supports_State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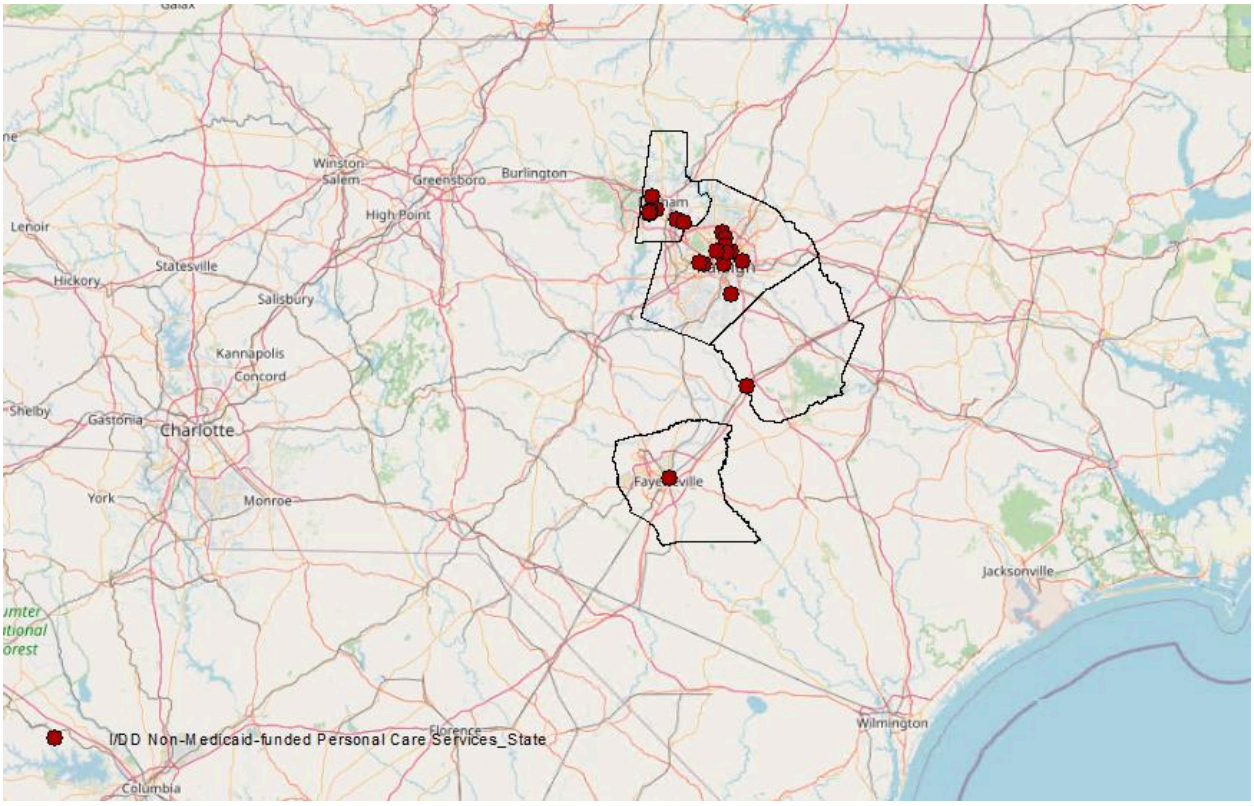
MH/SA Supported Employment Services (IPS-SE) (non-Medicaid-funded)_State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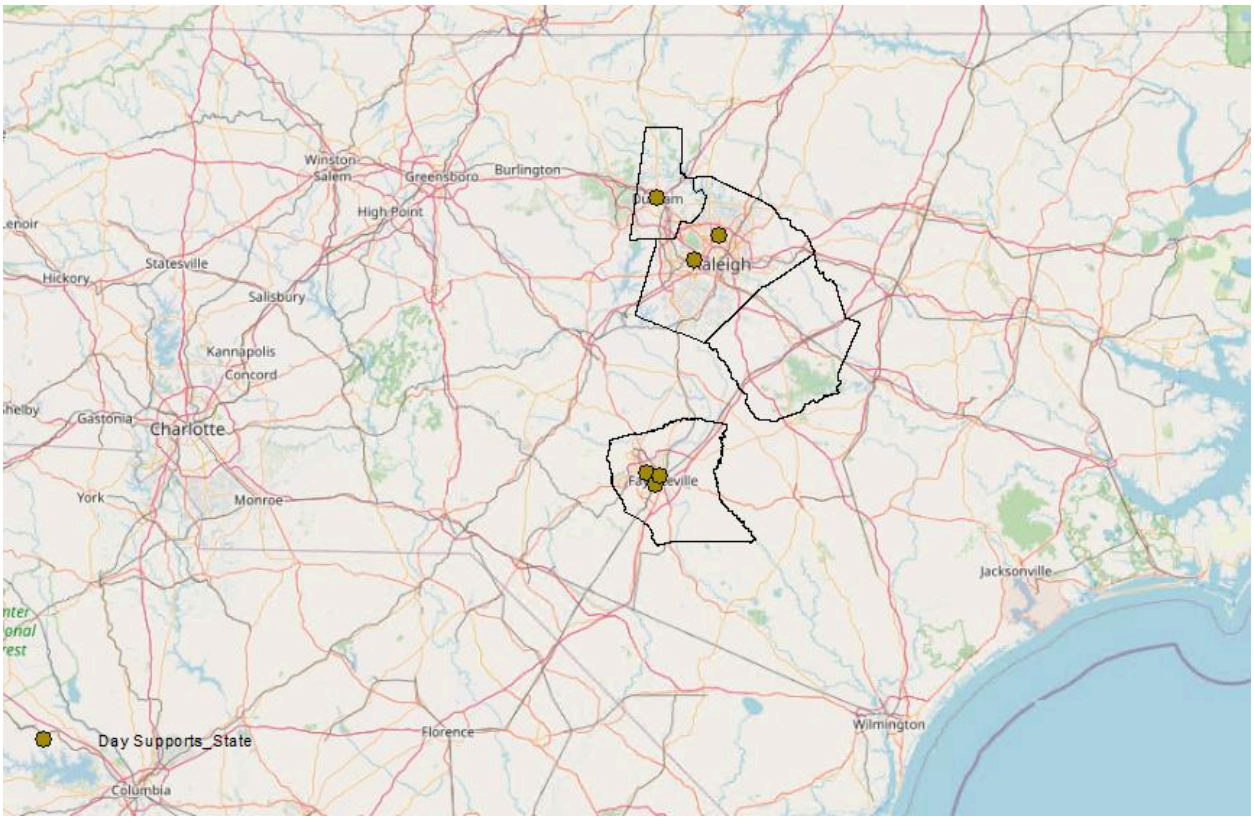
I/DD Non-Medicaid-funded Personal Care Services_State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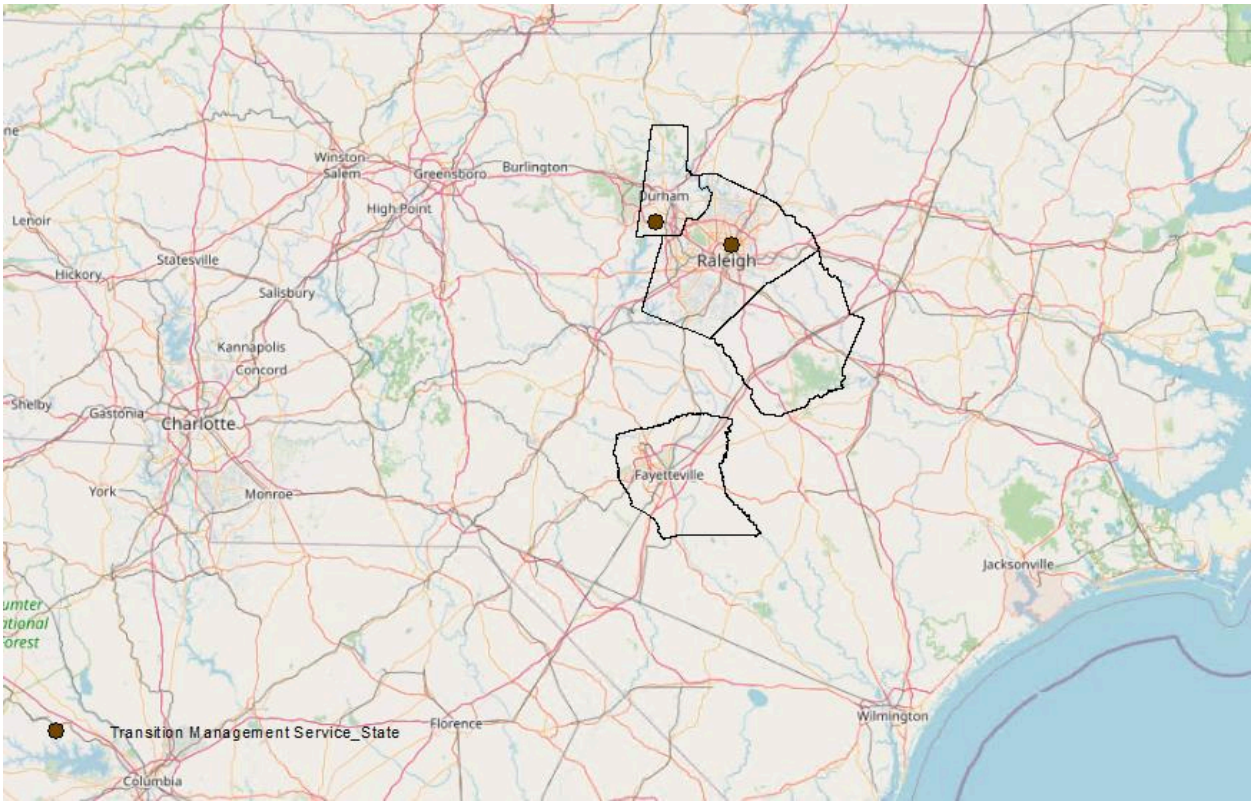
Day Supports_State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Transition Management Service_State
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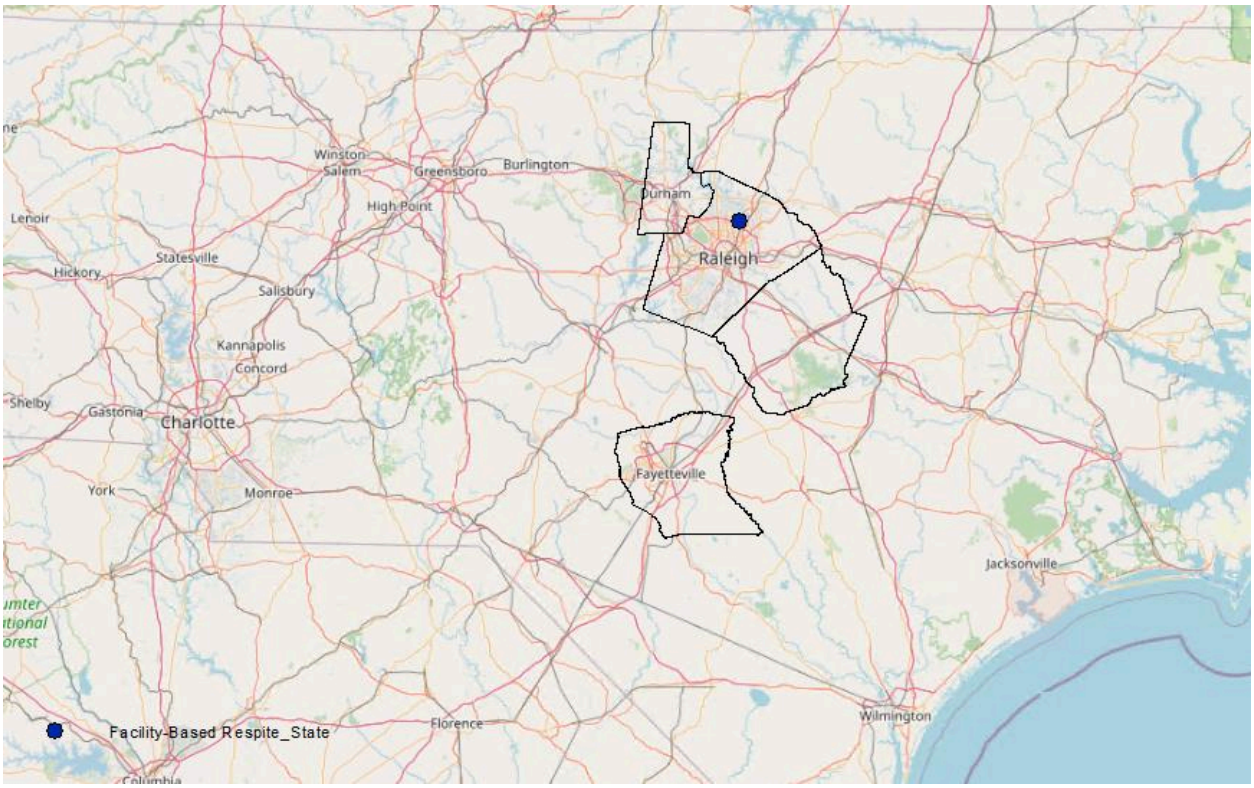
Columbia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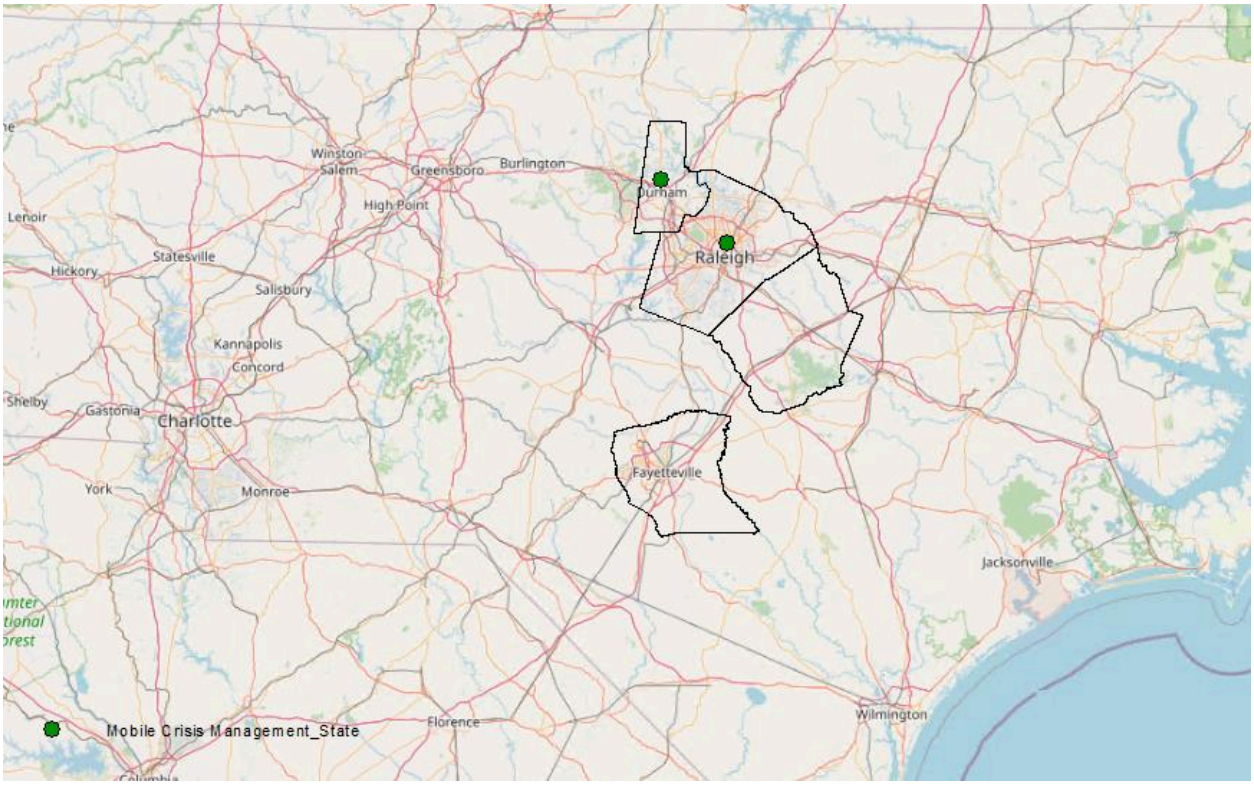
Facility-Based Respite_State
Florence
Wilmington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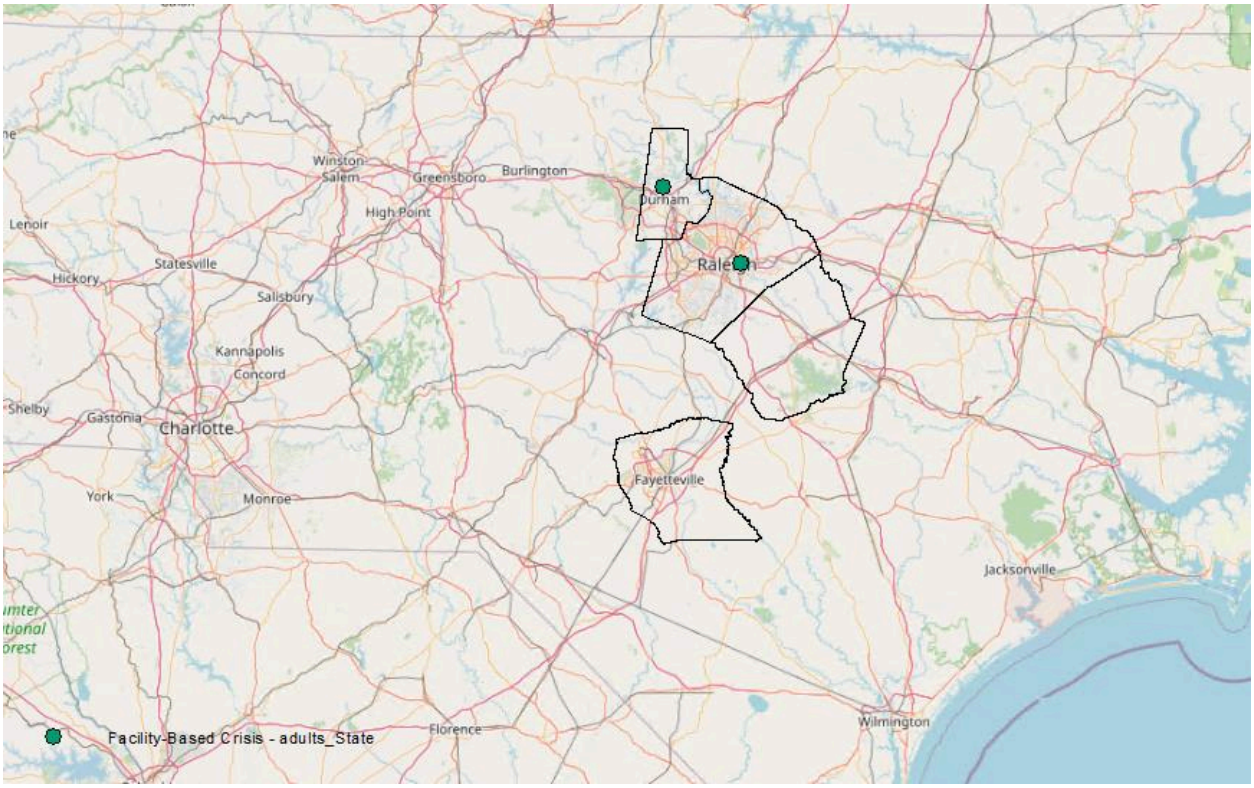
Mobile Crisis Management_State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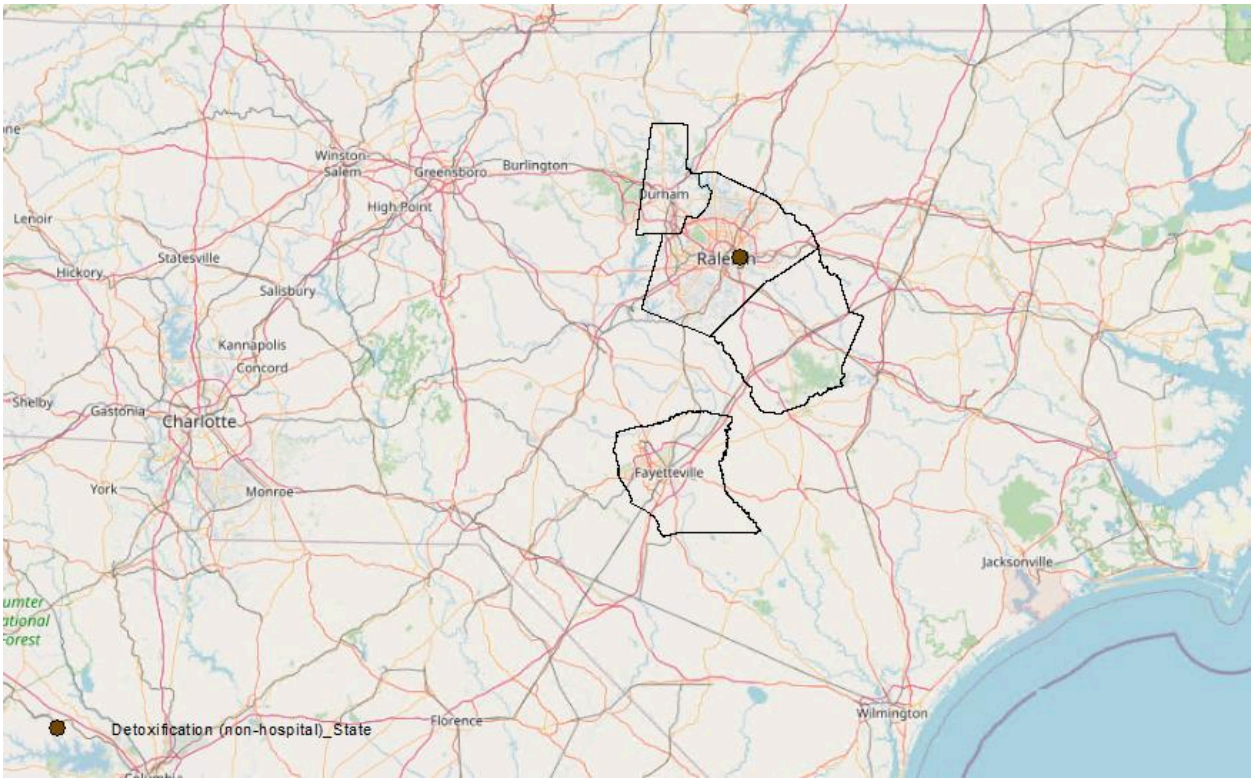
Facility-Based Crisis - adults_State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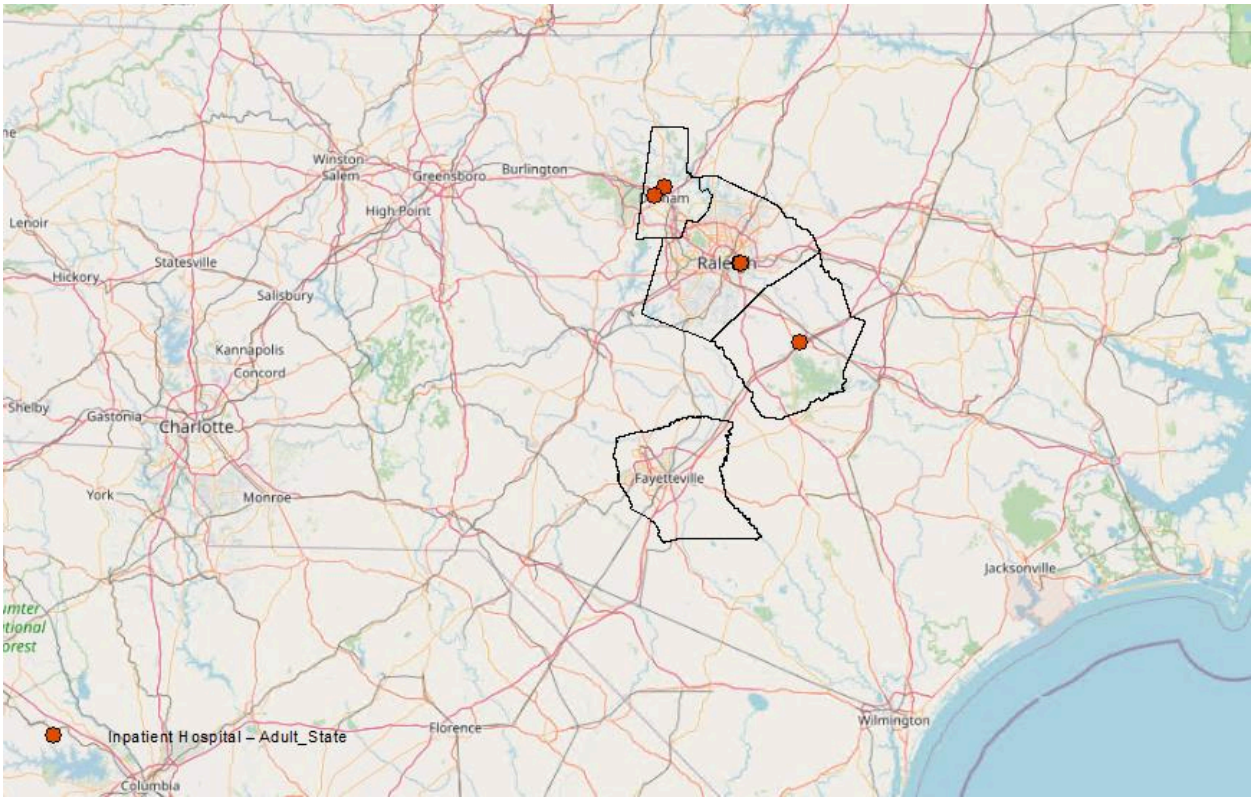
Florence
Wilmington
Detoxification (non-hospital)_State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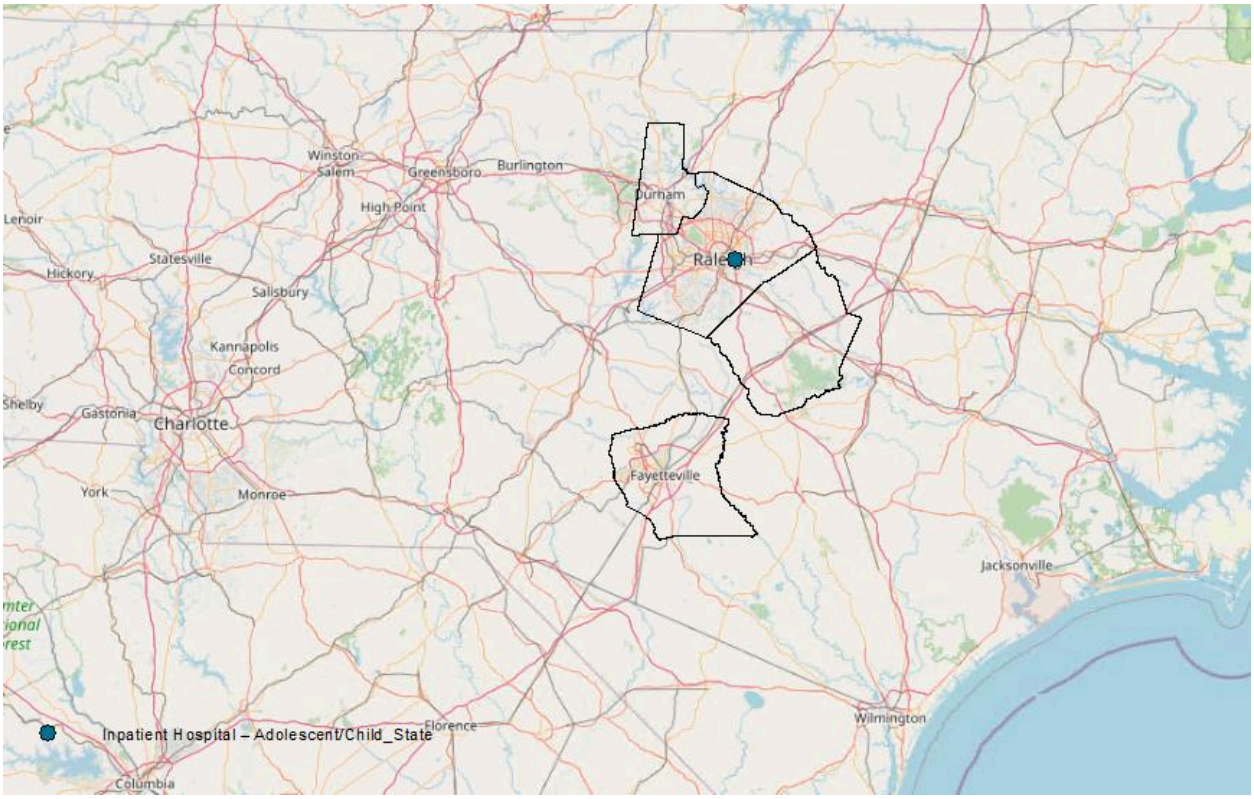
Wilmington
Inpatient Hospital – Adult_State
Columbia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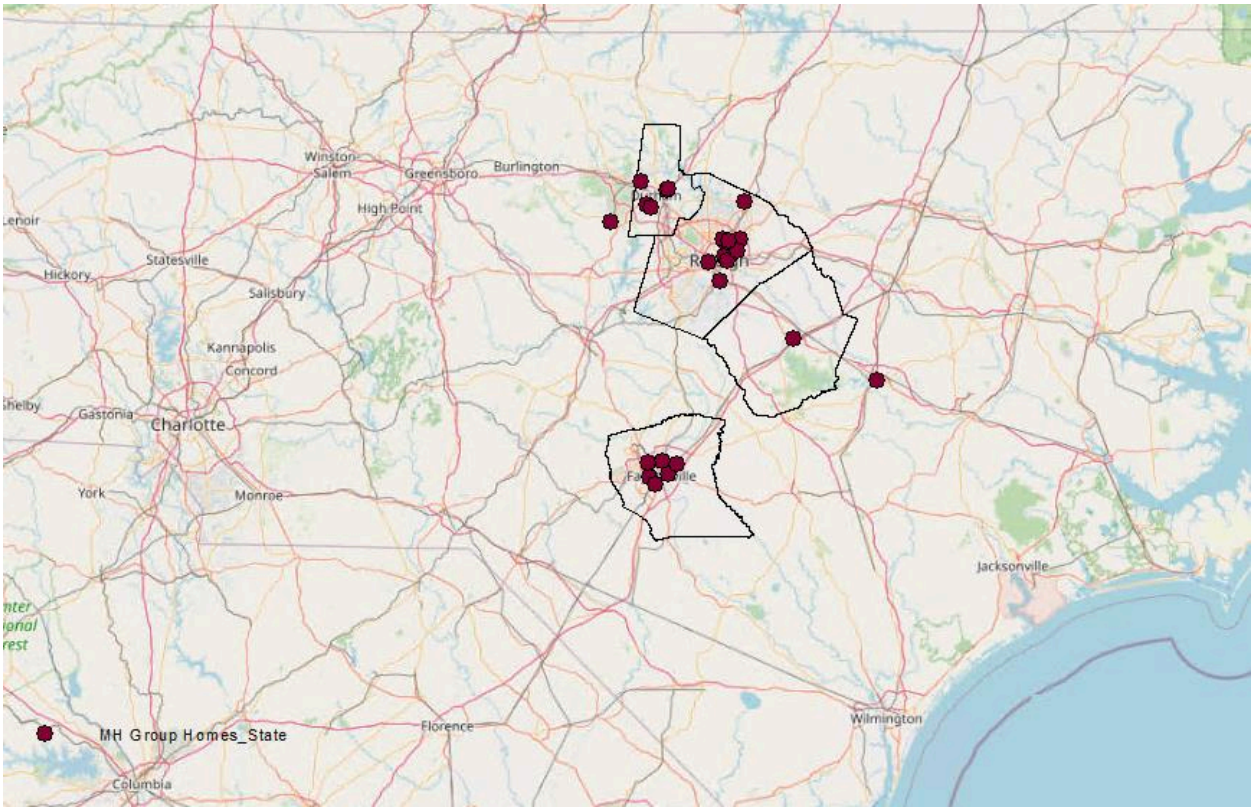
Inpatient Hospital – Adolescent/Child_State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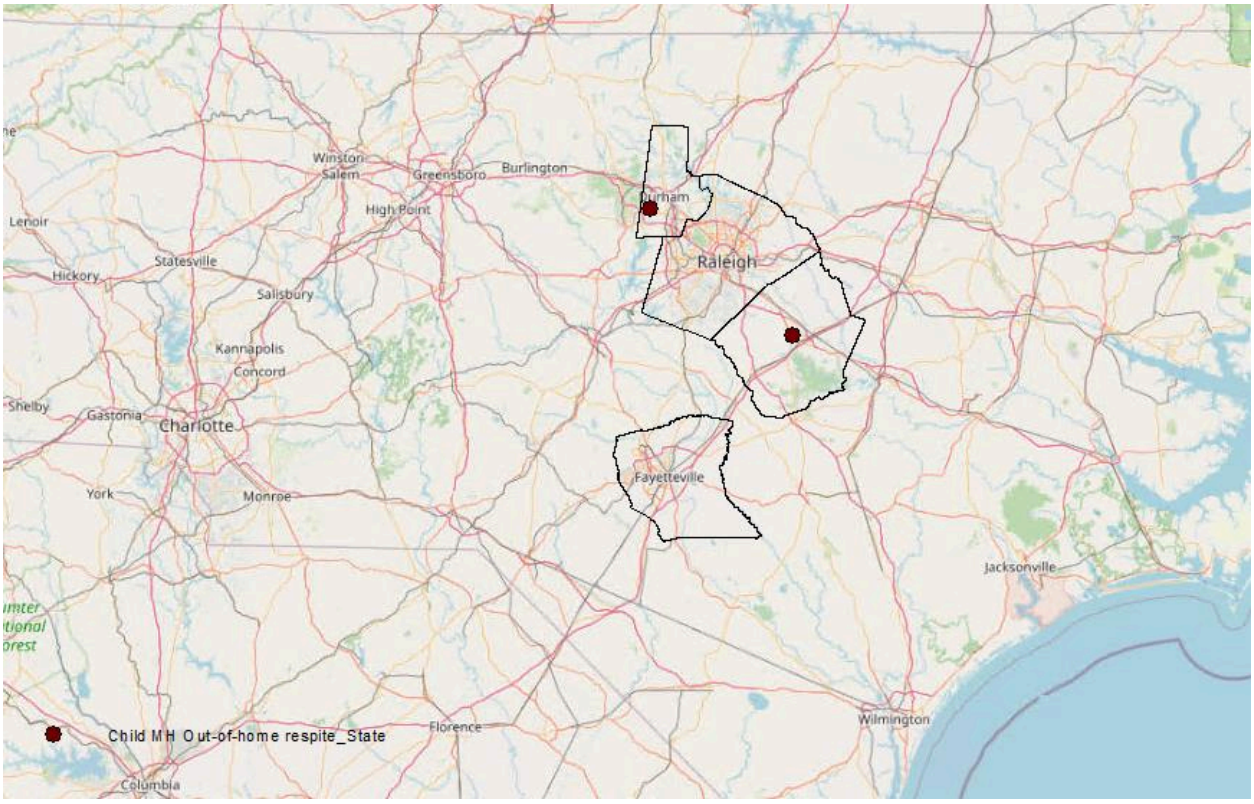
MH Group Homes_State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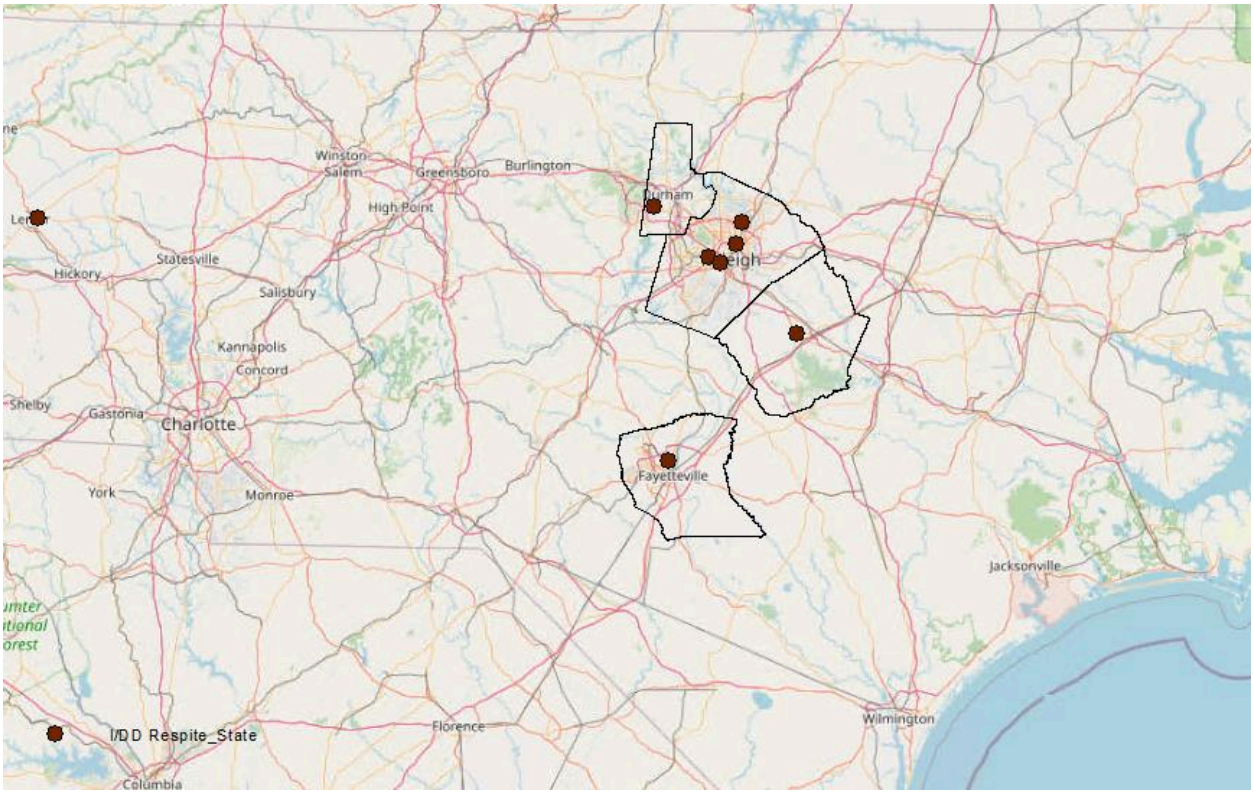
Child MH Out-of-home respite_State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Florence
Wilmington
Columbia
I/DD Respite_State

Office-Based Opioid Treatment Providers

Agency	Address	County
Greater Image Healthcare	401 Robeson St, Fayetteville, 28301	Cumberland
Life Net Services	1790 Metromedical Dr, Fayetteville, 28304	Cumberland
Recovery Innovations	1724 Roxie Ave, Fayetteville, 28304	Cumberland
Carolina Behavioral Care	4102 Ben Franklin Blvd, Durham, 27704	Durham
Carolina Outreach	2670 Durham Chapel Hill Blvd, Durham, 27707	Durham
Eleanor Health	3711 University Dr, Durham, 27707	Durham
Freedom House Recovery Center	400 Crutchfield St, Durham, 27704	Durham
Recovery Innovations	309 Crutchfield St, Durham, 27704	Durham
Structured Family Interventions	6011 Fayetteville Rd, Durham, 27713	Durham
The HOPE Centre for Advancement	701 Morreene RD, Durham, 27705	Durham
Cottage Health Care Services	3826 Bland Rd, Raleigh, 27609	Wake
Fellowship Health Resources	5509 Creedmoor Rd, Raleigh, 27612	Wake
Fellowship Health Resources	222 E Chatham St, Cary, 27511	Wake
Fernandez Community Center	8376 Six Forks Rd, Raleigh, 27615	Wake
Insight Family Center	5884 Faringdon Pl, Raleigh, 27609	Wake
Morse Clinic of North Raleigh	3209 Gresham Lake Rd, Raleigh, 27615	Wake
Morse Clinic of Zebulon	877 E Gannon Ave, Zebulon, 27597	Wake
Solas Health	8001 Creedmoor Road, Raleigh, 27613	Wake
Solaz	2231 E. Millbrook Rd, Raleigh, 27604	Wake
Southlight Healthcare	2101 Garner Rd, Raleigh, 27610	Wake
Southlight Healthcare	3117 Poplarwood Ct, Raleigh, 27604	Wake
UNC Faculty Physicians	111 Sunnybrook Rd, Raleigh, 27610	Wake

The agencies listed above have current contracts to provide Medicaid-funded Office-Based Opioid Treatment (OBOT) using modified E&M codes (99212 22, 99213 22, 99214 22) that have an enhanced reimbursement rate. Other agencies are also providing this service through billing of unmodified E&M codes. Information on specific prescribers for each agency is not currently available.

Two providers, identified in **bold** above, are also providing Non-Medicaid funded OBOT services.