Network Adequacy and Accessibility Analysis

September 21, 2018
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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 Fiscal Year 2016-17 and is submitted to the North Carolina Department of Health and Human Services by September 21, 2018 as required by DHHS-MCO contracts.

The FY17 Alliance Community Needs Assessment and Gaps Analysis includes a summary of the previous year’s actions, review of provider capacity, assessment of service accessibility and choice, and incorporation of community feedback about needs and gaps. The resulting analysis and conclusions are the basis for network development priorities and the Alliance Network Development Plan for FY18-19.

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

The Community Needs Assessment process has provided an opportunity to review the status of the FY18 Network Development Plan, obtain additional community input and identify strategic goals for network development for FY19. The following analysis provides a summary of information obtained through this process and the themes and objectives that have emerged as highest priority actions for FY19. 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.
Section One
Network Availability and Accessibility

I. Access and Choice Standards and Data

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 providers within a 30-mile radius or 30-minute drive time for any consumer residing in the Alliance catchment area. The tables provided below summarize geographic access and choice data for Alliance services in the following categories:

A. **Outpatient Services**: psychiatric care, medication management, evaluations, and individual, group and family psychotherapy.

B. **Location-Based Services**: array of services that are facility or site-based, such as Psychosocial Rehabilitation, Child and Adolescent Day Treatment, and SA Intensive Outpatient Treatment.

C. **Community-Based and Mobile Services**: provided in home and community settings such as Supported Employment, Peer Support and Intensive In-Home services.

D. **Crisis Services**: Facility-Based Respite, Facility-Based Crisis and Non-Hospital Detoxification services.

E. **Inpatient Services**: inpatient psychiatric care all ages.

F. **Specialized Services**: specific list of services, most of which are residential services.

G. **C-Waiver Services**: those that are covered through the Innovations / 1915(c) waiver.

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

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Medicaid</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>Choice of TWO (2) providers within 30 miles / 30 minutes</td>
<td>Choice of TWO (2) providers within 30 miles or 30 minutes</td>
</tr>
<tr>
<td>Location-Based</td>
<td>Choice of TWO (2) providers within 30 miles or 30 minutes</td>
<td>Access to ONE (1) provider within 30 miles or 30 minutes</td>
</tr>
<tr>
<td>Community / Mobile</td>
<td>Choice of TWO (2) providers within ABH catchment area</td>
<td>Access to ONE (1) provider within ABH catchment area</td>
</tr>
<tr>
<td>Crisis</td>
<td>Access to ONE (1) provider within ABH catchment area</td>
<td>Access to ONE (1) provider within ABH catchment area</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Access to ONE (1) provider within ABH catchment area</td>
<td>Access to ONE (1) provider within ABH catchment area</td>
</tr>
<tr>
<td>Specialized</td>
<td>Access to ONE (1) provider within North Carolina</td>
<td>Access to ONE (1) provider within North Carolina</td>
</tr>
<tr>
<td>C-Waiver (two sections)</td>
<td>Section A: Choice of TWO (2) providers within ABH catchment area</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Section B: Choice of ONE (1) provider within ABH catchment area</td>
<td></td>
</tr>
</tbody>
</table>
### A. Outpatient Services

<table>
<thead>
<tr>
<th>Categories</th>
<th>Medicaid</th>
<th>Non-Medicaid Funded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of providers</td>
<td># of enrollees with choice of two providers within 30 miles/minutes</td>
</tr>
<tr>
<td></td>
<td>accepting new Medicaid consumers</td>
<td>enrollees</td>
</tr>
<tr>
<td>Reside in urban counties</td>
<td>339</td>
<td>263,740</td>
</tr>
<tr>
<td>Reside in rural counties</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total (standard = 100%)</td>
<td>339</td>
<td>263,740</td>
</tr>
<tr>
<td>Adults (age 18+)</td>
<td>339</td>
<td>113,380</td>
</tr>
<tr>
<td>Children (age 17 and younger)</td>
<td>339</td>
<td>150,360</td>
</tr>
<tr>
<td>Total (standard = 100%)</td>
<td>339</td>
<td>263,740</td>
</tr>
</tbody>
</table>

### B. Location-Based Services

<table>
<thead>
<tr>
<th>Location-based Services</th>
<th>Medicaid</th>
<th>Non-Medicaid Funded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of providers accepting new Medicaid consumers</td>
<td># and % of enrollees with choice of two providers within 30 miles/minutes of their residences</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation</td>
<td>24</td>
<td>113,380</td>
</tr>
<tr>
<td>Child and Adolescent Day Treatment</td>
<td>8</td>
<td>114,605</td>
</tr>
<tr>
<td>SA Comprehensive Outpatient Treatment Program</td>
<td>15</td>
<td>263,740</td>
</tr>
<tr>
<td>SA Intensive Outpatient Program</td>
<td>20</td>
<td>263,740</td>
</tr>
<tr>
<td>Opioid Treatment</td>
<td>7**</td>
<td>78,446</td>
</tr>
<tr>
<td>Day Supports</td>
<td>1</td>
<td>413</td>
</tr>
</tbody>
</table>

* Table reflects the status as of January 1, but non-Medicaid Opioid Treatment referrals are currently suspended due to depletion of STR/Cures funding.

** In addition to Opioid Treatment services covered above, Alliance has added 14 contracts for Medicaid-funded Office-Based Opioid Treatment (OBOT) services in each county except Johnston.
C. Community/Mobile Services

<table>
<thead>
<tr>
<th>Community/Mobile Service</th>
<th>Medicaid</th>
<th>Non-Medicaid-Funded</th>
<th>Total # of Consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assertive Community Treatment Team</td>
<td># of providers accepting new Medicaid consumers</td>
<td># and % of enrollees with choice of two provider agencies within the LME-MCO catchment area</td>
<td>Total # of Medicaid enrollees</td>
</tr>
</tbody>
</table>
| Assertive Community Treatment Team             | 11                                           | 113,380                                                  | 100%                | 113,380                                              | 8                                           | 16,484                                                   | 100%                | 16,484
| Community Support Team                         | 12                                           | 113,378                                                  | 100%                | 113,380                                              | 8                                           | 16,484                                                   | 100%                | 16,484
| Intensive In-Home                              | 29                                           | 150,360                                                  | 100%                | 150,360                                              | 12                                          | 1,019                                                    | 100%                | 1,019
| Mobile Crisis                                  | 2                                            | 263,740                                                  | 100%                | 263,740                                              | 2                                           | 18,218                                                   | 100%                | 18,218
| Multi-systemic Therapy                         | 6                                            | 150,360                                                  | 100%                | 150,360                                              | 5                                           | 1,019                                                    | 100%                | 1,019
| (b)(3) MH Supported Employment Services        | 5                                            | 263,740                                                  | 100%                | 263,740                                              | 5                                           | 1,019                                                    | 100%                | 1,019
| (b)(3) I/DD Supported Employment Services      | 13                                           | 263,740                                                  | 100%                | 263,740                                              |                                             |                                                          |                      |                      |
| (b)(3) Waiver Community Guide                  | 10                                           | 263,740                                                  | 100%                | 263,740                                              |                                             |                                                          |                      |                      |
| (b)(3) Waiver Individual Support (Personal Care)| 8                                            | 263,740                                                  | 100%                | 263,740                                              |                                             |                                                          |                      |                      |
| (b)(3) Waiver Peer Support                     | 30                                           | 263,740                                                  | 100%                | 263,740                                              |                                             |                                                          |                      |                      |
| (b)(3) Waiver Respite                          | 36                                           | 263,740                                                  | 100%                | 263,740                                              |                                             |                                                          |                      |                      |
| I/DD Supported Employment Services (non-Medicaid-funded) | 8                                           | 715                                                       | 100%                | 715                                                  |                                             |                                                          |                      |                      |
| Long-term Vocational Supports (non-Medicaid-funded) | 11                                         | 415                                                       | 100%                | 415                                                  |                                             |                                                          |                      |                      |
| MH/SA Supported Employment Services (IPS-SE) (non-Medicaid-funded) | 5                                           | 16,484                                                   | 100%                | 16,484                                               |                                             |                                                          |                      |                      |
| I/DD Non-Medicaid-funded Personal Care Services | 22                                           | 715                                                       | 100%                | 715                                                  |                                             |                                                          |                      |                      |
| I/DD Non-Medicaid-funded Respite Community Services | 3                                           | 715                                                       | 100%                | 715                                                  |                                             |                                                          |                      |                      |
| I/DD Non-Medicaid-funded Respite Hourly Services not in a licensed facility | 4                                           | 715                                                       | 100%                | 715                                                  |                                             |                                                          |                      |                      |
| Developmental Therapies (Non-Medicaid)          | 17                                           | 715                                                       | 100%                | 715                                                  |                                             |                                                          |                      |                      |
### D. Crisis Services

<table>
<thead>
<tr>
<th>Crisis Service</th>
<th>Medicaid</th>
<th>Non-Medicaid Funded</th>
<th>Total # of Consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility-Based Crisis - adults</td>
<td>3</td>
<td>113,380 100%</td>
<td>113,380</td>
</tr>
<tr>
<td>Facility-Based Respite</td>
<td>n/a</td>
<td>n/a n/a</td>
<td>263,740</td>
</tr>
<tr>
<td>Detoxification (non-hospital)</td>
<td>2</td>
<td>263,740 100%</td>
<td>263,740</td>
</tr>
<tr>
<td>FOR INFORMATION</td>
<td>0</td>
<td>0 0</td>
<td>150,360</td>
</tr>
<tr>
<td>PURPOSES ONLY: Facility-Based Crisis - children</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### E. Inpatient Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid</th>
<th>Non-Medicaid-Funded</th>
<th>Total # of Consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital – Adult</td>
<td>6</td>
<td>113,380 100%</td>
<td>113,380</td>
</tr>
<tr>
<td>Inpatient Hospital – Adolescent/Child</td>
<td>1 150,360 100%</td>
<td>150,360</td>
<td>1 1,019 100%</td>
</tr>
</tbody>
</table>
## F. Specialized Services

Number of parent agencies* with LME/MCO contracts.

<table>
<thead>
<tr>
<th>Service</th>
<th>Number Parent Agencies with Current Medicaid Contract</th>
<th>Number Parent Agencies with Current Contract for Non-Medicaid Funded Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Hospitalization</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>MH Group Homes</td>
<td></td>
<td>31</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facility</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Residential Treatment Level 1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Residential Treatment Level 2: Therapeutic Foster Care</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td>Residential Treatment Level 2: other than Therapeutic Foster Care</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Residential Treatment Level 3</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Residential Treatment Level 4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Child MH Out-of-home respite</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>SA Non-Medical Community Residential Treatment</td>
<td>0**</td>
<td>0**</td>
</tr>
<tr>
<td>SA Medically Monitored Community Residential Treatment</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>SA Halfway Houses</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>I/DD Out-of-home respite (non-Medicaid-funded)</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>I/DD Facility-based respite (non-Medicaid-funded)</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>I/DD Supported Living (non-Medicaid-funded)</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>(b)(3) I/DD Out-of-home respite</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>(b)(3) I/DD Facility-based respite **</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>(b)(3) I/DD Residential supports</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Intermediate Care Facility/IDD</td>
<td>78</td>
<td></td>
</tr>
</tbody>
</table>

*Parent agencies are listed above as opposed to service sites. For example, a parent agency with six residential sites would count only as ‘1’ instead of ‘6’ in table calculations.

**SA Non-Medical Community Residential Treatment: this level of care is available to both Medicaid-funded and State-funded consumers through three CASAWORKS providers who are funded through State Non-UCR contracts.
### G. C-Waiver Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Adult</th>
<th>Child</th>
<th># and % of enrollees with choice of two provider agencies within the LME/MCO catchment area</th>
<th>Total # of C-Waiver Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Living and Supports</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Community Navigator</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Community Navigator Training for Employer of Record</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Community Networking</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Crisis Behavioral Consultation</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>In Home Intensive</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>In Home Skill Building</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Personal Care</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Crisis Consultation</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Crisis Intervention &amp; Stabilization Supports</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Residential Supports 1</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Residential Supports 2</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Residential Supports 3</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Residential Supports 4</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Respite Care – Community</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Respite Care Nursing – LPN &amp; RN</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>16 &amp; older</td>
<td>1,541 100%</td>
<td>1,541</td>
<td></td>
</tr>
<tr>
<td>Supported Employment – Long Term Follow-up</td>
<td>16 &amp; older</td>
<td>1,541 100%</td>
<td>1,541</td>
<td></td>
</tr>
<tr>
<td>Supported Living</td>
<td>18 &amp; older</td>
<td>1,404 100%</td>
<td>1,404</td>
<td></td>
</tr>
</tbody>
</table>

**C-Waiver Services – Access to at least one provider**

<table>
<thead>
<tr>
<th>Services</th>
<th>Adult</th>
<th>Child</th>
<th># and % of enrollees with choice of one of multiple services</th>
<th>Total # of C-Waiver Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Supports</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Out of Home Crisis</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Respite Care - Community Facility</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Financial Supports</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
<tr>
<td>Specialized Consultative Services (at least one provider of one of multiple services)</td>
<td>✓</td>
<td>✓</td>
<td>1,806 100%</td>
<td>1,806</td>
</tr>
</tbody>
</table>
II. Geographic Access Maps Overview

Geo maps are provided in Appendix A for all Medicaid-funded services listed in these requirements, except for outpatient services. Geo maps show provider agencies with Alliance contracts as of 1/1/2018 to provide Medicaid services in the following categories:

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

2. **Community/Mobile Services** – one geo map for each Medicaid crisis service that shows provider locations within the **Alliance catchment area**.

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

4. **Inpatient Services** – one geo map for each Medicaid crisis service that shows provider locations within the **Alliance catchment area**.

5. **Specialized Services** – one geo map for each Medicaid 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**.
III. 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, Behavioral Health Urgent Care, and Mobile Crisis Management services that help achieve timely access to 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.

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. 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.

Consumer 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. For those who contact providers directly, Alliance monitors timeliness of onset of care through provider monitoring and response to consumer complaints. 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 1,913,097. 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>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Square Miles</th>
<th>Persons per Square Mile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>332,546</td>
<td>652</td>
<td>510</td>
</tr>
<tr>
<td>Durham</td>
<td>311,640</td>
<td>286</td>
<td>1,089</td>
</tr>
<tr>
<td>Johnston</td>
<td>196,708</td>
<td>791</td>
<td>249</td>
</tr>
<tr>
<td>Wake</td>
<td>1,072,203</td>
<td>835</td>
<td>1,284</td>
</tr>
<tr>
<td>Alliance Total</td>
<td>1,913,097</td>
<td>2564</td>
<td>730</td>
</tr>
</tbody>
</table>

2017 U.S. Census Bureau Estimate, American Factfinder

Growth. All counties except Cumberland in the Alliance area anticipate growth over the next five years, and with the exception of Cumberland, all counties are expected to grow at a rate that exceeds the state growth rate. This growth will be a significant challenge for Alliance as population increases lead to increased demand for services and competition for available resources such as transportation, housing and public assistance.
Race and Ethnicity. Across the Alliance area the primary racial group is White followed by Black and Hispanic/Latino. There is some variability across region, however. Johnston has a higher percentage of white population, with Black and Hispanic/Latino populations roughly the same percentage. Compared to the state average, Alliance has a higher percentage of Hispanic/Latino population with Durham and Johnston having the highest percentage of Alliance counties.

<table>
<thead>
<tr>
<th>County</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>American Indian</th>
<th>Hispanic/ Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>51.8%</td>
<td>38.6%</td>
<td>2.8%</td>
<td>1.8%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Durham</td>
<td>53.5%</td>
<td>37.8%</td>
<td>5.2%</td>
<td>0.9%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Johnston</td>
<td>79.6%</td>
<td>16.5%</td>
<td>0.9%</td>
<td>0.9%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Wake</td>
<td>68.4%</td>
<td>21.1%</td>
<td>7.2%</td>
<td>0.8%</td>
<td>10.2%</td>
</tr>
<tr>
<td>NC</td>
<td>70.8%</td>
<td>22.2%</td>
<td>3.1%</td>
<td>1.6%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

*Will not equal 100% due to more than one race being reported. Source: US Census Bureau, 2017 QuickFacts*

Review of Alliance race and ethnicity data for persons served in FY17 reveals some discrepancies between population and service utilization demographics. Further evaluation is needed to explore the causes for observed discrepancies, such as economic disparities, cultural differences or differential access to health insurance and healthcare.

<table>
<thead>
<tr>
<th>County</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>American Indian</th>
<th>Hispanic/ Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>45.6%</td>
<td>47.9%</td>
<td>0.5%</td>
<td>2.1%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Durham</td>
<td>37.2%</td>
<td>53.5%</td>
<td>0.3%</td>
<td>0.4%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Johnston</td>
<td>75.2%</td>
<td>22.0%</td>
<td>0.2%</td>
<td>0.3%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Wake</td>
<td>53.2%</td>
<td>39.5%</td>
<td>0.8%</td>
<td>0.4%</td>
<td>14.4%</td>
</tr>
</tbody>
</table>

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

The Alliance catchment area includes several important resources for active military, veterans and their families, including the Fort Bragg military installations, VA Hospitals in Fayetteville and Durham, Reserve Command and local units, and NC National Guard units. An estimated 138,149 veterans live in the Alliance catchment area, according to the 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 FY 2016/17 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: [www.AllianceHealthPlan.org/consumers-families/veterans-resources/](http://www.AllianceHealthPlan.org/consumers-families/veterans-resources/).

### Homeless population

Three of the four Alliance counties have higher rates of homelessness than the surrounding region, and rates of homelessness in Alliance counties were highest in Cumberland, followed by Durham, Wake and Johnston, based on the 2017 North Carolina Point-in-Time Count of People Experiencing Homelessness.

### 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 F.

**Other potentially underserved populations.** For many potentially underserved populations, there is limited available prevalence data, or available data may be outdated or of limited generalizability to the Alliance covered population. For these populations, we have evaluated service capacity to ensure availability of services that can meet the needs of individuals in identified groups. The Provider Access Survey listed specific populations of interest, and asked respondents to identify service capacity and expertise for the following groups:

- people with traumatic brain injuries
- people with physical disabilities
- people with visual impairments
- people who are deaf or hard of hearing
- pregnant women with substance use disorders
- people who are LGBTQ
- people who are in jails or prisons
- youth in the juvenile justice system
- people who are homeless or have unstable housing
- people who have transportation barriers
- people with food insecurity
- individuals who are dually diagnosed with mental illness/intellectual & developmental disabilities (MI/IDD)
- individuals who are dually diagnosed with mental illness/substance use disorder (MI/SUD)

Although community-specific data for these groups are not available, responses to the Provider Access Survey indicate that there is capacity to provide services for each population in each county. Survey responses are summarized in Appendix D.
II. Access Barriers and Service Gaps for Specific Populations

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

- People who are homeless or who have unstable housing
- People with transportation barriers
- People who are court-involved or in jails/prisons
- Dually Diagnosed (IDD/MI & SUD/MI)
- Non-English speaking
- Uninsured / underinsured
- Individuals with IDD who are not on Innovations waiver
- People with Traumatic Brain Injuries
- People with physical disabilities
- Complex/co-occurring medical
- Autism spectrum
- Transition Age Youth, including youth aging out of foster care
- Individuals with substance use disorders
- Sex offenders, sexually aggressive youth and youth sex offenders
- Elderly
- Individuals with specialized treatment needs
Section Three
Acceptability

I. Methodology for Consumer and Family Input

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

1. Consumer and Family Advisory Committee (CFAC) feedback. Feedback approaches included presentation and discussion at CFAC meetings, and submission of a CFAC summary of identified needs and gaps. CFAC members followed up in each community to prepare local CFAC feedback for each county. CFAC members also helped inform others about the electronic survey and distributed hard copy version of the survey to those without internet access and those who preferred to submit a handwritten response.

2. Community Survey. Feedback was solicited through an internet-based survey using SurveyMonkey®. The survey included questions about access to care, barriers, populations with limited accessibility, and gaps in the service array. The same questions were used for all respondents, which included consumers and family members, stakeholders, providers and Alliance staff. The 2018 survey was redesigned to align with DHHS requirements and to reduce estimated completion time, which was reduced from 22 minutes (2017 survey) to 8 minutes.

Consumer and family respondents were also asked several additional questions regarding service access and linguistic accessibility. Surveys were administered anonymously and no identifying information was required. Survey links were posted on the Alliance website and were distributed to multiple consumer, provider and stakeholder e-mail lists. A request was sent to all Alliance staff requesting that links be forwarded to community contacts, and Alliance staff were surveyed regarding community needs and gaps.

In addition to the primary electronic version of the survey, a Spanish version of the electronic survey for consumers and family members was developed using a professional translation vendor. This survey was distributed through web site posting and e-mail messages to agencies known to serve individuals whose primary language is Spanish. Hard copies of English and Spanish versions were also posted on the website for downloading. Survey questions are provided in Appendix C.
II. Service Needs and Gaps Identified by Consumers & Family Members

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

- Residential options/residential treatment
- Vocational and educational needs
- Services to develop daily living skills
- Social networks and community connections
- Relief to primary caretakers
- Daily structured programs
- Crisis continuum
- Services to promote independence
- Community supports and activities
- Personal care and self-help needs
- Housing
- Services to address transportation challenges
- Additional service capacity to improve timely access

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

- **Adult Mental Health**: Community-based intensive treatment for adults, Inpatient psychiatric treatment
- **Child Mental Health**: Day Treatment, Child inpatient and crisis continuum, School behavioral health
- **Adult and Child I/DD**: Development and implementation of behavior plans, services for individuals on Innovations waitlist, services for individuals with autism spectrum diagnosis
- **Substance Use Disorders**: Broader array of SUD services

In addition to survey feedback about specific needs and gaps, consumers and family members also provided input regarding barriers to accessing care and identified the following as the most significant barriers:

- Limited information about how to obtain services
- Lack of reliable transportation to appointments
- Lack of insurance
- Homeless/housing issues
- Limited service availability and long waits for appointments
- IDD waitlist
- Stigma

Additional information about consumer and family feedback is available in Appendix D.
Additional consumer and family survey input was obtained through the following State surveys:

- 2017 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).
- 2017 Adult Experience of Care and Health Outcomes (Adult Medicaid ECHO Report): adult version of the consumer satisfaction survey described above
- 2017 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.

Each of these surveys is available on the Alliance website at the following links:


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 areas identified through review of these surveys include:

- Timely access to care
- Social connectedness, e.g., availability of social supports, friends, and perception of social inclusion
- Information about services, system navigation and available treatment options
- Development of recovery-oriented and person-centered service array

Each of these priority areas has been incorporated into the FY19 Network Access Plan described in Section Five.
III. Methodology for Stakeholder Input

The process for soliciting stakeholder feedback included the following approaches:

1. **Alliance Provider Advisory Committee (APAC) feedback.** Provider feedback included discussion at APAC and All-Provider meetings as well as request for follow-up discussion and feedback from local PAC meetings in each county.

2. **Community Survey.** As described above, the online survey solicited responses from consumers, family members, providers, stakeholders and staff.

3. **Collective feedback from community workgroups, collaboratives and committees.** Alliance staff contacted existing groups such as crisis collaboratives, System of Care collaboratives, provider collaboratives, and Alliance staff meetings to request collective responses regarding highest priority needs and gaps. A survey form was provided to each group with suggested questions for group discussion, and groups submitted summaries of group recommendations. The Alliance Stakeholder and Staff Group Feedback Form is provided in Appendix B and the list of community stakeholder input sources is provided in Appendix D.

An additional option for group feedback was added this year as a new feature of the Community Survey. The survey allowed members of identified groups such as Crisis Collaboratives to identify group affiliation when completing the surveys. This has enabled analysis of group responses to survey questions.
IV. Service Needs and Gaps Identified by Stakeholders

The following identified gaps are applicable for all age and disability groups:
- Residential options/residential treatment
- Relief for primary caretakers
- Housing
- Social networks and community connections
- Services to develop daily living skills
- Daily structured programs
- Vocational and educational needs
- Crisis continuum
- Additional service capacity to improve timely access
- Case Management

The following areas were identified as gaps for specific age/disability groups:
- **Adult Mental Health**: Inpatient psychiatric treatment
- **Child Mental Health**: residential treatment for children and adolescents, peer supports, Day Treatment, Child inpatient and crisis continuum, School behavioral health
- **Adult and Child I/DD**: Development and implementation of behavior plans, services for individuals on Innovations waitlist, services for individuals with autism spectrum diagnosis
- **Substance Use Disorders**: residential treatment for SUD, intensive outpatient treatment for SUD, broader array of SUD services, medication assisted treatment

In addition to survey feedback about specific needs and gaps, stakeholders also provided input regarding barriers to accessing care and identified the following as the most significant barriers:
- Lack of reliable transportation to appointments
- Homeless/housing issues
- Lack of insurance
- Limited information about how to obtain services
- Limited service availability and long waits for appointments
- Language barriers
- IDD waitlist

Additional information about consumer and family feedback is available in Appendix D.
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:** We have experienced no barriers, and In-Reach staff are engaged and meeting Alliance contractual requirements.

b. **Transition of individuals to community-based supported housing:** 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. In FY18 Alliance started a Landlord Incentive program that provided private landlords with incentive payments upon new leases and renewals for TCL participants. Landlord risk-mitigation resources also assisted with the recruitment of new landlords. Our other 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.

c. **Transition of individuals within 90 days of assignment:** Currently Transition Coordinators a backlog of individuals who are past the 90 day benchmark, each one housed will count towards the denominator, but not the numerator for this measure. Certain individuals have housing requirements that can take longer to accommodate, properties that meet such unique criteria may be more difficult to identify. Delays by TMS providers in revising and submitting PCPs can impact Alliance's ability to meet the benchmark, but Alliance has limited ability to compel providers to complete PCPs sooner.
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 an increase in the number of housing separations. The 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. Having a post transition team would create the staff capacity to do this kind of monitoring and provide better ongoing technical assistance to the providers.

B. **IPS-Supported Employment**

a. **Network capacity of IPS-SE services:** Alliance contracts with seven teams through five IPS-SE Supported Employment providers, including three providers 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, however, there will be a need for an additional provider in the Raleigh/Durham area as we increase enrollment. Our ability to continue to increase the number of individuals served will be dependent on both the ability to add teams as well as increasing funding of services. Of the seven current teams, only one has a waitlist, so the remaining six teams are open to new referrals. Additional gaps or barriers continue to revolve around insufficient rates or reimbursement for licensed clinicians to attend meetings, availability of benefits counselors and the ability to bill for benefits counseling, inability for IPS to bill for outreach in adult care homes, and high turn-over rates on IPS Teams.
b. **Engagement and referral of TCLI priority population:** Alliance has increased the number of individuals newly enrolled in IPS-SE that meet the in/at risk of ACH dramatically. During FY17 only 50 individuals were newly enrolled. During FY18 we will meet or be very close to our state target of 127. We are discussing the possibility of adding an additional team but must assure that sufficient funding will be available through state allocation in order support this intervention.

We are working on incentives with IPS-SE providers to intentionally focus on the highest priority of the in/at-risk category – those individuals who are part of the TCL Initiative. We have requested funding for incentive payments for both outreach and enrollment for these individuals. Much of the work to outreach these individuals is not billable. These payments are just one strategy to provide incentives to providers and make sure that individuals that are or are interested in transitioning to the community have the opportunity to obtain and maintain employment (or seek educational opportunities).

We are hopeful that more of our IPS-SE providers will reach “good” fidelity. We only have one of seven teams in this category – the others are in the “fair” fidelity category (while several are close to ‘good’). This increase in fidelity will result in a higher reimbursement rate for the providers which will make the service more sustainable for their agencies. With additional funding the agencies may be able to reach a higher fidelity level. As mentioned above if benefits counselors and IPS teams were able to bill for meeting with individuals to discuss IPS prior to authorization it would be beneficial. Recent activities to increase referral of TCLI population include:

- Resumption of the monthly IPS Collaborative. Members from the TCL Team are now attending the collaborative and invitations have also been extended to the TMS Providers to link more TCL individuals with IPS services and providers.

- Creation of a new TCL Referral form to identify TCL members as part of the priority population for providers.

- Additional trainings to In-Reach staff was provided on IPS-SE

- Implementation of value-based contracts in FY18 for IPS providers who increased their number of TCL members receiving services.
C. Community-Based Mental Health Services

The following summarizes the array, intensity and sufficiency of community-based mental health services provided to individuals living in supportive housing, as indicated by individuals’ ability to obtain and maintain stable housing and by other personal outcomes indicative of greater integration in the community. Personal outcomes addressed by these services include the following:

a. supportive housing tenure and maintenance of chosen living arrangement;
b. hospital, adult care home, or inpatient psychiatric facility admissions;
c. use of crisis beds and community hospital admissions;
d. emergency room visits;
e. incidents of harm;
f. time spent in congregate day programming;
g. employment;
h. school attendance/ enrollment; and engagement in community life.

This section also addresses service needs and gaps, obstacles and barriers, and actions taken to address identified gaps and barriers.

Sufficiency of service array:

- IPS-SE – there is a sufficient number of providers for current services need, however, there will be a need for an additional provider in the Raleigh/Durham area as we increase enrollment.
- ACT – there is a sufficient number of providers – however there is a need for an increased focus on tenancy and employment supports for individuals receiving service
- Peer Support – Alliance has a robust provider network with plenty of capacity. However, we appear to be underutilizing this service with our TCLI population
- TMS – Two agencies (Easter Seals/UCP & B&D) had one team each throughout FY18. In order to meet service definition requirements each agency has expanded to two teams as of July 1. This meets current requirements but does not allow for growth.
Service gaps, obstacles and actions taken to resolve them

The primary service gaps for the TCLI population are community engagement, natural supports development, and choice in daily living. 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. For this reason we are embarking on a collaborative relationship with the Alliance of Disability Advocates NC (ADA) in Raleigh to work with individuals that move into supportive house with a focus on community inclusion. We have been involved with Community Inclusion initiative by Temple University and their work with ADA. The goals of this initiative are exactly what is needed in order to assist individuals in making friends and being a part of their community. We plan to expand upon this opportunity and work with our provider agencies serving TCLI individuals in order to increase their knowledge and efforts regarding community inclusion.

Our challenges are two-fold – funding and provider engagement. Adequate funding is critical to support our providers in the delivery of service – 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.

Based on the number of individuals who will be transitioning to supportive housing in FY19, we project that each of the agencies will need to expand to 3-4 teams each by the end of fiscal year. This is concerning due to funding issues and the anticipated revised CST service definition. Our providers are concerned about continuing to expand a service that may eliminated and require them to become CST providers.

We are working on incentives with IPS-SE providers to intentionally focus on the highest priority of the in/at-risk category – those individuals who are part of the TCL Initiative. We have requested funding for incentive payments for both outreach and enrollment for these individuals. Much of the work to outreach these individuals is not billable. These payments are just one strategy to provide incentives to providers and make sure that individuals that are or are interested in transitioning to the community have the opportunity to obtain and maintain employment (or seek educational opportunities).

We are hopeful that more of our IPS-SE providers will reach “good” fidelity. We only have one of seven teams in this category – the others are in the “fair” fidelity category (while several are close to good). This increase in fidelity will result in a higher reimbursement rate for the providers which will make the service more sustainable for their agencies. With additional funding the agencies may be able to reach a higher fidelity level.
In regard to Peer Support, the challenge will be making sure that providers are working collaboratively and have a clear understanding of roles. TMS has a peer support component and in many cases the peers are working most closely with an individuals that are transitioning to or in supportive housing. The addition of the b3 Peer Support service can be duplicative without clarification – TMS peers focus primarily on tenancy and b3 service peers focus primarily on recovery. The work often crosses over. By providing additional education for both providers we can reduce role confusion and hopefully offer b3 Peer Support to more TCLI individuals.

Additional steps taken to address service-specific gaps include:

- **IPS-SE** – Alliance has increased the number of individuals newly enrolled in IPS-SE that meet the in/at risk of ACH dramatically. During FY17 only 50 individuals were newly enrolled. During FY18 we will meet or be very close to our state target of 127. We are discussing the possibility of adding an additional team but must assure that sufficient funding will be available through state allocation in order support this intervention.

- **ACT** – Provided two trainings through UNC Center for Excellence 1) Functional Skills Assessment and Intervention training, 2) Social Skills Building. We plan to expand on these topic areas in the coming year. During FY18 we reconvened the ACT Collaborative and held monthly meetings and have increased the teams “TCL IQ”. We have emphasized the importance of tenancy and employment and working with the teams to develop strategies to improve in this area.

- **Peer Support** – We recently become aware of the underutilization of this service and plan to review service eligibility of individuals receiving TMS. In addition will be working with In-Reach staff to fully incorporate the discussion of this during visits.

- **TMS** – worked closely with agencies to facilitate this expansion. There were delays with team expansion due to funding shortages for this service that resulted in agencies declining new referrals.
D. Crisis Services

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 TCL1 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.

**Network adequacy of the Alliance crisis continuum**

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 FY18, Alliance continued to develop the crisis continuum through the initiatives described below. These actions were priorities for the Alliance Network Development Plan, and additional information is available in Section Five below.

- Behavioral Health Urgent Care: 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 was added in Durham in FY18 and will be expanded to Wake County in FY19.

- Enhanced Mobile Crisis Pilot with Wake EMS: this model enhances the current Mobile Crisis Management model to improve timeliness of mobile crisis response. Licensed clinicians are embedded with Advanced Practice Paramedics to respond to individuals in the community in a more timely manner than is typically experienced with most mobile crisis responses. This project is expected to begin Fall, 2018.
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.

Service Gaps and Access Barriers
The Settlement agreement resulted in part because of a known problem with network provider adequacy and availability to meet the needs of children described as eligible for the settlement. Most simply stated, the historic expectation has been for children to be served “either on the mental health/substance use disorder side or on the IDD side.” Care Coordination has collected data for over a year reflecting provider denial of referrals for children who have complex behavioral presentations due to acuity and lack of staffing. Development of additional child residential service lines has been slow, waiting lists continue for ABA services, and turnover rates remain high among providers who serve this population.

Periodic providers also offer few “safe” summer options for children who meet eligibility for this definition. There is a small network of psychologists, most of whom are at capacity, who write and follow implementation of positive behavioral support plans for children with Innovations services. In state specialty program options for high levels of residential (PRTF and ICF) are limited for children with acute behavioral support needs (eg Murdoch Specialty programs PATH and STARS) with most autism specialty PRTF programs being out of state (eg LEAP, New Hope, The Hughes Center, Springbrook).

There is currently a waiting list of 83 children from Alliance for the NCSTART Child program.

Initiatives to Improve Access and Address Service Gaps
The Complex Integrated Care (CIC) team started in 2018 to combine efforts of MHSUD and IDD Care Coordination to address adult and child cases who demonstrate repeated challenges with maintenance of community tenure and provider engagement. There is now a Provider Liaison to this team who is working toward expansion of case management services for children identified as eligible for Complex Children’s agreement.

In late July, Alliance hired a Child Services Specialist, who joined the CIC team, and whose purpose is to work with clinical operations to identify specific needs of the cohort and to work with provider network to improve capacity of in network providers to serve these
children. The state provided a special allocation of training resources to extend the NADD Competency Based Certification to at least 120 network professionals who are currently or may potentially serve children identified.

The Child Services Specialist is building a proposal to extend this training to network providers with high volume of authorizations who are serving identified children to get the training to the ground level where services are being provided. These include both mental health and IDD network providers including those offering residential services. As part of the Alliance Complete Care initiative, the Olmstead Liaisons within IDD Care Coordination have identified 2 ICF-IID providers who are exploring the feasibility of building out community based options for children who may benefit from a step down from Murdoch Specialty programs and autism PRTF programs. Efforts continue among ABA providers to recruit and expand capacity of ABA teams to take more referrals.
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 utilization, and input from service recipients, stakeholders, providers and Alliance staff. This report serves as the basis for the FY19 Network Access Plan, the final section of the community needs assessment that details specific priorities for addressing identified community needs and gaps.

For the FY19 Network Access Plan, we have selected service gaps and identified network development priorities that align with the Alliance strategic plan, North Carolina medication transformation goals, and in particular a strategic emphasis toward population health management approaches to addressing health and well-being across the Alliance covered population. Though these are proposed strategies for FY19, timeframes and resources for completion of these goals are contingent upon availability of funding and are subject to pending legislation at both State and Federal levels.

Accomplishments and Updates. Alliance has made progress on a number of significant needs and gaps that were identified as priorities for the FY18 Network Development Plan. Over the past year, we have:

- Increased walk-in behavioral health capacity by implementing Behavioral Health Urgent Care in Durham County
- Purchased a building and selected a provider for a new child Facility-Based Crisis center in Wake County.
- Implemented a Remote Monitoring Pilot Home for individuals with I/DD to promote independent living through use of remote monitoring technology.
- Implemented self-management pilot initiatives including Whole Health Action Management training, self-management guides for members and shared decision-making tools for prescribers
- Increased access to interventions for high intensity youth such as trauma-informed therapeutic foster care, intensive wrap-around services, tiered case management and initiatives for gang-involved youth.
- Expanded Day Treatment capacity in Cumberland County in collaboration with the Cumberland County Public School System
• Provided training for Psychosocial Rehabilitation (PSR) providers on psychiatric rehabilitation, initiated transition to recovery-oriented PSR models, and supported PSR supervisors in training for national certification as Certified Psychiatric Rehabilitation Practitioners (CPRP)
• Addressed social determinants of health through multiple projects involving housing, transportation and employment.
• Improved service access through modification of the Alliance Non-Medicaid benefit plan to reduce geographic disparities
• Expanded evidence-based Medication Assisted Treatment for uninsured individuals with opioid use disorder in all counties, serving an additional 850 people who would otherwise not be able to afford care

**Focus on Population Health Strategies**
Consistent with NC Medicaid transformation plans and our strategic goal to improve health outcomes for the people we serve, Alliance continues to move toward population health management to address health and well-being across our entire covered population. Population health management moves beyond reactive interventions towards population monitoring and proactive approaches for promoting prevention, wellness, early identification and tailored intervention programs continuously evaluated for effectiveness. The Alliance Complete Care model builds upon these principles and objectives and made significant advances in the past year in our understanding of population health, development of multidisciplinary care management approaches, and use of advanced data analytics to improve outcomes.

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

**Service Needs and Gaps.** Alliance conducted an extensive review of service needs that included review of data and input from consumers and families, stakeholders, providers and staff. Analysis of survey results identified consistent issues and themes both across and within age/disability areas. Consistent with the findings of past network gaps analysis, service access for the uninsured and underinsured, residential treatment, housing, and transportation remain areas of concern and ongoing barriers for promoting treatment engagement and positive outcomes. Other consistently endorsed priorities are the expansion of the crisis continuum, development of a recovery oriented system of care, continued development of an effective and accessible continuum for substance use disorders, access to services and supports for individuals with intellectual and developmental disabilities services and those with co-occurring conditions, and service access for non-English speaking.
A. Network Adequacy and Accessibility Priority Areas for FY19

Expand capacity for crisis, hospital diversion and respite services for all ages/disabilities
- Implement Enhanced Mobile Crisis Pilot in Wake County
- Implement Behavioral Health Urgent Care (Tier II Same Day Access) in Wake County
- Develop Facility Based Crisis capacity for children in Wake County
- Improve timely access to aftercare appointments following inpatient, facility-based crisis or non-hospital detoxification treatment

Increase interventions and supports for individuals with complex needs
- Continue implementation/expansion of Day Treatment services in Cumberland
- Evaluate residential treatment service needs
- Evaluate service capacity needs for dually diagnosed and develop recommendations for improving access, reducing barriers and improving systems of care

Develop an array of recovery-oriented, individualized and person-centered services that promote community inclusion
- Transition PSR programs to recovery-oriented psychiatric rehabilitation models
- Improve quality and consistency of Peer Support services
- Revise Peer Support service definition and contract requirements
- Provide technical support/training for providers
- Other initiative(s) to improve services to promote independence, social connections, independent living skills, personal care and self-help needs
- Expand vocational and educational services & supports

Improve service outcomes by addressing social determinants of health
- Housing initiatives, including Supportive Housing and Group Living Step Down projects
- Social Determinants pilot initiatives
- Services to address transportation challenges
- Implement Health Literacy initiatives
**Improve public awareness of services**
- Improve availability of information to the public about service availability and access
- Explore use of peer and family navigators and community health workers to assist with system navigation

**Improve service availability and access**
- Improve access to services for non-English speaking consumers
- Identify and implement strategies for improving access and availability of appointments
- Evaluate barriers to accessing respite service and develop strategies for improving access

**Develop and enhance the continuum of care for individuals with Substance Use Disorders**
- Expand opioid treatment availability (open network to new Medicaid-funded OTP providers in Cumberland and Durham)
- Other expansion of continuum (e.g., SACOT gaps, withdrawal management, residential capacity, adolescent tx)?

**Improve access to services for individuals with I/DD who are not on Innovations waiver**
- Development and implementation of behavior plans, services for individuals on Innovations waitlist, services for individuals with autism spectrum diagnosis
B. Progress and Achievements in Addressing Service Gaps (Update on FY18 Network Development Plan)

In response to needs and gaps identified in the 2017 Community Needs Assessment and Gaps Analysis, Alliance developed a FY17-18 Network Development Plan to address identified priorities. The initial plan was submitted to DHHS in June, 2017 as a supplement to the FY17 Community Needs Assessment, and the final plan was developed later based on funding availability and the FY18 Alliance plan for reinvestment of Medicaid savings. Several of the initial proposed strategies were removed due to budget reductions, and the update provided below reflects the final FY18 Network Development Plan.

The following tables summarize progress from July 1, 2017 through June 30, 2018 for the FY2017-18 Network Development Plan.

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

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<tr>
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<tr>
<td>Assure the availability of high quality, accessible, and effective Mobile Crisis services in all counties</td>
<td>In addition to working with our current Mobile Crisis providers to improve access, we are expanding Mobile Crisis access in Wake County through development of an Enhanced Mobile Crisis Pilot. The new service model embeds licensed clinicians with Advanced Practice Paramedics at Wake County EMS and provides a shorter response time (goal of 30 minutes). Implementation is planned for Fall 2018.</td>
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<tr>
<td>Expand access to Behavioral Health Urgent Care Centers (Tier II Same Day Access)</td>
<td>Increased walk-in behavioral health capacity by implementing Behavioral Health Urgent Care in Durham County. This model provides timely access to brief assessments, crisis intervention services and on-site prescribers in an outpatient setting with expanded hours of operation. Implementation required development and DMA approval of a Medicaid in-lieu of service definition. FY18 plans include expansion of BHUC to Wake County.</td>
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<tr>
<td>Develop Facility Based Crisis capacity for children</td>
<td>We have purchased a facility, are resolving zoning issues and working with an architect to plan construction. This project is scheduled for completion in late 2019</td>
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<tr>
<td>Expand access to respite services</td>
<td>We added two additional providers, but this service is currently underutilized, causing providers to use their beds for other services. We are now looking at an alternative payment structure to support crisis beds.</td>
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## Develop and promote the use of engagement and self-management approaches

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<tr>
<td>Remote Monitoring Pilot Home</td>
<td>Alliance has developed a Remote Monitoring Pilot Home for individuals with I/DD to promote independent living through use of remote monitoring technology. Accomplishments for FY18 include:</td>
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<td>• Provided 21 tours of the Remote Monitoring Pilot Home to stakeholders (Innovations Waiver beneficiaries, families, providers, and Alliance staff)</td>
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<td>• Seven individuals who took a tour also completed a stay at the Home to determine if remote monitoring could be used to (1) reduce reliance on overnight in-person supports and (2) provide a safe alternative to having live staff present.</td>
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<td>• QM conducted pre/post experience surveys for participants who completed stays at the Home.</td>
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<td>• Four individuals who took a tour also submitted requests for remote monitoring equipment to be installed in their private/family home.</td>
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<td>Implement self-management pilot initiatives</td>
<td>• Contracted with the National Council for Behavioral Health to provide Whole Health Action Management (WHAM) trainings to over 50 peer support specialists in the Alliance provider network</td>
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<td>• Developed a member card that helps members identify their physician, medications, general information about health and well-being and hints about how to stay healthy. Developed a guide for medication management that utilizes pictures instead of wording to help members remember their medication</td>
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<td></td>
<td>• Developed shared decision making tools for prescribers to utilize with individuals being served to help educate them about medication, options available to them, and benefits and risks associated with medications, so individuals and families can truly make shared decisions about care</td>
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## Increase interventions and supports for high intensity youth and adults with complex needs:

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<td>Expand Trauma Informed Therapeutic Foster Care</td>
<td>Paid for rostered providers to disseminate Resource Parent Curriculum to our Therapeutic Foster Care (TFC) agencies and train families. They conducted six training sessions in the last year of the Resource Parent Curriculum, which trained approximately 50 families on this model.</td>
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<tr>
<td>Implement Intensive Wrap-Around for children and transition age youth</td>
<td>This definition was written in a workgroup and submitted to the state for approval in February, and it was fully approved in late June, 2018. Alliance has readied it for implementation and identified Youth Villages as the provider, and services for Hi Fidelity Wraparound will be available in Wake and Durham Counties as of August 2018.</td>
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<tr>
<td>Implement EBPs in Therapeutic Foster Care programs</td>
<td>This initiative is still in process. All agencies are currently working with model developers to move to fidelity in one of two identified EBPs for Therapeutic Foster Care. One third of the providers are certified in one of two models with others moving closer.</td>
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| Expand implementation of integrated physical/behavioral healthcare programs | We are continuing to pilot integrated models in our communities. These initiatives assure coordinated medical and behavioral care treatment that considers whole health when making treatment decisions, supports individuals to obtain specialty care when needed, and works to increase individuals’ health literacy and engagement through psychoeducation and advance care planning. Examples of integrated care initiatives include:  
  - Partnership with UNC Health Care at WakeBrook, one of Alliance’s Crisis and Assessment Centers, to improve health outcomes and increase preventive care for individuals with serious mental illness, a traditionally underserved population.  
  - Establishment of an Alliance care coordinator position in the WakeBrook primary care clinic as well as consultation time between WakeBrook primary care and Adult Community Treatment Team medical staff.  
  - Integration of a physical health perspective into care for our members with complex needs by incorporating nursing into special teams and processes. This includes formation of a Complex Integrated Care (CIC) team that coordinates care for individuals with complex needs and other organizational changes that promote whole person care perspectives. |
<p>| Develop and implement specialized interventions for gang-involved youth | Partnerships to reduce youth involvement with gangs include collaboration with MST teams, the Haven House Gang Intervention/Outreach program, participation with Juvenile Crime Prevention Council programs, and referral to the Sean Ingram Academy, which works with gang-involved youth. |</p>
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| **Implement case management initiatives (Tiered Case Management, Complex Needs Children Case Management)** | • At the end of the FY, we had 93 referrals and 17 youth served in High Fidelity Wraparound. Another 200 referrals are anticipated once DSS completes gathering information regarding youth in services through DSS and foster care. Plans are under way for Youth Villages to add another team for wraparound to meet anticipated demand.  
• An In Lieu of Definition was approved and set to be implemented on 8/1/18. The Family Navigator was hired and now is embedded with Juvenile Justice and with DSS. Transition plans are underway for the program to move fully under Care Coordination. Effective 8/10, the System Navigator position duties were combined with the Care Coordination Liaisons to Juvenile Justice and Department of Social Services. At present there are 277 referrals to be assessed for Tiers I, II and III.  
• For Complex Needs Youth, the youth are being referred to High Fidelity Wraparound or Tiered Case Management |
| **Collaborate with schools to develop improved services for high-needs youth (Day Treatment planning in Cumberland)** | Alexander Youth Network has been selected to provide Day Treatment, co-located within the Cumberland County Public School System. It is anticipated that they will expand to a second location in another school in the near future. AYN is currently awaiting licensure for Day Treatment and expects to begin services Fall 2018. |
| **Develop plans for addressing gaps for individuals in need of long-term services and supports** | • Child Services Specialist has developed NADD training schedule for high volume network providers serving children with Complex Needs  
• Olmstead team is working with targeted providers to develop a mid-step level of ICF (between SDC and community ICF) to expand capacity to serve children with extreme behaviors in a safe community based setting. Proposed start of this mid step level is Spring 2019.  
• ABA providers will continue to recruit and expand team capacity to increase number of children served.  
• We are working on expansion of capacity of Tiered Case Management providers to take referrals for case management services for children identified in the Complex Needs cohort. |
| **Transition PSR programs to evidence-based psychiatric rehabilitation approaches** | As a step in our development of a recovery-oriented system of care, Alliance PSR providers are required to incorporate principles of recovery and psychiatric rehabilitation into their programs. PSR team leads will be required to obtain certification through the Psychiatric Rehabilitation Association (PRA) as Certified Psychiatric Rehabilitation Practitioners (CPRP), and Alliance has supported this by sponsoring and funding the following: |
### Initiative | Status
--- | ---
**PSR Collaborative through a contract with a peer-run organization that provides consultation and training on recovery principles**
**Training through PRA/Boston University Center for Psychiatric Rehabilitation on psychiatric rehabilitation principles and purchase of on-line training in preparation for CPRP certification**

### Improve service outcomes by addressing social determinants of health

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| Housing initiatives, including Supportive Housing and Group Living Step Down projects | Actions taken in FY18 include the following:  
- Workgroup convened to design a more comprehensive continuum of housing and supports to promote permanent supportive housing  
- Financial assistance provided through Independent Living Initiative (ILI), a short-term financial assistance program for adults and families currently involved in services. Funds are used for eviction prevention and rapid re-housing. Total FY18 ILI spending was $878,909  
- Permanent Supportive Housing programs including Durham DASH Program ($164,632 to serve 13 households), Home Again Program (in partnership with Durham Housing Authority), serving chronically homeless families (currently 8 households with 14 minor children), and TCLI subsidies of almost $450K to transition 119 persons  
- Capital investments of $750K with developers to expand housing capacity  
- Integrated Supportive Housing Program ($2.7M DOJ Settlement-state funds) for new construction  
- Supportive Housing Pilots with Health and Housing (Duke) Wraparound  
- Homeless multidisciplinary care review |

| Social Determinants pilot initiatives | • Preparing to implement transportation pilot that will reduce transportation barriers for persons being discharged from hospitals or crisis facilities or have urgent treatment needs. Planned implementation date is 10/1/18  
• Hosted 2 trainings to implement a peer led health literacy curriculum (WHAM)  
• Implemented the Virginia Commonwealth Social Needs Assessment |
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<td>• Developed health literacy items including updated brochures, wallet cards and social media content</td>
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<td>• Supportive housing pilot with Southlight to address housing and employment needs for persons engaged in methadone treatment</td>
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<tr>
<td>• Supportive housing pilot with Duke Healthcare to address housing and employment needs for persons with complex medical and behavioral health needs</td>
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**Improve system access, service availability and access to services for underserved populations.**

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<tr>
<td>Improve access to services for non-English speaking consumers</td>
<td>Convened workgroup to review provider network capacity, identify foreign language interpretation needs, and prepare recommendations for expanding services to non-English speaking consumers. Workgroup recommendations are planned for Fall 2018.</td>
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<tr>
<td>Revise non-Medicaid benefit plan to reduce geographic disparities</td>
<td>The Alliance non-Medicaid benefit plan has been revised to reduce county-specific disparities.</td>
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<tr>
<td>Enhance continuum of services for justice-involved youth and adults, and improve continuity of care for individuals who are transitioning from jails and prisons</td>
<td>Alliance staff have contributed to improvements in the continuum of care by participating in numerous community partnerships addressing justice-involved youth and adults, including:</td>
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<td>• Local JJSAMHP teams, coordination of the JJSAMHP Work Plans and development of two quality improvement projects annually for each county</td>
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<td>• Local Reentry Councils, which work to reduce barriers and ensure people are getting into needed MH/SUD services.</td>
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<td>• Department of Public Safety Mental Health &amp; Substance Use Disorder Subcommittee for Raise the Age (RTA), which is looking at current evidenced-based programs and potential needs for youth over 16. Alliance is considering participation in a pilot project for MST-EA: Multi-Systemic Therapy Emerging Adults.</td>
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<td>• Durham Juvenile Crime Prevention Council, which develops strategies to intervene, respond to, and treat the need of juveniles in the county who are at risk of delinquency or who have been adjudicated undisciplined or delinquent</td>
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<td>• Criminal Justice Committee, which is reviewing the process for people who are being released from prison</td>
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<tr>
<td>Enhance continuum of services for justice-involved youth and adults, and improve continuity of care for individuals who are transitioning from jails and prisons (continued from previous page)</td>
<td>and need MH/SUD services. The team is working closely with DPS to improve communication and service coordination.</td>
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<td>• DHHS pilot project on Child Tiered Case Management that provides Trauma Informed Case Management and Care Coordination for Youth with behavioral health challenges involved with child welfare and juvenile justice systems</td>
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<td>• Component of the ILI Housing Program called the <em>Restoring Hope Initiative</em>, which is a 3-6 month longer rental assistance program targeting frequent utilizers who are homeless or precariously housed. Frequent utilizers tend to be an individual who frequent emergency rooms, the criminal justice system and shelters.</td>
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<td>• Alliance is a part of the National and State Wide Stepping Up Initiative in the counties we serve. Stepping Up Initiative’s main focus is diverting people with mental illnesses from the prison system so that they can access the care that they need.</td>
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<td>• Alliance has multiple positions assigned specifically to work with the judicial system, including Court Liaisons, Criminal Justice Specialists in each county, and care coordinators assigned to work with individuals in jail settings.</td>
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<td></td>
<td>• Alliance Court Liaison in Wake County who works closely with DJJ to ensure juveniles are getting needed services and supports. Wake also has a School-based Teen Diversion Coordinator who works with the school and DA’s office to divert youth over 16 from the criminal justice system into services and supports.</td>
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<td>• Criminal Justice Specialist in each of the counties in our catchment area facilitate CIT classes multiple times per year</td>
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<td>• Durham Jail also has a Mental Health Team, which operates within the Jail and managed through CJRC. That team has a Discharge Planner who calls the Alliance Access and Information Center to set the Discharging Individuals up with an Assessment Appointment prior to being discharge to bridge that gap and if that person is on medications then they are provided with a 30 day medication script so that they can remain on their meds at least up to their initial assessment/intake appointment.</td>
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| Improve availability of information to the public about service availability and access | • Revised provider search function on Alliance web page to comply with new CMS requirements. Provider search now includes information to identify providers that are accepting referrals and search capacity by language.  
• We have also improved availability of information about a variety of other topics such as traumatic brain injuries and opioid use disorder through improvements in our website, increased use of social media, and development of a new website focusing on the opioid epidemic. |
| Identify strategies for improving access and availability of appointments  | Alliance is continuing a Quality Improvement Project to improve the show rate of individuals who choose to call our Access & Information Center. Strategies to improve the access and availability of appointments have included:  
• Encouraging providers to enter more appointment times in our provider portal. We have seen some success with our providers serving the Medicaid population, while struggled to see improvement in availability of appointments for providers serving both Medicaid and non-Medicaid populations. This is primarily due to the substantial cuts in funding for individuals without Medicaid.  
• Connecting callers with providers in a 3-way call to make an appointment outside of our provider portal system. This initiative has resulted in a substantial increase of callers receiving appointments outside of our system.  
• Expanding the use of Mobile Crisis Management services to high risk individuals identified as Urgent. Alliance revised its Clinical Decision Support Tool to create another level within Urgent for callers needing care within 8 hours. Callers are offered Mobile Crisis Management services when they are unable to walk-in to a crisis facility. |
### Develop and enhance the continuum of care for individuals with Substance Use Disorders

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<td>Improve service quality and continuity of care through training, consultation, technical assistance and other efforts as identified in the 2017 analysis of the Alliance SUD continuum</td>
<td>Alliance has convened provider collaboratives to promote consistency, quality and continuity of care for SUD services, and has contracted with Southern Regional AHEC and Duke to facilitate collaboratives for substance use disorder providers (SUD Collaborative) and opioid treatment programs (OTP Collaborative). Consultation with OTP providers has included on-site program reviews/consultation visits as well as extensive technical assistance.</td>
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<tr>
<td>Expand opioid treatment availability</td>
<td>With funding from 21st Century Cures grant, we have expanded service capacity for uninsured, including the following service additions:</td>
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<td>- Added five contracts for State-funded Opioid Treatment Program (OTP), expanding capacity from one to six providers</td>
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<td>- Implemented Office-Based Opioid Treatment (OBOT) for uninsured individuals in Durham</td>
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<td>- Implemented Peer Support services within OTP programs for uninsured clients</td>
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<td>- Initiated social determinants pilot project (see above) for uninsured OTP service recipients</td>
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<td>- Through the above service additions, providers were able to serve an additional 850 individuals who otherwise would not have received care</td>
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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 FY19.

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, Community/Mobile, Crisis, Inpatient and C-Waiver service categories. Several services within the Location-Based and Specialized sections did not meet geographic access/choice requirements, as described below:

Location-Based:

- Child and Adolescent Day Treatment: limited choice for Medicaid-funded services in Cumberland, and limited access for Non-Medicaid-funded services in all but Wake County.
- Opioid Treatment: limited choice of Medicaid-funded Opioid Treatment Program services in Cumberland County and part of Johnston County. Non-Medicaid-funded services are closed to new admissions in all counties.
- SA Comprehensive Outpatient Treatment (Non-Medicaid): services are available only in Durham and Wake counties.
- Day Supports (Non-Medicaid): services are available only in Wake County.

Specialized Services:

- Residential Treatment Level 2: other than Therapeutic Foster Care (Non-Medicaid)
- I/DD Supported Living (Non-Medicaid)

Plans for addressing gaps:

- Non-Medicaid-funded services are limited in availability primarily due to funding limitations, so Alliance will not be able to address these gaps without 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.
- Child and Adolescent Day Treatment: Medicaid choice is limited only in Cumberland, where we have been working closely with the Cumberland County Public School System to improve access. We will request a waiver of provider choice while we continue to work with Cumberland schools,
stakeholders and providers to evaluate and respond to identified needs for this service.

- Opioid Treatment Program: Medicaid-funded choice of Opioid Treatment Program (OTP) providers is limited in Cumberland County and parts of Johnston County. Members have access to Office-Based Opioid Treatment (OBOT) in each county. We will request a waiver of provider choice while we reach out to existing opioid treatment providers to pursue service expansion in Cumberland and Johnston counties.

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

As described in Section Two, Alliance survey respondents identified multiple populations as being underserved, including court-involved, non-English speaking, people on the Innovations waiting list, those with Traumatic Brain Injuries, and individuals 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
- Continued implementation of the Alliance Complete Care model, which emphasizes whole-person, population-based approaches to management of chronic and complex conditions
- Service review and revision for individuals with IDD to increase access to Medicaid-funded services for individuals on the Innovations waiting list
- 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

Consumers, families and other stakeholders identified several gaps and barriers that align with current or planned activities for FY19. Similar to feedback noted above, consumers and stakeholders identified barriers associated with social determinants such as housing and transportation as significant impediments to service access. Additional identified priorities were development of the crisis continuum, enhancement of residential options, improved service availability and access, development of a broader array of SUD services, and improved public awareness of services.
In addition to the plans described above, the following initiatives are planned to address feedback provided by consumers and stakeholders:

- Expansion of crisis continuum
- Development of an array of recovery-oriented, individualized and person-centered services
- Improvements in public awareness of services
- Enhancement of the continuum of care for substance use disorders
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 22 Z2, H2022 U3 HE):** available in all ABH counties
- **Service capacity:** limited by expansion potential of each agency, but not currently restrained by funding limitations
- **Gaps addressed:** need for evidence-based family-focused approaches to in-home care for children and adolescents.
- **Barriers and challenges:** 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 EN, 90837 U3 HE, H0036 22 EN):** available in all ABH counties
- **Service capacity:** Service is limited to nine eligible providers, but of these, only eight are providing services at this time. Service capacity depends upon expansion potential of each agency, but is not currently constrained by funding limitations
- **Gaps addressed:** Gap between intensive services and outpatient
- **Barriers 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):** available in all ABH counties
- **Service capacity:** all in-network ACTT teams have this service available, and capacity is constrained only by the capacity of each ACTT team
- **Gaps addressed:** gap between ACTT and lower level services
- **Barriers 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
Service capacity: currently 11 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.

Behavioral Health Urgent Care (T2016 U5): Durham County
Service capacity: Currently available only in Durham County. Plans are underway to open a second facility in Wake County in early 2019. Currently the service in Durham County is provided by one provider with a second provider preparing to open the Wake County BHUC.
Gaps addressed: availability of walk-in crisis services
Barriers and challenges: Cost of expansion to other counties.

Non-Medicaid Alternative Service Definitions

Assertive Engagement (YA323): Cumberland, Durham and Wake
Service capacity: limited to one provider in Cumberland, two in Durham and seven in Wake
Gaps addressed: assistance for individuals who have difficulty engaging in treatment, especially those with severe and persistent mental illnesses who are transitioning from crisis or inpatient care, jails or homelessness.
Barriers 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): Cumberland and Durham
Service capacity: limited to one crisis facility in Cumberland County and one in Durham County.
Gaps addressed: short-term evaluation and observation for individuals whose symptoms warrant careful evaluation to determine if inpatient care is necessary, as well as the need for specialized behavioral health evaluation in a setting that can serve as an alternative to hospital emergency departments.
Barriers and challenges: Barriers include limited State funding as well as limited reimbursement for insured and underinsured service recipients. Plans are under way to develop a bundled Tier IV BHUC alternative definition inclusive of Crisis Evaluation and Observation to facilitate seamless services to divert from facility-based crisis when appropriate.
Recovery Support (YA325): Durham

Service capacity: limited to one provider in Durham

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

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

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

Service capacity: provided by only one provider in Wake County

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

Barriers 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

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.

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

Service capacity: limited to one provider in Cumberland, one provider in Johnston, two providers in Durham and four 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: Geographic Access Maps

The following geo maps are provided for all Medicaid-funded services listed in Section One, except for outpatient services, and reflect contracted provider agencies as of January 1, 2018.
COMMUNITY / MOBILE SERVICES
CRISIS SERVICES
INPATIENT SERVICES
SPECIALIZED SERVICES
C-WAIVER SERVICES
Appendix B: Stakeholder and Staff Survey Questions

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

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

Please send responses to Carlyle Johnson at cjohnson@AllianceHealthPlan.org by July 31, 2018.

Group Name:
Date of Meeting:                Number of participants:
Submitted by (name and e-mail contact information):

Group Feedback:

1. Identify any groups or populations that you believe are underserved, have special needs or have difficulty obtaining needed care.

2. What are the most significant service needs and gaps in your community? Please note whether these gaps affect specific communities, populations or funding sources (e.g., Medicaid vs. uninsured).

3. What are the most significant barriers to accessibility of these services?

4. Describe some situations in which the system worked well to meet consumer needs. What was most helpful and what would we need to do to replicate these successes?

5. Has your group prepared any written reports, surveys, or other documents in the past year that discuss community needs and service gaps? Are you aware of any other documentation of community needs that has been prepared by other organizations? If so, please provide additional information and/or send copies by e-mail.

6. Do you have any other feedback that may help Alliance understand community needs, service gaps and priorities for network development?

7. What actions or strategies would you recommend as Alliance priorities for the upcoming year to help address these needs and gaps?
Appendix C: Community Surveys

Alliance Health 2018 Community Needs Survey: Main Survey

ABH 2018 Community Needs Survey

Community Needs Assessment Survey 2018

Alliance Behavioral Healthcare is committed to the continuous improvement of the services offered to our residents with mental health, developmental disabilities, and substance use needs. 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.

This survey is being distributed to multiple groups, including individuals who receive services and their families, community providers, stakeholders, and Alliance staff. Please select the option below that you believe applies best.

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

Please complete the survey by Friday, July 6.

Thank you!

* 1. Please tell us which of the following describes you best:
   - Person receiving services for mental illness, substance use or intellectual / developmental disabilities
   - Family member, guardian, or friend of individual who receives services
   - Community Provider
   - Community Stakeholder
   - Alliance Staff
2. Which race/ethnicity best describes you (Please choose only one.)

- American Indian or Alaskan Native
- Asian / Pacific Islander
- Black or African American
- Hispanic
- White / Caucasian
- Prefer not to answer
- Multiple / Other (please specify)

3. What best describes your gender (Please choose only one)?

- Female
- Male
- I prefer not to say
- I self describe as...

[Blank space for specification]
4. Please let us know if you participate in any Alliance committees or workgroups (select all that apply)

- None
- Alliance Provider Advisory Council (APAC)
- Consumer and Family Advisory Committee (CPAC)
- Alliance Human Rights Committee
- Alliance Hospital Partners
- Cumberland Crisis Collaborative
- Durham Crisis Collaborative
- Wake Crisis Collaborative
- Cumberland SOC Community Collaborative
- Durham Community Collaborative
- Johnston SOC Community Collaborative
- Wake County Community Collaborative for Children and Families
- Cumberland Juvenile Justice SA/MH Partnership (JJSAMHP)
- Durham Juvenile Justice SA/MH Partnership (JJSAMHP)
- Johnston Juvenile Justice SA/MH Partnership (JJSAMHP)
- Wake Juvenile Justice SA/MH Partnership (JJSAMHP)
- Cumberland CIT Collaborative
- Durham CIT Collaborative
- Johnston CIT Collaborative
- Wake CIT Collaborative
- NAMI-Cumberland
- NAMI-Durham
- NAMI-Johnston
- NAMI-Wake
- School Health Advisory Council (Cumberland)
- School Health Advisory Council (Durham)
- School Health Advisory Council (Johnston)
- School Health Advisory Council (Wake)

Other (please list any not included above)
5. Please let us know the type of services you or your family member receive (select all that apply):

- [ ] Child/Adolescent Mental Health
- [ ] Adult Mental Health
- [ ] Child/Adolescent Developmental Disabilities
- [ ] Adult Developmental Disabilities
- [ ] Child/Adolescent Substance Abuse
- [ ] Adult Substance Abuse
- [ ] Other (please specify)

6. In which county do you live (parents, family and guardians: please indicate county of residence for person who receives services)?

- [ ] Cumberland
- [ ] Durham
- [ ] Johnston
- [ ] Wake
- [ ] Other (please specify)

7. What language do you mainly speak at home?

- [ ] English
- [ ] Spanish
- [ ] Other language (please specify):

8. Are you able to receive services in your preferred language?

- [ ] Yes
- [ ] No
9. In the past year, have you or your family member had to travel outside of the county where you live to receive mental health, intellectual/developmental disability or substance use disorder services because the service was not available in your county?

- Yes
- No

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

[Text Box]

10. Are you receiving the mental health, substance use or intellectual/developmental disability services that you need?

- Yes
- No

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

[Text Box]
**ABH 2018 Community Needs Survey**

**Stakeholder Information**

* 11. Please tell us which of the following describes your agency’s primary mission best:

- [ ] Advocacy
- [ ] Church or other religious
- [ ] Criminal Justice
- [ ] Juvenile Justice
- [ ] Law Enforcement
- [ ] Housing/homelessness
- [ ] Local Department of Social Services
- [ ] Other Human Services
- [ ] Local Public Health Department
- [ ] Primary Healthcare
- [ ] Specialty Healthcare Practice
- [ ] Hospital
- [ ] Department of Veterans Affairs
- [ ] Public School System
- [ ] Other (please specify)

* 12. In which of the Alliance catchment counties do you provide services (select all that apply)?

- [ ] Cumberland
- [ ] Durham
- [ ] Johnston
- [ ] Wake
- [ ] Other (please specify)

13. What is your role within your organization?

[ ]
14. (Optional) What is the name of your agency?
ABH 2018 Community Needs Survey

Provider Information

* 15. Please tell us which of the following describes you best:
   - [ ] Solo Practitioner
   - [ ] Group Practice
   - [ ] Agency
   - [ ] Hospital
   - [ ] Other (please specify)

* 16. In which of the Alliance catchment counties do you provide services (select all that apply)?
   - [ ] Cumberland
   - [ ] Durham
   - [ ] Johnston
   - [ ] Wake
   - [ ] Other (please specify)

17. What is your role within your organization?
   
18. Please let us know the populations that you or your agency serves (select all that apply):
   - [ ] Child/Adolescent Mental Health
   - [ ] Adult Mental Health
   - [ ] Child/Adolescent Developmental Disabilities
   - [ ] Adult Developmental Disabilities
   - [ ] Child/Adolescent Substance Abuse
   - [ ] Adult Substance Abuse
   - [ ] Other (please specify)
19. My current position at Alliance is in the following department/unit:

- Administration
- Business Operations
- Care Coordination
- Community Relations
- Customer Services/Call Center
- Information Technology
- Legal & Compliance
- Network Development and Evaluation
- Utilization Management
- Other (please specify)

20. My office location is:

- Corporate
- Cumberland
- Durham
- Johnston
- Morrisville
- Wake
- Off-Site or Other
21. Which of the following do you consider to be significant barriers to accessing services (select all that apply)?

- Lack of reliable transportation to appointments
- Services not available nearby
- Inconvenient hours
- Limited information about how to obtain services
- Lack of childcare
- Language barrier
- Cost of medication
- Wait too long for appointments
- Lack of insurance
- Not satisfied with quality or choice of providers
- Homeless/housing issues
- Availability of qualified staff
- Medical problems or physical disability
- No access to phone or e-mail

Other (please specify)
22. Please identify any of the following groups that you believe have difficulty accessing appropriate care (select all that apply)

- People with traumatic brain injuries
- People with physical disabilities
- People with visual impairments
- People who are deaf or hard of hearing
- Veterans, military members and their families
- Pregnant women with substance use disorders
- People who are LGBTQ
- People who are in jails or prisons
- Youth in the juvenile justice system
- People who are homeless or have unstable housing
- People who have transportation barriers
- People with food insecurity
- Specific ethnic groups (please provide additional details below)

Other: please provide additional details about groups not listed above or additional information about those that you selected above.
23. Please identify any specific services that are not available in your community (select all that apply).

- Inpatient psychiatric treatment
- Institutional care (ICF/IID)
- Crisis Services (including residential, facility-based crisis, walk-in crisis, NC START and mobile crisis services)
- Services to support development and implementation of behavior plans (Specialized Consultative Service, Behavior Plan Development)
- Outpatient psychotherapy (individual, group, family)
- Psychiatric services / medication evaluation and management
- Outpatient treatment of opioid abuse (e.g., medication-assisted treatment for opioid addiction)
- Community-based intensive treatment services for adults (e.g., Community Support Team, Assertive Community Treatment Team)
- Home-based family services for children and adolescents (e.g., Intensive In-Home, Multisystemic Therapy)
- Daily structured programs to support behavioral and emotional stability (e.g., day treatment, partial hospitalization, psychosocial rehabilitation)
- Intensive outpatient treatment for substance use (e.g., substance abuse intensive outpatient and comprehensive outpatient treatment programs)
- Services to provide relief to primary caretakers (Respite, Crisis respite, emergency and planned respite)
- Residential treatment for children and adolescents (Psychiatric Residential Treatment Facility (PRTF), Level IV, IAFT, therapeutic foster care family type)
- Residential treatment for individuals with substance use disorders (e.g., transitional living, half-way houses, housing with supports)
- Residential options for individuals with mental illness, Intellectual/Developmental Disabilities or Traumatic Brain Injury (Group Living, Supervised Living, Residential Supports, Semi- and/or independent living)
- Services to develop daily living skills (Individual Support, Developmental Therapy, In-Home Skill Building, Community Networking)
- Services that assist with developing social networks and community connections (e.g., Community Guide)
- Services to assist with vocational and educational needs (Supported Employment, Long Term Vocational Supports)
- Services for support with personal care and self-help needs (Personal Assistance, Personal Care)
- Supports to provide modifications to assist with increased independent functioning (Vehicle Adaptations, Home Modifications, Augmentative Communication Devices, Specialized Equipment and Supplies)
- Support by peers who have personal experience with mental illness or substance use (Peer Supports)
- Other (please specify)
24. Do you have any other comments regarding service needs or service gaps that you would like us to consider?


25. Finally, in addition to service needs and gaps, we would like to identify areas that are performing well. Please describe any services or experiences that have exceeded your expectations for quality, access or customer service. What do you believe was responsible for a satisfactory outcome?


Thanks for completing the survey! Please select 'DONE' to submit your feedback and exit the survey.
Alliance Behavioral Healthcare is committed to the continuous improvement of the services offered to our residents with mental health, developmental disabilities, and substance use needs. 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 Behavioral Healthcare at 4600 Emperor Blvd., Durham NC 27703, or

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

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

Please complete the survey by Friday, July 6.

Thank you!

1. Please tell us which of the following describes you best:
   - Person receiving services for mental illness, substance use or intellectual / developmental disabilities
   - Family member, guardian, or friend of individual who receives services

2. Which race/ethnicity best describes you (Please choose only one.)
   - American Indian or Alaskan Native
   - Asian / Pacific Islander
   - Black or African American
   - Hispanic
   - White / Caucasian
   - Prefer not to answer
   - Multiple / Other (please specify)
3. What best describes your gender (Please choose only one)?

- Female
- Male
- I prefer not to say
- I self describe as...

4. Please let us know if you participate in any Alliance community committees or workgroups (select all that apply)

- None
- Alliance Provider Advisory Council (APAC)
- Consumer and Family Advisory Committee (CPAC)
- Alliance Human Rights Committee
- Alliance Hospital Partners
- Cumberland Crisis Collaborative
- Durham Crisis Collaborative
- Wake Crisis Collaborative
- Cumberland SOC Community Collaborative
- Durham Community Collaborative
- Johnston SOC Community Collaborative
- Wake County Community Collaborative for Children and Families
- Cumberland Juvenile Justice SA/MH Partnership (JJSAMHP)
- Durham Juvenile Justice SA/MH Partnership (JJSAMHP)
- Johnston Juvenile Justice SA/MH Partnership (JJSAMHP)
- Wake Juvenile Justice SA/MH Partnership (JJSAMHP)
- Cumberland CIT Collaborative
- Durham CIT Collaborative
- Johnston CIT Collaborative
- Wake CIT Collaborative
- NAMI-Cumberland
- NAMI-Durham
- NAMI-Johnston
- NAMI-Wake
- School Health Advisory Council (Cumberland)
- School Health Advisory Council (Durham)
- School Health Advisory Council (Johnston)
- School Health Advisory Council (Wake)

Other (please list any not included above)
5. Please let us know the type of services you or your family member receive (select all that apply):

- [ ] Child/Adolescent Mental Health
- [ ] Adult Mental Health
- [ ] Child/Adolescent Developmental Disabilities
- [ ] Adult Developmental Disabilities
- [ ] Child/Adolescent Substance Abuse
- [ ] Adult Substance Abuse
- [ ] Other (please specify)

6. In which county do you live (parents, family and guardians: please indicate county of residence for person who receives services)?

- [ ] Cumberland
- [ ] Durham
- [ ] Johnston
- [ ] Wake
- [ ] Other (please specify)

7. What language do you mainly speak at home?

- [ ] English
- [ ] Spanish
- [ ] Other language (please specify):

8. Are you able to receive services in your preferred language?

- [ ] Yes
- [ ] No

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

- [ ] Yes
- [ ] No

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

10. Are you receiving the mental health, substance use or intellectual/developmental disability services that you need?

- [ ] Yes
- [ ] No

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

11. Which of the following do you consider to be significant barriers to accessing services (select all that apply)?

- [ ] Lack of reliable transportation to appointments
- [ ] Services not available nearby
- [ ] Inconvenient hours
- [ ] Limited information about how to obtain services
- [ ] Lack of childcare
- [ ] Language barrier
- [ ] Cost of medication
- [ ] Wait too long for appointments
- [ ] Lack of insurance
- [ ] Not satisfied with quality or choice of providers
- [ ] Homeless/housing issues
- [ ] Availability of qualified staff
- [ ] Medical problems or physical disability
- [ ] No access to phone or e-mail

Other (please specify)
12. Please identify any of the following groups that you believe have difficulty accessing appropriate care (select all that apply)

- People with traumatic brain injuries
- People with physical disabilities
- People with visual impairments
- People who are deaf or hard of hearing
- Veterans, military members and their families
- Pregnant women with substance use disorders
- People who are LGBTQ
- People who are in jails or prisons
- Youth in the juvenile justice system
- People who are homeless or have unstable housing
- People who have transportation barriers
- People with food insecurity
- Specific ethnic groups (please provide additional details below)

Other: please provide additional details about groups not listed above or additional information about those that you selected above.
13. Please identify any specific services that are not available in your community (select all that apply).

- Inpatient psychiatric treatment
- Institutional care (ICF/MR)
- Crisis Services (including residential, facility-based crisis, walk-in crisis, NC START and mobile crisis services)
- Services to support development and implementation of behavior plans (Specialized Consultative Service, Behavior Plan Development)
- Outpatient psychotherapy (individual, group, family)
- Psychiatric services / medication evaluation and management
- Outpatient treatment of opioid abuse (e.g., medication-assisted treatment for opioid addiction)
- Community-based intensive treatment services for adults (e.g., Community Support Team, Assertive Community Treatment Team)
- Home-based family services for children and adolescents (e.g., Intensive In-Home, Multisystemic Therapy)
- Daily structured programs to support behavioral and emotional stability (e.g., day treatment, partial hospitalization, psychosocial rehabilitation)
- Intensive outpatient treatment for substance use (e.g., substance abuse intensive outpatient and comprehensive outpatient treatment programs)
- Services to provide relief to primary caretakers (Respite, Crisis respite, emergency and planned respite)
- Residential treatment for children and adolescents (Psychiatric Residential Treatment Facility (PRTF), Level IV, IAFT, therapeutic foster care family type)
- Residential treatment for individuals with substance use disorders (e.g., transitional living, half-way houses, housing with supports)
- Residential options for individuals with mental illness, Intellectual/Developmental Disabilities or Traumatic Brain Injury (Group Living, Supervised Living, Residential Supports, Semi- and/or independent living)
- Services to develop daily living skills (Individual Support, Developmental Therapy, In-Home Skill Building, Community Networking)
- Services that assist with developing social networks and community connections (e.g., Community Guide)
- Services to assist with vocational and educational needs (Supported Employment, Long Term Vocational Supports)
- Services for support with personal care and self-help needs (Personal Assistance, Personal Care)
- Supports to provide modifications to assist with increased independent functioning (Vehicle Adaptations, Home Modifications, Augmentative Communication Devices, Specialized Equipment and Supplies)
- Support by peers who have personal experience with mental illness or substance use (Peer Supports)
- Other (please specify)
14. Do you have any other comments regarding service needs or service gaps that you would like us to consider?

15. Finally, in addition to service needs and gaps, we would like to identify areas that are performing well. Please describe any services or experiences that have exceeded your expectations for quality, access or customer service. What do you believe was responsible for a satisfactory outcome?

Thanks for completing the survey!
Instrucciones:

Alliance Behavioral Healthcare está comprometida con la mejora continua de los servicios ofrecidos a nuestros residentes con necesidades de salud mental, discapacidades del desarrollo y uso de sustancias. Estamos realizando una evaluación de necesidades para analizar las necesidades de servicios y las brechas dentro de las comunidades de Alliance.

Tómese unos pocos minutos para completar esta breve encuesta. Sus respuestas son muy importantes para ayudarnos a comprender las necesidades de servicios en nuestra comunidad. La información que recibamos a través de este proceso será útil para nuestras iniciativas de planificación y desarrollo de servicios para el próximo año, y nos ayudará a prestar un mejor servicio a los adultos, los niños y las familias de nuestras comunidades.

Las encuestas completadas se pueden devolver de la siguiente manera:

1) Mediante la entrega o el envío postal a la siguiente dirección: Alliance Behavioral Healthcare at 4600 Emperor Blvd., Durham NC
   -O BIEN-

2) Mediante la digitalización y el envío por mensaje de correo electrónico a cjohnson@alliancebhc.org

Todas las respuestas son anónimas y no recopilamos ninguna información de identificación de los encuestados.

Complete la encuesta antes del viernes, 6 de julio.

¡Muchas gracias!

1. Indique cuál de las siguientes opciones lo describe mejor:
   - Persona que recibe servicios de salud mental, uso de sustancias o discapacidades intelectuales/del desarrollo
   - Familiar, tutor o amigo de una persona que recibe servicios
   - Otros (especificar)
2. ¿Qué raza/origen étnico lo describe mejor? (Elige solo una opción).
   - Nativo estadounidense o nativo de Alaska
   - Asian / Pacific Islander
   - Asiático/nativo de las islas del Pacífico
   - Negro o afroestadounidense
   - Hispano
   - Blanco/caucásico
   - Prefiere no responder
   - Razas múltiples/otra raza (especificar)

3. ¿Qué opción describe mejor su sexo? (Elige solo una opción).
   - Mujer
   - Hombre
   - Prefiere no decirlo
   - Me describo a mí mismo como...

4. Indique qué tipo de servicios recibe usted o su familiar (marque todas las opciones que correspondan):
   - Salud mental para niños/adolescentes
   - Discapacidades del desarrollo para niños/adolescentes
   - Abuso de sustancias para niños/adolescentes
   - Salud mental para adultos
   - Discapacidades del desarrollo para adultos
   - Abuso de sustancias para adultos
   - Otros (especificar)
5. ¿En qué condado vive (padres, familiares y tutores: indique el condado de residencia de la persona que recibe servicios)?
   - Cumberland
   - Durham
   - Johnston
   - Wake
   - Otro (especificar): 

6. ¿Qué idioma habla principalmente en el hogar?
   - Inglés
   - Español
   - Otro idioma (especifique):

7. ¿Es capaz de recibir servicios en su idioma preferido?
   - Sí
   - No

8. En el último año, ¿ha tenido usted o su familiar que viajar fuera del condado donde reside para recibir servicios de salud mental, discapacidad intelectual/del desarrollo o trastorno por uso de sustancias porque el servicio no estaba disponible en su condado?
   - Sí
   - No

   * Si su respuesta es "sí", ¿qué servicios no están disponibles en su condado?

9. ¿Está recibiendo los servicios de salud mental, uso de sustancias o discapacidad intelectual/del desarrollo que necesita?
   - Sí
   - No

   De no ser así, ¿qué servicios necesita, pero no puede recibir?
10. ¿Cuáles de las siguientes considera que son barreras significativas para el acceso a los servicios (seleccione todas las opciones que correspondan)?

- [ ] Falta de transporte confiable a las citas
- [ ] Servicios no disponibles en zonas cercanas
- [ ] Horarios inconvenientes
- [ ] Información limitada sobre cómo obtener servicios
- [ ] Falta de cuidado de niños
- [ ] Barrera idiomática
- [ ] Costo de los medicamentos
- [ ] Esperas demasiado prolongadas para las citas
- [ ] Falta de seguro
- [ ] Insatisfacción con la calidad o la elección de proveedores
- [ ] Personas sin techo/problemas de vivienda
- [ ] Disponibilidad de personal calificado
- [ ] Problemas médicos o discapacidad física
- [ ] Ausencia de acceso a teléfono o correo electrónico

Otro (especificar)
11. Identifique cualquiera de los siguientes grupos que considere que tienen dificultades para acceder a la atención adecuada (seleccione todas las opciones que correspondan).

- Personas con lesiones cerebrales traumáticas
- Personas con discapacidades físicas
- Personas con deficiencias visuales
- Personas sordas o con dificultades auditivas
- Veteranos, militares y sus familias
- Mujeres embarazadas con trastornos de uso de sustancias
- Personas del grupo LGBTQ
- Personas que están en cárceles o prisiones
- Jóvenes que están en el sistema de justicia juvenil
- Personas sin techo o que tienen una vivienda inestable
- Personas con barreras relacionadas con el transporte
- Personas con inseguridad alimentaria
- Grupos étnicos específicos (proporcionar detalles adicionales a continuación)

Otros: proporcionar detalles adicionales sobre grupos no incluidos anteriormente o información adicional sobre los seleccionados antes
12. Identifique cualquier servicio específico que no esté disponible en su comunidad (seleccione todas las opciones que correspondan).

- [ ] Atención institucional para tratamiento psiquiátrico con internación
- [ ] Atención institucional en un Centro de Atención Intermedia para Pacientes con Discapacidades Intelectuales
- [ ] Servicios ante crisis (centro de atención intermedia para personas con discapacidades intelectuales (lo que incluye cuestiones residenciales, crisis basadas en centros, crisis sin necesidad de citas, NC START y servicios para crisis por teléfono móvil)
- [ ] Servicios para respaldar el desarrollo y la implementación de planes conductuales (servicio de consulta especializado, plan de desarrollo conductual)
- [ ] Psicoterapia ambulatoria (individual, grupal, familiar)
- [ ] Servicios psiquiátricos/evaluación y control de medicamentos
- [ ] Tratamiento ambulatorio para abuso de opioides (p. ej., tratamiento asistido con medicamentos para la adicción a opioides)
- [ ] Servicios de tratamiento intensivo comunitarios para adultos (p. ej., equipo de asistencia comunitario, equipo de tratamiento asertivo en la comunidad)
- [ ] Servicios familiares basados en el hogar para niños y adolescentes (p. ej., servicios intensivos en el hogar, terapia multisistémica)
- [ ] Programas de estructuración diaria para respaldar la estabilidad conductual y emocional (p. ej., tratamiento durante el día, hospitalización parcial, rehabilitación psicosocial)
- [ ] Tratamiento ambulatorio intensivo para uso de sustancias (p. ej., programas de tratamiento ambulatorio integral y ambulatorio intensivo para abuso de sustancias)
- [ ] Servicios para brindar alivio a los cuidadores primarios (relevo, relevo ante crisis, emergencia y relevo planificado)
- [ ] Tratamiento residencial para niños y adolescentes (centro de tratamiento residencial psiquiátrico, tratamiento familiar alternativo intensivo, tipo de familia de hogar de crianza terapéutico)
- [ ] Tratamiento residencial para personas con trastornos de uso de sustancias (p. ej., vivienda transitoria, hogares de tránsito, viviendas con asistencia)
- [ ] Opciones residenciales para personas con enfermedad mental, discapacidades intelectuales/del desarrollo o lesiones cerebrales traumáticas (vida en grupo, vida con supervisión, asistencia residencial, vida semindependiente e/ó independiente)
- [ ] Servicios para desarrollar habilidades de la vida cotidiana (asistencia individual, terapia del desarrollo, formación de destrezas en el hogar, servicios de red comunitaria)
- [ ] Servicios que ayudan en el desarrollo de redes sociales y conexiones comunitarias (p. ej., guía comunitaria)
- [ ] Servicios para brindar asistencia con necesidades vocacionales y educativas (asistencia en el empleo, apoyo vocacional a largo plazo)
- [ ] Servicios de asistencia con el cuidado personal y las necesidades de autoayuda (asistencia personal, cuidado personal)
- [ ] Asistencia para brindar modificaciones para ayudar a un mayor funcionamiento independiente (adaptaciones en vehículos, modificaciones en el hogar, dispositivos de comunicación aumentativa, equipos y suministros especializados)
- [ ] Asistencia de pares con experiencia personal en la salud mental o el uso de sustancias (asistencia de pares)
- [ ] Otro (especificar)
13. ¿Tiene algún otro comentario sobre las necesidades de servicios o las brechas de servicios que le gustaría que consideremos?

14. Finalmente, además de las necesidades y las brechas de servicios, nos gustaría identificar áreas que se estén desempeñando bien. Describa cualquier servicio o experiencia que haya superado sus expectativas en lo relativo a la calidad, el acceso o el servicio al cliente. ¿Qué cree que fue responsable de tales resultados satisfactorios?

¡Gracias por completar la encuesta!
# Alliance Health Provider Access Survey

Alliance Behavioral Healthcare is evaluating network service adequacy and availability through the following provider survey. **Please submit only one response per agency to the following questions.**

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.

Although we are asking that you identify yourself and your agency in the survey, your identifying information will be used primarily to verify survey completion, and no personally identifiable information will be shared in the presentation of survey results.

Please complete the survey by Friday, July 26.

1. Please provide your contact information (we will use this only to identify missing data and to contact you if we have questions about your responses)

<table>
<thead>
<tr>
<th>Agency, Group or LIP Name</th>
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</table>

<table>
<thead>
<tr>
<th>Name of individual completing survey</th>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Email Address</th>
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<td></td>
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</tbody>
</table>

2. Please indicate the counties that you serve under contract with Alliance (select all that apply)

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

   [ ] Other (please specify)
3. Are you currently accepting new referrals for individuals with Medicaid for all services and counties served?
   - [ ] Yes, for all services and counties served
   - [ ] Not accepting referrals for some services and/or some counties served (please identify services and counties that are not taking referrals)

4. Are you currently accepting new Non-Medicaid referrals (i.e., uninsured, state or county funded, IPRS) for all services and counties served?
   - [ ] Yes, for all services and counties served
   - [ ] Not accepting referrals for some services and/or some counties served (please identify services and counties that are not taking referrals)

5. If you are not accepting new referrals for all services or counties served, what are the reasons that you are not accepting referrals? (check all that apply)
   - [ ] Service is at capacity based on current staffing and/or service requirements
   - [ ] Preparing to discontinue service (please provide additional details below)
   - [ ] Staffing shortage
   - [ ] Alliance referral suspension or other sanction
   - [ ] Difficulty finding prescriber
   - [ ] Other (please specify below)
   - [ ] Low rate of reimbursement
   - [ ] None or N/A

Please provide additional details
* 6. Select any of the following that your agency provides to improve access to care. (select all that apply)

- [ ] Evening appointments (provide information below about days and hours of evening appointment availability)
- [ ] Weekend appointments
- [ ] In-home services
- [ ] Transportation assistance
- [ ] Telepsychiatry
- [ ] Walk-in hours (please provide information below about days and hours of walk-in availability)
- [ ] Service availability to individuals who speak a language other than English
- [ ] Other (provide additional details below)
- [ ] None or N/A

Provide additional details about items selected above

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* 7. How do you make services available to individuals who do not speak English?

- [ ] Services only available in English
- [ ] Use of language line
- [ ] Use of interpreters
- [ ] Staff are available who speak other languages (please provide details about languages spoken and services that are available in these languages)

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* 8. Do you provide any services that are tailored specifically to meet the needs of those whose primary language is Spanish?

- [ ] No
- [ ] Yes (please provide additional details about this service)

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9. Please indicate whether your agency has specialized services for any of the specific populations listed below. Please select only those areas in which your organization has taken extra efforts to tailor services to identified population needs, and please provide specific details about how your services are designed to address these needs.

- People with traumatic brain injuries
- People with physical disabilities
- People with visual impairments
- People who are deaf or hard of hearing
- Veterans, military members, and their families
- Pregnant women with substance use disorders
- People who are LGBTQ
- Sex offenders
- Youth in the juvenile justice system
- People who are homeless or have unstable housing
- People who have transportation barriers
- People with food insecurity
- Specific ethnic groups (please provide additional details below)
- Dually diagnosed MI/IDD
- Dually diagnosed MI/SUD
- Other (please describe below)

Provide additional details about groups not listed above or additional information about those that you selected above.

* 10. What is your average in-office wait time for clients?

- Less than 15 minutes
- 15-30 minutes
- 30-45 minutes
- Over 45 minutes
- Do not know

11. For each of the following types of appointment requests, select the average wait time in days before new referrals can be seen for an intake assessment.

<table>
<thead>
<tr>
<th>Wait Time (Days)</th>
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</thead>
<tbody>
<tr>
<td>Follow-up appointment after hospitalization</td>
</tr>
<tr>
<td>Referral from Alliance Call Center (Routine)</td>
</tr>
<tr>
<td>Referral from Alliance Call Center (Urgent)</td>
</tr>
</tbody>
</table>

12. For each item below, how long does it take for new clients to be seen from the date of the intake assessment? (Select number of weeks/days, or ‘N/A’ if item does not apply to your agency)

<table>
<thead>
<tr>
<th>First outpatient treatment appointment (weeks/days between intake assessment and first appointment)</th>
<th>Weeks</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment with psychiatrist/prescriber when indicated (weeks/days between intake assessment and psychiatrist/prescriber appointment)</td>
<td>Weeks</td>
<td>Days</td>
</tr>
<tr>
<td>Enhanced services for MH or SUD (e.g., IIP, CST, SAIOP; weeks/days between intake and enhanced services initiation)</td>
<td>Weeks</td>
<td>Days</td>
</tr>
<tr>
<td>Services for IDD and/or Autism Spectrum Disorders (e.g., ABA; weeks/days between intake assessment and initiation of services)</td>
<td>Weeks</td>
<td>Days</td>
</tr>
</tbody>
</table>

* 13. Do you have any practitioners within your agency who can bill for the following insurance coverage options? (select all that apply)

- [ ] Individuals with both Medicare and Medicaid
- [ ] Individuals with both Medicaid and Private Insurance
- [ ] Individuals with both Medicaid and Tricare Insurance
- [ ] None of the above
- [ ] Other (please specify)
* 14. Has your agency ever used the Alliance slot scheduler?
   
   □ Yes, and we are currently using
   □ Yes, but we are no longer using
   □ No

   Please provide additional information about challenges and barriers to using the slot scheduler

15. What are the most significant barriers to receiving timely and appropriate care?

16. What suggestions do you have for improving access to care, addressing barriers to access or improving accessibility for specific populations.

Thanks for completing the survey! Please select ‘DONE’ to submit your feedback and exit the survey.
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 the months of June and July 2018 and yielded a total of 691 responses. The following provides a breakdown of submissions by respondent group and county:

- Consumer and Family..............152
- Provider................................247
- Stakeholder .........................106
- Staff....................................182
- TOTAL ..................................691

<table>
<thead>
<tr>
<th>County</th>
<th>Consumers &amp; Families</th>
<th>Providers</th>
<th>Stakeholders</th>
<th>County Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland</td>
<td>35</td>
<td>51</td>
<td>10</td>
<td>96</td>
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<tr>
<td>Durham</td>
<td>13</td>
<td>120</td>
<td>29</td>
<td>162</td>
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<tr>
<td>Johnston</td>
<td>10</td>
<td>65</td>
<td>10</td>
<td>85</td>
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<tr>
<td>Wake</td>
<td>86</td>
<td>141</td>
<td>60</td>
<td>287</td>
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<tr>
<td>Other</td>
<td>8</td>
<td>9</td>
<td>2</td>
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<tr>
<td>TOTAL</td>
<td>148</td>
<td>247</td>
<td>106</td>
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</table>
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. Alliance staff attended meetings of many of these groups to solicit and summarize feedback. The following groups provided feedback through written summaries of focus groups or 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
- 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)
- Provider Collaboratives for Substance Use Disorders (SUD), Intensive In-Home (IIH), 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)
- Healing Transitions participants on both men’s and women’s campuses
- NC DHHS/Division of State Operated Healthcare Facilities (DSOHF) staff
- Alliance staff: focus group discussions with specific departments and staff that are in a position to observe network gaps and barriers (ABH Staff)
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)
- 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

**Guide to Interpretation of Tables**

The following tables include separate summaries of responses to questions about **underserved populations**, **service gaps**, and **barriers to service access**. Two tables are provided for each topic:

1. **Stakeholder Survey** Feedback: summary of responses by each identified respondent group to questions on the electronic survey of community needs and gaps. For each group, the top five priorities are listed, ranked in order from highest (1) to lowest. Results are color-coded (see legend for each table) to identify the % of respondents who endorsed items. When groups had ranked items beyond the top five that fell into color-coded categories, these items were included in the summary table.

2. **Stakeholder Focus Group** Feedback: summary of items endorsed by each identified respondent group in their focus group feedback. Items are listed in order of highest number of endorsements across groups (i.e., number of respondent groups identifying a specific area as an underserved population, service gaps or barrier.)
### Stakeholder Survey Feedback on Populations Identified as Underserved

<table>
<thead>
<tr>
<th>Population</th>
<th>Community Survey</th>
<th>CFAC</th>
<th>APAC</th>
<th>Crisis Collaboratives</th>
<th>CIT Collaboratives</th>
<th>CCC&amp;Fs</th>
<th>JJSAMHPs</th>
<th>Consumers</th>
<th>Family Members</th>
<th>Providers</th>
<th>Stakeholders</th>
<th>ABH Staff</th>
<th>Cumberland</th>
<th>Durham</th>
<th>Johnston</th>
<th>Wake</th>
<th>Child MH</th>
<th>Child IDD</th>
<th>Child SUD</th>
<th>Adult MH</th>
<th>Adult IDD</th>
<th>Adult SUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who are homeless or have unstable housing</td>
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<td>People who have transportation barriers</td>
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<td>People who are in jails or prisons</td>
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<td>People with physical disabilities</td>
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<tr>
<td>People with traumatic brain injuries</td>
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<td>Youth in the juvenile justice system</td>
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<td>People with food insecurity</td>
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<td>Veterans, military members &amp; families</td>
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<td>Pregnant women with substance use disorders</td>
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<td>People who are LGBTQ</td>
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**Green** = endorsed by 50% or more of respondents  
**Yellow** = endorsed by 40 - 49% or more of respondents
**Underserved Populations**

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

1. Dually diagnosed: need for improved provider network capacity to serve individuals with co-occurring behavioral health conditions
2. Non-English: including refugees, undocumented, uninsured
3. Uninsured and underinsured: includes those with insurance, including Tricare, whose insurance does not cover needed levels of care
4. IDD: any member not receiving Innovations services, individuals with IDD in nursing homes or other settings that are not well-prepared to provide care; includes waitlist, those with complex needs, aging IDD with limited service availability
5. Homeless
6. Complex/co-occurring medical
7. Autism spectrum: includes limited access to ABA, limited services for higher functioning autistic clients
8. Transition age youth
9. Complex, high needs clients: dual diagnosis, severity of illness, challenging behaviors
10. Individuals with substance use disorders: including uninsured, those with legal history, Spanish-speaking individuals with SUD
11. Sex offenders / sexualized behaviors
12. Elderly: elderly IDD with no place to go during day, elderly with dementia; need for enhanced Senior Center expertise
13. Court-involved / jail discharges
14. Individuals with specialized treatment needs (e.g., eating disorders, RAD, personality disorders, trauma)
15. Foster children/aging out of foster care
16. LGBT
17. Pregnant women
18. Young children
19. Disabilities: including blind
20. Aggressive/violent
### Stakeholder Focus Group Feedback on Populations Identified as Underserved

<table>
<thead>
<tr>
<th></th>
<th>CFAC</th>
<th>APAC</th>
<th>Compliance</th>
<th>Cumberland Crisis</th>
<th>Cumberland IDD SH</th>
<th>Cumberland SOC</th>
<th>Durham IDD SH</th>
<th>Hospital Partners</th>
<th>MH/SU CC</th>
<th>SUD Collaborative</th>
<th>TFC</th>
<th>Wake Crisis</th>
<th>Wake JCPC</th>
<th>Wake JISAMHP</th>
<th>DSHOF</th>
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<td>Dually diagnosed</td>
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<td>Non-English</td>
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<tr>
<td>Uninsured &amp; underinsured / low income</td>
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<td>IDD (especially non-Innovations)</td>
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Others listed: SPMI, families (e.g., needing shelter), individuals who fall between the cracks re: IQ, runaways, individuals with Medicare and Medicaid, undocumented
## Stakeholder Survey Feedback on Service Gaps

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Orange = endorsed by 40% + of respondents  
Green = endorsed by 30-39% of respondents  
Yellow = endorsed by 25 - 29% of respondents
Service Gaps

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

1. Residential treatment: includes need for additional Level IV homes, residential tx for pregnant women, residential for young adults (too young for nursing homes); wider array of residential options; SUD-friendly and MAT-friendly residential treatment; services for families wanting residential who are denied, includes oversight of group homes, support for individuals residing in group homes with low cognitive functioning.

2. Housing, affordable housing, housing supports, shelters: includes need for more availability of affordable housing as well as services such as supported housing and transitional housing. There were also significant concerns about capacity of these facilities to serve individuals with complex needs, and group homes refusal to accept consumers back at their facilities after crisis or inpatient visits. Other identified needs included transitional housing, housing for transition age youth, emergency shelters, and housing for individuals with special needs or barriers to entry (criminal records, pregnant women, co-occurring medical problems, etc.); SUD-friendly housing.

3. Services to address transportation challenges: in-home services and transportation assistance.


5. Broader array of SUD: includes residential, initiation of MAT in detox facilities prior to discharge, rural SUD tx; longer term SUD tx; trauma-informed SUD tx; more effective aftercare; long-term residential treatment, settings that support treatment of dually diagnosed, including access to medication, residential SUD treatment for women who are pregnant or who have custody of children, and expansion of options similar to Healing Transitions or TROSA.

6. Additional service capacity to improve timely access: need for improved accessibility of current providers and/or more providers, including those willing to serve outlying areas and to accept complex cases. Increased availability of in-home treatment options, expanded hours of appointments, and assistance with transportation. Access is reported to be most limited for individuals without insurance or those who with limited insurance coverage.

7. Employment services: Assistance with obtaining and maintaining employment, businesses willing to employ youth with disabilities.

8. Expansion of crisis array: BHUC, alternatives to EDs, ability of EMS and LEO to drop off patients on IVC in Cumberland; holistic crisis facilities that do not need to send out for lab work; MCM with 30-minute response time.

9. Day Treatment: including children who have been suspended.
10. Services for autism spectrum: increased access to ABA, increased individualization of treatment options, summer camps
11. IDD services for individuals who are not on the Innovations Waiver
12. Case Management
13. Life skills, services to promote independence: ADL assistance
14. School behavioral health: collaboration with school system on service access and coordination; resources in school settings
15. Improved aftercare access & follow-up: used to have trial discharge from DSOHF facilities; appropriate step-down services and facilities
16. MAT: including services for uninsured, initiation of MAT before discharge
17. Residential Level IV
18. Youth programming
19. Community supports, activities: physical activities & exercise; more opportunities to be part of the community
20. Individualized design of services
21. Jail post-release and other services for criminal justice involved: Expanded service continuum for justice system involved, including jail transition services, improved coordination of care and step-down services for higher needs violent Juvenile offenders. Several groups also recommended addition of a Forensic ACTT team, access to medication after discharge
### Stakeholder Focus Group Feedback on Service Gaps

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<td>Jail post-release and other services for criminal justice involved</td>
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</tbody>
</table>

**Others listed:** Specialty services (e.g., DBT, trauma-focused CBT), respite, inpatient treatment, member access to electronic resources (phone, internet), assertive engagement, hospital transition team, peer support for uninsured, access to medical care (including hearing aids, dental and vision care), intensive behavioral health outpatient services, independent assessments, opioid tx oversight, telemedicine standards and quality, services for uninsured, non-hospital detox in Johnston County.
## Stakeholder Survey Feedback on Barriers

<table>
<thead>
<tr>
<th>Barriers</th>
<th>SH Survey</th>
<th>CFAC</th>
<th>APAC</th>
<th>Crisis Collabs</th>
<th>CIT Collabs</th>
<th>CCC&amp;Fs</th>
<th>JJSAMHPs</th>
<th>Consumers</th>
<th>Family</th>
<th>Providers</th>
<th>Stakeholders</th>
<th>ABH Staff</th>
<th>Cumberland</th>
<th>Durham</th>
<th>Johnston</th>
<th>Wake</th>
<th>Child MH</th>
<th>Child IDD</th>
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**Green** = endorsed by 50% or more of respondents | **Yellow** = endorsed by 40 - 49% or more of respondents
**Barriers**

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

1. Lack of insurance (uninsured and underinsured): inadequate funding for SUD services for uninsured, some have too much income to qualify for Medicaid, but need enhanced benefit services; gap between Medicaid eligibility and affordability of insurance
2. Limited service availability: limited hours of operation, long waits at open access sites, waiting lists, limited number of providers, limited funding for uninsured; challenges with staff retention, finding staff for some services; employees constantly changing agencies
3. Limited service information / difficulty navigating system: difficulty obtaining information about system, complexity of navigating entry and challenges for coordinating care; poor understanding in community about behavioral health needs and resources; public information about Alliance and its services; need better way to search for providers (list is overwhelming); need for clarification of services, how to access care and navigate the system, more information about provider availability, capacity and expertise; ability to speak to person live
4. Transportation/ lack of service access in rural areas: options for individuals not on bus line or in rural areas; individuals unable to afford public transportation, those living in outlying/rural areas of all counties (e.g., outlying areas of Wake and Durham)
5. Affordable housing / homelessness: affordable housing, shelters,
6. Service availability for non-English speakers: costs of translation
7. IDD waitlist
8. Residential service eligibility limitations: programs that can serve women with children, high risk youth, complex cases, SUD
9. Stigma
10. Childcare
11. Alliance requirements, expectations and rules: expectations for step-down of IDD not realistic, wait time for authorization, unrealistic expectations;
12. Assistance with appointment reminders / challenges in contacting clients
13. Service continuity for individuals leaving jail: includes access to medication
<table>
<thead>
<tr>
<th>Stakeholder Focus Group Feedback on Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lack of insurance (uninsured and underinsured)</strong></td>
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<tr>
<td><strong>Limited service availability</strong></td>
</tr>
<tr>
<td><strong>Limited service information / difficulty navigating system</strong></td>
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<tr>
<td><strong>Transportation/ lack of service access in rural areas</strong></td>
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<tr>
<td><strong>Affordable housing / homelessness</strong></td>
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<td><strong>IDD waitlist</strong></td>
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<td><strong>Residential service eligibility limitations</strong></td>
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<td><strong>Stigma</strong></td>
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<td><strong>Childcare</strong></td>
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<tr>
<td><strong>MCO requirements, expectations and rules</strong></td>
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<tr>
<td><strong>Assistance with appointment reminders / challenges in contacting clients</strong></td>
</tr>
<tr>
<td><strong>Service continuity for individuals leaving jail</strong></td>
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</tbody>
</table>

**Others listed:** client complexity, access to medication, employment, poverty, lack of income, food insecurity, need for improved oversight of group homes
Provider Access Survey Responses: Barriers to Receiving Timely and Appropriate Care

132 providers responded to the Provider Access Survey, and reported the following primary barriers to receiving timely and appropriate care:

- Transportation (20): need for additional transportation availability, especially in rural areas and even outlying areas of urban counties; expansion of telehealth options and in-home services
- Staffing (15): high staff turnover, difficulty finding qualified staff, difficulty hiring due to low reimbursement rates
- No-shows (14)
- MCO authorization approval (12): delays in treatment initiation due to waits for authorizations, delays of up to 14 days due to authorization turnaround time
- Funding (11): low reimbursement rates, no funding for services, limited funding for uninsured
- Limited capacity (10): large caseloads, lack of residential beds or waiting lists for residential placement
- Administrative barriers (8): excessive paperwork demands, credentialing timeframe, unclear feedback about reasons for claims denials, fear of MCO sanctions and recoupments
- Uninsured/underinsured (6): clients without insurance, with high deductibles and inability to afford copays
- Client communication (4): difficulty reaching consumers due to lack of telephones, especially for homeless
- Housing (3)
- Service hours (2)
Provider Access Survey Responses: Service Availability for Specific Populations

Providers were asked to report their capacity to serve specific populations for the counties that each serves. The following is a summary by county of reported provider capacity. Given the relatively low response rate, the following data is likely to be an underrepresentation of actual reported capacity.

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<thead>
<tr>
<th>Population</th>
<th>Cumberland</th>
<th>Durham</th>
<th>Johnston</th>
<th>Wake</th>
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<td>Traumatic Brain Injuries</td>
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<td>3</td>
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<td>Physical Disabilities</td>
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<td>4</td>
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<tr>
<td>Deaf or Hard of Hearing</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Veterans, Military &amp; Families</td>
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<td>9</td>
<td>3</td>
<td>11</td>
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<tr>
<td>Pregnant with SUD</td>
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<td>LGBTQ</td>
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<td>Youth / Juvenile Justice</td>
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<td>Homeless / Unstable Housing</td>
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<td>6</td>
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</table>

Additional information about language capacity is available through an existing database. The following is a summary of reported language capacity by county, based on provider specialties reported during credentialing:

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<th>Italian</th>
<th>Japanese</th>
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<th>Persian</th>
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<tr>
<td>Durham</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Johnston</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Wake</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>51</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Continuum</th>
<th>Cumberland</th>
<th>Durham</th>
<th>Johnston</th>
<th>Wake</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Responder</td>
<td>Larger provider is Carolina Outreach. All Alliance contracts require any enhanced service provider to be a First Responder</td>
<td>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</td>
<td>Available; ACTT only serves part of the county; need greater services. All Alliance contracts require any enhanced service provider to be a First Responder</td>
<td>All Alliance contracts require any enhanced service provider to be a First Responder</td>
</tr>
<tr>
<td>NC START</td>
<td>Eastern region – managed by ECBH</td>
<td>Managed by Alliance; respite beds available</td>
<td>Eastern region - managed by ECBH</td>
<td>Managed by Alliance; respite beds available</td>
</tr>
<tr>
<td>Outpatient Provider</td>
<td>Available, but more providers are needed; especially those with Spanish language capacity</td>
<td>Multiple providers</td>
<td>Basic and enhanced services are provided</td>
<td>Multiple providers</td>
</tr>
<tr>
<td>Same Day Access Providers</td>
<td>Limited walk-in capacity at the Cape Fear Valley Health Outpatient Mental Health Center</td>
<td>Limited availability – however, there are several providers offering same day access. Behavioral Health Urgent Care is also available to meet this need.</td>
<td>Not available</td>
<td>Several providers offer same day access, with one provider offering extended hours. Behavioral Health Urgent Care expansion in process</td>
</tr>
</tbody>
</table>
### Early Intervention

<table>
<thead>
<tr>
<th>Continuum</th>
<th>Cumberland</th>
<th>Durham</th>
<th>Johnston</th>
<th>Wake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family &amp; Community Support</td>
<td>Homeless shelters available; limited providers under Shelter Plus Care (PATH) contracts</td>
<td>Shelters include Urban Ministry (offers specific programs like vets &amp; 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. BECOMING – TAY (16-21 year olds) services &amp; Family Partner Halfway house and Oxford House</td>
<td></td>
<td>Healing Place Raleigh Rescue Mission Helen Wright Center Oxford House</td>
</tr>
<tr>
<td>School-based</td>
<td>Not available</td>
<td>One care coordinator at CC Spalding (elementary school); Not available</td>
<td>School-based team (includes Family Partner on team) School-based crisis intervention team</td>
<td></td>
</tr>
<tr>
<td>Crisis Telephone Line</td>
<td>Alliance; Hopeline of NC; 211 United Way of NC; National Suicide Prevention Lifeline; county resources</td>
<td>Alliance; Hopeline of NC; 211 United Way of NC; National Suicide Prevention Lifeline; county resources</td>
<td>Alliance; Hopeline of NC; 211 United Way of NC; National Suicide Prevention Lifeline; county resources</td>
<td>Alliance; Hopeline of NC; 211 United Way of NC; National Suicide Prevention Lifeline; county resources</td>
</tr>
<tr>
<td>MCO Access Center</td>
<td>Alliance</td>
<td>Alliance</td>
<td>Alliance</td>
<td>Alliance</td>
</tr>
<tr>
<td>Continuum</td>
<td>Cumberland</td>
<td>Durham</td>
<td>Johnston</td>
<td>Wake</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>------------</td>
<td>----------------------------------------------------</td>
<td>---------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Peer Support living room</td>
<td>Not available</td>
<td>Part of the model at the Durham Recovery Response Center operated by Recovery Innovations</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>Rapid Response (youth)</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
<td>Beds available through Methodist Home for Children</td>
</tr>
<tr>
<td>Mobile Crisis Team</td>
<td>Therapeutic Alternatives</td>
<td>Freedom House Recovery Center</td>
<td>Therapeutic Alternatives</td>
<td>Therapeutic Alternatives Enhanced Mobile Crisis Pilot with Wake EMS APPs to launch in 2018</td>
</tr>
<tr>
<td>CIT Partnership</td>
<td>Active CIT program with numerous officers trained.</td>
<td>Active CIT program with numerous officers trained.</td>
<td>Active CIT with increasing numbers of officers being trained</td>
<td>Active CIT program with numerous officers trained.</td>
</tr>
<tr>
<td>EMS Partnership</td>
<td>Paramedics and 911 operators are CIT trained but no advanced paramedics</td>
<td>Community Paramedicine Program fully launched in 2018operators are CIT trained</td>
<td>Paramedics and 911 operators are CIT trained but no advanced paramedics; some community paramedics focused on top utilizers (physical health also)</td>
<td>Advanced Practice paramedics; also Paramedics and 911 operators are CIT trained. Enhanced Mobile Crisis Pilot with Wake EMS APPs to launch in 2018</td>
</tr>
<tr>
<td>24/7 Crisis Walk-in Clinic</td>
<td>Cape Fear Roxie Avenue Crisis Facility available for walk-ins and voluntary law enforcement drop offs;</td>
<td>Durham Recovery Response Center operated by Recovery Innovations</td>
<td>Johnston Public Health - available Monday to Friday (8 to 5)</td>
<td>Wakebrook Crisis and Assessment Services</td>
</tr>
<tr>
<td>Hospital Emergency Department</td>
<td>Cape Fear Hospital</td>
<td>Duke; Duke Regional and UNC-Chapel Hill (in Orange County)</td>
<td>Johnston Health System</td>
<td>UNC Rex, Duke Raleigh, WakeMed</td>
</tr>
<tr>
<td>Continuum</td>
<td>Cumberland</td>
<td>Durham</td>
<td>Johnston</td>
<td>Wake</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Crisis Respite Housing</td>
<td>Not available</td>
<td>Not available; some respite for children available with special authorization (provide by Alpha Management MH)</td>
<td>Not available</td>
<td>2 beds available for NC START (2 each for crisis and planned)</td>
</tr>
<tr>
<td>Crisis for Kids</td>
<td>Freedom House &amp; Cape Fear plan to implement</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>23 Hour Observation</td>
<td>Cape Fear Roxie Avenue Crisis Facility available for walk-ins and voluntary law enforcement drop offs;</td>
<td>Durham Recovery Response Center operated by Recovery Innovations</td>
<td>Crisis Stabilization Unit at UNC Johnston Health Hospital - 7 beds in the ED that operate like CEO and FBC;</td>
<td>UNC WakeBrook Crisis &amp; Assessment Services – 12 chair/beds for children and adults</td>
</tr>
<tr>
<td>Facility Based Crisis</td>
<td>Cape Fear Valley; 16 beds shared with FBC and detox; when crisis is on diversion, sent to ED to access detox bed</td>
<td>Durham Recovery Response Center operated by Recovery Innovations - 16 FBC /non-medical detox</td>
<td>Not available</td>
<td>UNC WakeBrook FBC – 16 beds</td>
</tr>
<tr>
<td>Non-hospital detox</td>
<td>Cape Fear Valley- doctors are shared with outpatient and crisis; 16 beds shared with FBC and detox;</td>
<td>Durham Recovery Response Center operated by Recovery Innovations - 16 FBC /non-medical detox</td>
<td>Not available</td>
<td>UNC WakeBrook Alcohol and Drug Detox Unit (ADU) – 16 beds</td>
</tr>
<tr>
<td>Community Hospital Incl 3 way bed</td>
<td>Three-way beds Inpatient Psych Unit</td>
<td>Three-way beds Inpatient Psych Unit</td>
<td>Three-way beds Inpatient Psych Unit</td>
<td>Three-way beds Inpatient Psych Unit</td>
</tr>
<tr>
<td></td>
<td>Cape Fear Valley Health</td>
<td>Duke University Hospital</td>
<td>UNC Johnston Health System</td>
<td>WakeBrook</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Duke Regional Hospital</td>
<td></td>
<td>Holly Hill –County sponsored beds for uninsured</td>
</tr>
<tr>
<td>State Psych &amp; ADATC</td>
<td>Central Regional Hospital, Broughton, Cherry Hill, RJ Blakely</td>
<td>Central Regional Hospital, Broughton, Cherry, RJ Blakely</td>
<td>Central Regional Hospital, Broughton, Cherry, WB Jones</td>
<td>Central Regional Hospital, Broughton, RJ Blakely</td>
</tr>
<tr>
<td>Continuum</td>
<td>Cumberland</td>
<td>Durham</td>
<td>Johnston</td>
<td>Wake</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------</td>
<td>-------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Critical Time Intervention</td>
<td>New grant received; in the start-up phase</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>Peer Crisis Navigators</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>LME/MCO Care Coordination</td>
<td>Provided by Alliance; includes jail liaison</td>
<td>Provided by Alliance; includes jail liaison &amp; social workers contracted at CJRC; Alliance funds Duke ED embedded care coordinator</td>
<td>Provided by Alliance includes jail liaison</td>
<td>Provided by Alliance; includes jail liaison</td>
</tr>
<tr>
<td>Care Review Teams</td>
<td>Alliance</td>
<td>Alliance. Adult, youth, transitional aged-youth, homeless, Spanish-speaking, etc.</td>
<td>Alliance</td>
<td>Alliance</td>
</tr>
<tr>
<td>Hospital Transition Team</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
<td>Available</td>
</tr>
<tr>
<td>Continuum</td>
<td>Cumberland</td>
<td>Durham</td>
<td>Johnston</td>
<td>Wake</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>WRAP</td>
<td>Need to determine how widely used</td>
<td>Need to determine how widely used</td>
<td>Need to determine how widely used</td>
<td>Need to determine how widely used</td>
</tr>
<tr>
<td>Crisis Planning</td>
<td>Training &amp; expectations provided to provider network</td>
<td>Training &amp; expectations provided to provider network</td>
<td>Training &amp; expectations provided to provider network</td>
<td>Training &amp; expectations provided to provider network</td>
</tr>
<tr>
<td>Integration/re-integration into treatment and support system</td>
<td>Training &amp; expectations provided to provider network</td>
<td>Training &amp; expectations provided to provider network</td>
<td>Training &amp; expectations provided to provider network</td>
<td>Training &amp; expectations provided to provider network</td>
</tr>
<tr>
<td>Advanced directive</td>
<td>Available but needs to be promoted</td>
<td>Available but needs to be promoted</td>
<td>Available but needs to be promoted</td>
<td>Available but needs to be promoted</td>
</tr>
<tr>
<td>MH First Aid</td>
<td>Available &amp; utilized</td>
<td>Available &amp; utilized</td>
<td>Available &amp; utilized</td>
<td>Available &amp; utilized</td>
</tr>
<tr>
<td>Transitional Living</td>
<td>Myrover Reese</td>
<td>Freedom House; Durham Recovery; Dove House and TROSA</td>
<td>Not available</td>
<td>Southlight NC Recovery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recovery Center of Durham</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drop-in Center</td>
<td>Not available</td>
<td>Wellness City (Recovery Innovations)</td>
<td>Available but not peer run; Southeastern Healthcare (PSR provider)</td>
<td>Fellowship Health Resources</td>
</tr>
</tbody>
</table>
## Appendix F: County Health Data

<table>
<thead>
<tr>
<th>Health Outcomes (rank 1-100)</th>
<th>Goal</th>
<th>US Avg</th>
<th>NC Avg</th>
<th>NC Best</th>
<th>Cumberland</th>
<th>Durham</th>
<th>Johnston</th>
<th>Wake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Outcomes (rank 1-100)</td>
<td>↓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of Life (rank 1-100)</td>
<td>↓</td>
<td>1</td>
<td>77</td>
<td>75</td>
<td>11</td>
<td>17</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Premature death: years of potential life lost before age 75 per 100,000 population</td>
<td>↓</td>
<td>6,700</td>
<td>7,300</td>
<td>4,500</td>
<td>9,100</td>
<td>6,100</td>
<td>6,800</td>
<td>4,500</td>
</tr>
<tr>
<td>Quality of Life (rank 1-100)</td>
<td>↓</td>
<td></td>
<td></td>
<td>76</td>
<td>30</td>
<td>20</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Poor or fair health: adults reporting fair or poor health</td>
<td>↓</td>
<td>16%</td>
<td>18%</td>
<td>13%</td>
<td>22%</td>
<td>17%</td>
<td>17%</td>
<td>13%</td>
</tr>
<tr>
<td>Poor physical health days: physically unhealthy days reported in past 30 days</td>
<td>↓</td>
<td>3.7</td>
<td>3.6</td>
<td>2.9</td>
<td>4.0</td>
<td>3.5</td>
<td>3.7</td>
<td>2.9</td>
</tr>
<tr>
<td>Poor mental health days: mentally unhealthy days reported in past 30 days</td>
<td>↓</td>
<td>3.8</td>
<td>3.9</td>
<td>3.4</td>
<td>4.3</td>
<td>4.0</td>
<td>4.0</td>
<td>3.6</td>
</tr>
<tr>
<td>Low birthweight: live births with low birthweight (&lt; 2500 grams)</td>
<td>↓</td>
<td>8%</td>
<td>9%</td>
<td>6%</td>
<td>10%</td>
<td>9%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Health Factors (rank 1-100)</td>
<td>↓</td>
<td></td>
<td></td>
<td>62</td>
<td>14</td>
<td>39</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Health Behaviors (rank 1-100)</td>
<td>↓</td>
<td></td>
<td></td>
<td>65</td>
<td>16</td>
<td>49</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Adult smoking: adults who are current smokers</td>
<td>↓</td>
<td>17%</td>
<td>18%</td>
<td>14%</td>
<td>18%</td>
<td>16%</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>Adult obesity: adults that report a BMI of 30 or more</td>
<td>↓</td>
<td>28%</td>
<td>30%</td>
<td>23%</td>
<td>33%</td>
<td>26%</td>
<td>35%</td>
<td>23%</td>
</tr>
<tr>
<td>Food environment index: access to healthy food and food insecurity (index ranges from low of 0 to high of 10)</td>
<td>↑</td>
<td>7.7</td>
<td>6.4</td>
<td>8.5</td>
<td>6.0</td>
<td>6.8</td>
<td>8.3</td>
<td>7.9</td>
</tr>
<tr>
<td>Physical inactivity: adults reporting no leisure-time physical activity</td>
<td>↓</td>
<td>23%</td>
<td>24%</td>
<td>17%</td>
<td>25%</td>
<td>20%</td>
<td>28%</td>
<td>17%</td>
</tr>
<tr>
<td>Access to exercise opportunities: adequate access to locations for physical activity</td>
<td>↑</td>
<td>83%</td>
<td>76%</td>
<td>100%</td>
<td>79%</td>
<td>92%</td>
<td>69%</td>
<td>92%</td>
</tr>
<tr>
<td>Goal</td>
<td>Goal</td>
<td>US Avg</td>
<td>NC Avg</td>
<td>NC Best</td>
<td>Cumberland</td>
<td>Durham</td>
<td>Johnston</td>
<td>Wake</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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<td>---------</td>
<td>------------</td>
<td>--------</td>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td><strong>Excessive drinking:</strong> adults reporting binge or heavy drinking</td>
<td>↓</td>
<td>18%</td>
<td>17%</td>
<td>12%</td>
<td>16%</td>
<td>17%</td>
<td>18%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Alcohol-impaired driving deaths:</strong> driving deaths with alcohol involvement</td>
<td>↓</td>
<td>29%</td>
<td>31%</td>
<td>0%</td>
<td>32%</td>
<td>31%</td>
<td>27%</td>
<td>37%</td>
</tr>
<tr>
<td><strong>Sexually transmitted infections:</strong> newly diagnosed chlamydia cases per 100,000 population</td>
<td>↓</td>
<td>478.8</td>
<td>647.4</td>
<td>92.2</td>
<td>1185.3</td>
<td>937.3</td>
<td>438.2</td>
<td>577.9</td>
</tr>
<tr>
<td><strong>Teen births:</strong> births per 1,000 females ages 15-19</td>
<td>↓</td>
<td>27</td>
<td>29</td>
<td>6</td>
<td>38</td>
<td>27</td>
<td>31</td>
<td>16</td>
</tr>
</tbody>
</table>

### Clinical Care (rank 1-100)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Goal</th>
<th>20</th>
<th>6</th>
<th>79</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uninsured:</strong> population under age 65 without health insurance</td>
<td>↓</td>
<td>11%</td>
<td>13%</td>
<td>10%</td>
<td>11%</td>
</tr>
<tr>
<td><strong>Primary care physicians:</strong> ratio of population to primary care physicians</td>
<td>↓</td>
<td>1,320:1</td>
<td>1,420:1</td>
<td>530:1</td>
<td>1,350:1</td>
</tr>
<tr>
<td><strong>Dentists:</strong> ratio of population to dentists</td>
<td>↓</td>
<td>1,480:1</td>
<td>1,830:1</td>
<td>470:1</td>
<td>1,040:1</td>
</tr>
<tr>
<td><strong>Mental health providers:</strong> ratio of population to mental health providers</td>
<td>↓</td>
<td>470:1</td>
<td>460:1</td>
<td>160:1</td>
<td>360:1</td>
</tr>
<tr>
<td><strong>Preventable hospital stays:</strong> hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees</td>
<td>↓</td>
<td>49</td>
<td>49</td>
<td>23</td>
<td>52</td>
</tr>
<tr>
<td><strong>Diabetes monitoring:</strong> diabetic Medicare enrollees, ages 65-75, that receive HbA1c monitoring</td>
<td>↑</td>
<td>85%</td>
<td>89%</td>
<td>93%</td>
<td>84%</td>
</tr>
<tr>
<td><strong>Mammography screening:</strong> female Medicare enrollees, ages 67-69, that receive mammography screening</td>
<td>↑</td>
<td>63%</td>
<td>68%</td>
<td>53%</td>
<td>63%</td>
</tr>
</tbody>
</table>
### Social & Economic Factors (rank 1-100)

<table>
<thead>
<tr>
<th>Goal</th>
<th>US Avg</th>
<th>NC Avg</th>
<th>NC Best</th>
<th>Cumberland</th>
<th>Durham</th>
<th>Johnston</th>
<th>Wake</th>
</tr>
</thead>
<tbody>
<tr>
<td>High school graduation: ninth-grade cohort that graduates in 4 years</td>
<td>↑</td>
<td>83%</td>
<td>86%</td>
<td>94%</td>
<td>82%</td>
<td>81%</td>
<td>89%</td>
</tr>
<tr>
<td>Some college: adults ages 25-44 with some post-secondary education</td>
<td>↑</td>
<td>65%</td>
<td>66%</td>
<td>81%</td>
<td>72%</td>
<td>74%</td>
<td>60%</td>
</tr>
<tr>
<td>Unemployment: population 16+ that are unemployed but seeking work</td>
<td>↓</td>
<td>4.9%</td>
<td>5.1%</td>
<td>3.8%</td>
<td>6.3%</td>
<td>4.5%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Children in poverty: children under age 18 living in poverty</td>
<td>↓</td>
<td>20%</td>
<td>22%</td>
<td>11%</td>
<td>27%</td>
<td>24%</td>
<td>19%</td>
</tr>
<tr>
<td>Income inequality: ratio of 80th/20th percentile of income</td>
<td>↓</td>
<td>5.0</td>
<td>4.8</td>
<td>3.5</td>
<td>4.2</td>
<td>4.9</td>
<td>4.1</td>
</tr>
<tr>
<td>Children in single-parent households: children that live in a household headed by a single parent</td>
<td>↓</td>
<td>34%</td>
<td>36%</td>
<td>21%</td>
<td>42%</td>
<td>43%</td>
<td>32%</td>
</tr>
<tr>
<td>Social associations: social associations per 10,000 population</td>
<td>↑</td>
<td>9.3</td>
<td>11.5</td>
<td>28.2</td>
<td>9.2</td>
<td>10.4</td>
<td>8.3</td>
</tr>
<tr>
<td>Violent crime: violent crime offenses per 100,000 population</td>
<td>↓</td>
<td>380</td>
<td>342</td>
<td>62</td>
<td>541</td>
<td>613</td>
<td>183</td>
</tr>
<tr>
<td>Injury deaths: deaths due to injury per 100,000 population</td>
<td>↓</td>
<td>65</td>
<td>68</td>
<td>35</td>
<td>74</td>
<td>51</td>
<td>60</td>
</tr>
</tbody>
</table>

### Physical Environment (rank 1-100)

<table>
<thead>
<tr>
<th>Goal</th>
<th>US Avg</th>
<th>NC Avg</th>
<th>NC Best</th>
<th>Cumberland</th>
<th>Durham</th>
<th>Johnston</th>
<th>Wake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air pollution: average daily density (µg/m³) of fine particulate matter (2.5)</td>
<td>↓</td>
<td>8.7</td>
<td>9.1</td>
<td>7.2</td>
<td>9.5</td>
<td>9.4</td>
<td>9.3</td>
</tr>
<tr>
<td>Drinking water violations: population potentially exposed to water exceeding violation limit during past year</td>
<td></td>
<td>No</td>
<td>n/a</td>
<td>n/a</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Severe housing problems: households with ≥ 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen or plumbing facilities</td>
<td>Goal</td>
<td>US Avg</td>
<td>NC Avg</td>
<td>NC Best</td>
<td>Cumberland</td>
<td>Durham</td>
<td>Johnston</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------</td>
<td>--------</td>
<td>--------</td>
<td>---------</td>
<td>-------------</td>
<td>--------</td>
<td>----------</td>
</tr>
<tr>
<td>↓</td>
<td>19%</td>
<td>17%</td>
<td>11%</td>
<td>17%</td>
<td>18%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Driving alone to work: workforce that drives alone to work</td>
<td>↓</td>
<td>76%</td>
<td>81%</td>
<td>67%</td>
<td>82%</td>
<td>76%</td>
<td>84%</td>
</tr>
<tr>
<td>Long commute - driving alone: among workers who commute in their car alone, those that commute more than 30 minutes</td>
<td>↓</td>
<td>35%</td>
<td>31%</td>
<td>17%</td>
<td>23%</td>
<td>25%</td>
<td>48%</td>
</tr>
</tbody>
</table>

<p>| Additional Data |
|-----------------|------|--------|---------|---------|-------------|--------|----------|-------|
| Length of Life  | Goal | NC Avg | NC Best | Cumberland | Durham | Johnston | Wake |
| Premature age-adjusted mortality: deaths among residents &lt; 75, per 100,000 population | ↓    | 370    | 240     | 450     | 310      | 370    | 240      |
| Child mortality: deaths among children &lt; 18, per 100,000 population | ↓    | 60     | 30      | 90      | 70       | 50     | 40       |
| Infant mortality: infant deaths (within 1 year), per 100,000 live births | ↓    | 7      | 4       | 9       | 7        | 6      | 6        |
| Quality of Life  |      |        |         |         |           |        |          |       |
| Frequent physical distress: adults reporting 14 or more days of poor physical health per month | ↓    | 11%    | 9%      | 12%     | 11%      | 11%    | 9%       |
| Frequent mental distress: adults reporting 14 or more days of poor mental health per month | ↓    | 12%    | 11%     | 13%     | 12%      | 12%    | 11%      |
| Diabetes prevalence: adults with diagnosed diabetes | ↓    | 11%    | 8%      | 12%     | 8%       | 13%    | 8%       |
| HIV prevalence: persons aged 13 years and older living with diagnosis of HIV infection, per 100,000 population | ↓    | 355    | 55      | 482     | 677      | 248    | 373      |
| Health Behaviors |      |        |         |         |           |        |          |       |</p>
<table>
<thead>
<tr>
<th><strong>Goal</strong></th>
<th><strong>Food insecurity:</strong> people who lack adequate access to food</th>
<th><strong>Limited access to healthy foods:</strong> people who are low income and do not live close to a grocery store</th>
<th><strong>Drug overdose deaths:</strong> drug poisoning deaths per 100,000 population</th>
<th><strong>Motor vehicle crash deaths:</strong> motor vehicle crash deaths per 100,000 population</th>
<th><strong>Insufficient sleep:</strong> adults who report fewer than 7 hours of sleep on average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NC Avg</strong></td>
<td>↓</td>
<td>17%</td>
<td>11%</td>
<td>20%</td>
<td>18%</td>
</tr>
<tr>
<td><strong>NC Best</strong></td>
<td>↓</td>
<td>7%</td>
<td>0%</td>
<td>13%</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Cumberland</strong></td>
<td>↓</td>
<td>16</td>
<td>6</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td><strong>Durham</strong></td>
<td>↓</td>
<td>14</td>
<td>7</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td><strong>Johnston</strong></td>
<td>↓</td>
<td>34%</td>
<td>29%</td>
<td>38%</td>
<td>34%</td>
</tr>
<tr>
<td><strong>Wake</strong></td>
<td>↓</td>
<td>34%</td>
<td>29%</td>
<td>38%</td>
<td>34%</td>
</tr>
</tbody>
</table>

**Clinical Care**

| **Uninsured adults:** adults under 65 without health insurance | ↓ | 16% | 12% | 14% | 17% | 18% | 12% |
| **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 | ↓ | 975:1 | 471:1 | 589:1 | 499:1 | 1,650:1 | 1,026:1 |

**Social & Economic Factors**

| **Disconnected youth:** teens and young adults ages 16-24 who are neither working nor in school | ↓ | 15% | 4% | 16% | 13% | 16% | 8% |
| **Median household income** | ↓ | $50,600 | $76,200 | $45,300 | $54,300 | $55,200 | $76,200 |
| **Children eligible for free or reduced price lunch** | ↓ | 57% | 29% | 66% | 59% | 45% | 33% |
| **Residential segregation - black/white:** index of dissimilarity; higher values indicate greater residential segregation (index ranges from 0-100) | ↓ | 50 | 5 | 30 | 40 | 25 | 43 |
| **Residential segregation - non-white/white** index of dissimilarity; higher values indicate greater residential segregation (index ranges from 0-100) | ↓ | 45 | 0 | 27 | 36 | 22 | 36 |
| **Homicides:** deaths due to homicide per 100,000 | ↓ | 6 | 2 | 11 | 11 | 4 | 3 |
population

<table>
<thead>
<tr>
<th></th>
<th>Goal</th>
<th>NC Avg</th>
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<th>Cumberland</th>
<th>Durham</th>
<th>Johnston</th>
<th>Wake</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Firearm fatalities</strong>: deaths due to firearms per 100,000 population</td>
<td>↓</td>
<td>13</td>
<td>5</td>
<td>19</td>
<td>13</td>
<td>10</td>
<td>6</td>
</tr>
</tbody>
</table>

*Source: Robert Wood Johnson Foundation, County Health Rankings and Roadmaps, [www.countyhealthrankings.org](http://www.countyhealthrankings.org)*