North Carolina

UNIFORM APPLICATION
FY 2020/2021 Substance Abuse Prevention and Treatment Block Grant Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 12/11/2019 9.17.45 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State DUNS Number

Number 809785363

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name NC Dept of Health and Human Services

Organizational Unit Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS)

Mailing Address 3004 Mail Service Center

City Raleigh

Zip Code 27699-3004

II. Contact Person for the Grantee of the Block Grant

First Name Kody

Last Name Kinsley

Agency Name DMHDDSAS, NC DHHS

Mailing Address 3001 Mail Service Center

City Raleigh

Zip Code 27699-3001

Telephone 919-733-7011

Fax 919-508-0951

Email Address kody.kinsley@dhhs.nc.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 10/1/2019 3:50:56 PM

Revision Date 12/11/2019 9:16:50 AM

V. Contact Person Responsible for Application Submission

First Name DeDe

Last Name Severino

Telephone 919-733-4670

Fax 919-508-0960

Email Address dede.severino@dhhs.nc.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

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Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

See signed copy in the Attachments section.

Office of the Governor
State of North Carolina

Roy Cooper
Governor

20301 Mail Service Center
Raleigh, N.C. 27699-0301

May 15, 2017

Ms. Virginia Simmons, Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse & Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20850

Dear Ms. Simmons:

As the Governor of the State of North Carolina, for the duration of my tenure, I delegate authority to the current Secretary of the North Carolina Department of Health and Human Services, or anyone officially acting in this role in the instance of a vacancy, as the single state agency (SSA), for all transactions required to administer the Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

Very truly yours,

Roy Cooper

cc: Mandy Cohen, MD, MPA

Location: The State Capitol Building, Raleigh, N. C. 27602
Phone: 919-814-2100

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

July 22, 2019

Memorandum

From: Mandy Cohen, MD, MPH
Secretary

Re: Delegation of Authority

As of this date, I am delegating my signature authority to Susan Perry-Manning, Principal Deputy Secretary; Rob Kindsvatter, Chief Financial Officer; Dave Richard, Deputy Secretary, NC Medicaid; Sam Gibbs, Deputy Secretary for Technology and Operations; Ben Money, Deputy Secretary for Health Services; Tara Myers, Deputy Secretary for Human Services; and Kody Kinsley, Deputy Secretary for Behavioral Health & Intellectual and Development Disabilities for the Department of Health and Human Services. During such times as I designate, Ms. Perry-Manning, Mr. Kindsvatter, Mr. Richard, Mr. Gibbs, Mr. Money, Ms. Myers or Mr. Kinsley may have the authority to sign official Departmental documents for which my signature is required.

Also, I give delegating authority to Mr. Mark Benton, Assistant Secretary for Public Health, to sign matters related to the Division of Public Health, such as grant activity, its sources/amounts, where it may align with our department initiatives, etc.

Any such documents will have the same force and authority as if they had been signed by me.

Such authority continues until revoked by me, either orally or in writing.

WWW.NCDHHS.GOV
TEL 919-855-4800 • FAX 919-715-4645
LOCATION: 101 BLAIR DRIVE • ADAMS BUILDING • RALEIGH, NC 27603
MAILING ADDRESS: 2001 MAIL SERVICE CENTER • RALEIGH, NC 27699-2001
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2020

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As the duly authorized representative of the applicant I certify that the applicant:

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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. **Certifications Regarding Lobbying**

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. **Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. **Certification Regarding Environmental Tobacco Smoke**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: North Carolina

Name of Chief Executive Officer (CEO) or Designee: Kody H. Kinsley

Signature of CEO or Designee[1]: DocuSigned by: D7816E4CBA6F4A8...

Title: Deputy Secretary of Behavioral Health and I/DD Date Signed: 9/30/2019 | 9:14 PM EDT

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

See signed copy in the Attachments section.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
Standard Form LLL (click here)

Name

Kody H. Kinsley

Title

Deputy Secretary for Behavioral Health and IDD

Organization

NC Department of Health and Human Services, DMHDDSAS

Signature: DocuSigned by: D7816E4CBA6F4A8...

Date: 9/30/2019 | 9:14 PM EDT

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No lobbying activities.

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Title

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NC Department of Health and Human Services, DMHDDSAS

Signature: Date:

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Footnotes:

No lobbying activities. See signed copy in Attachments.

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

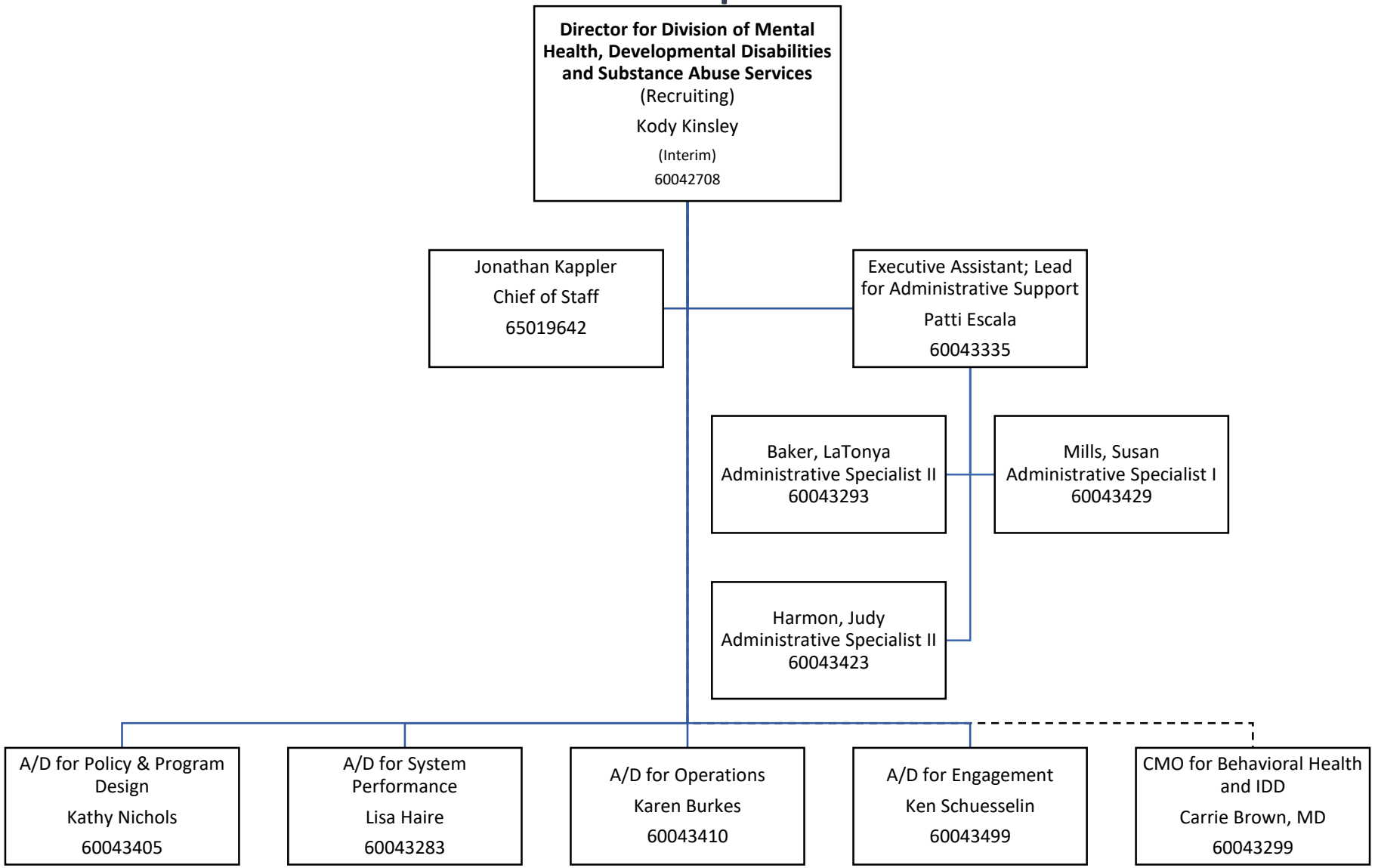
Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

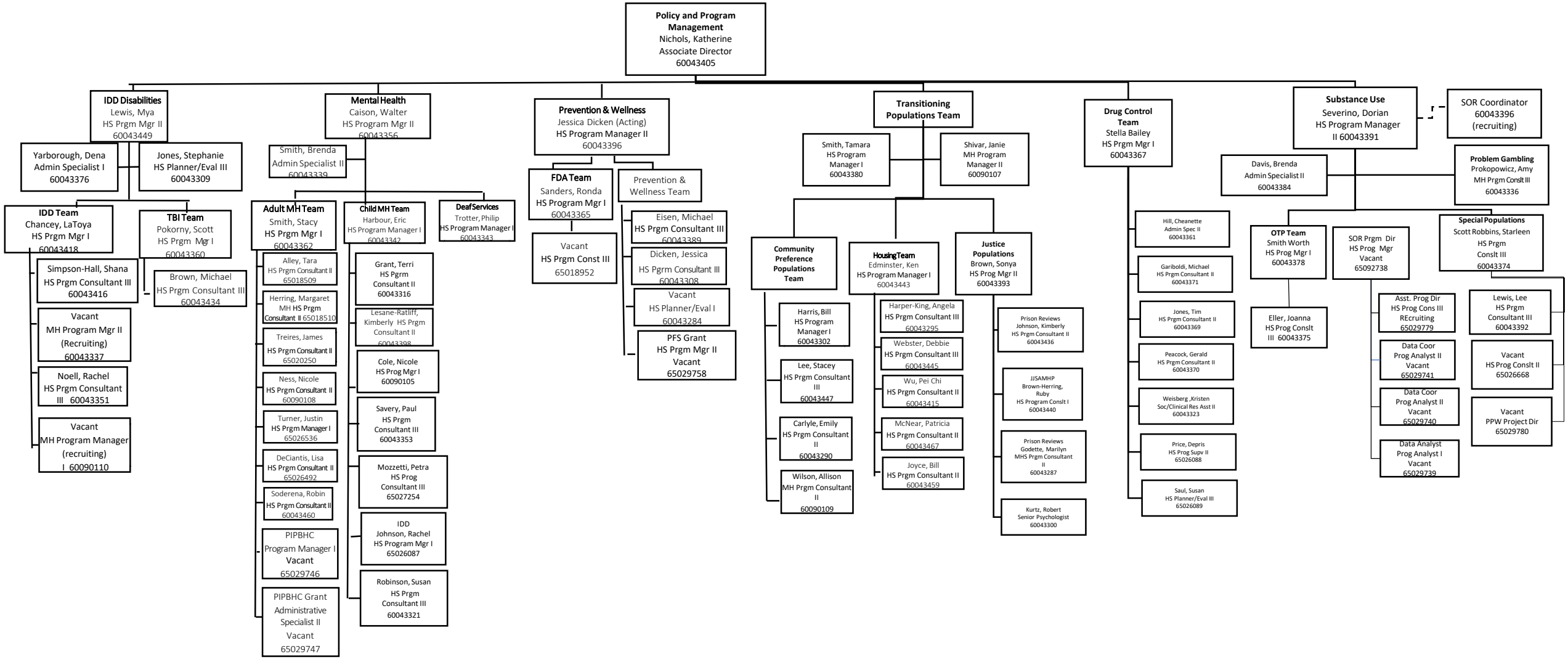
OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

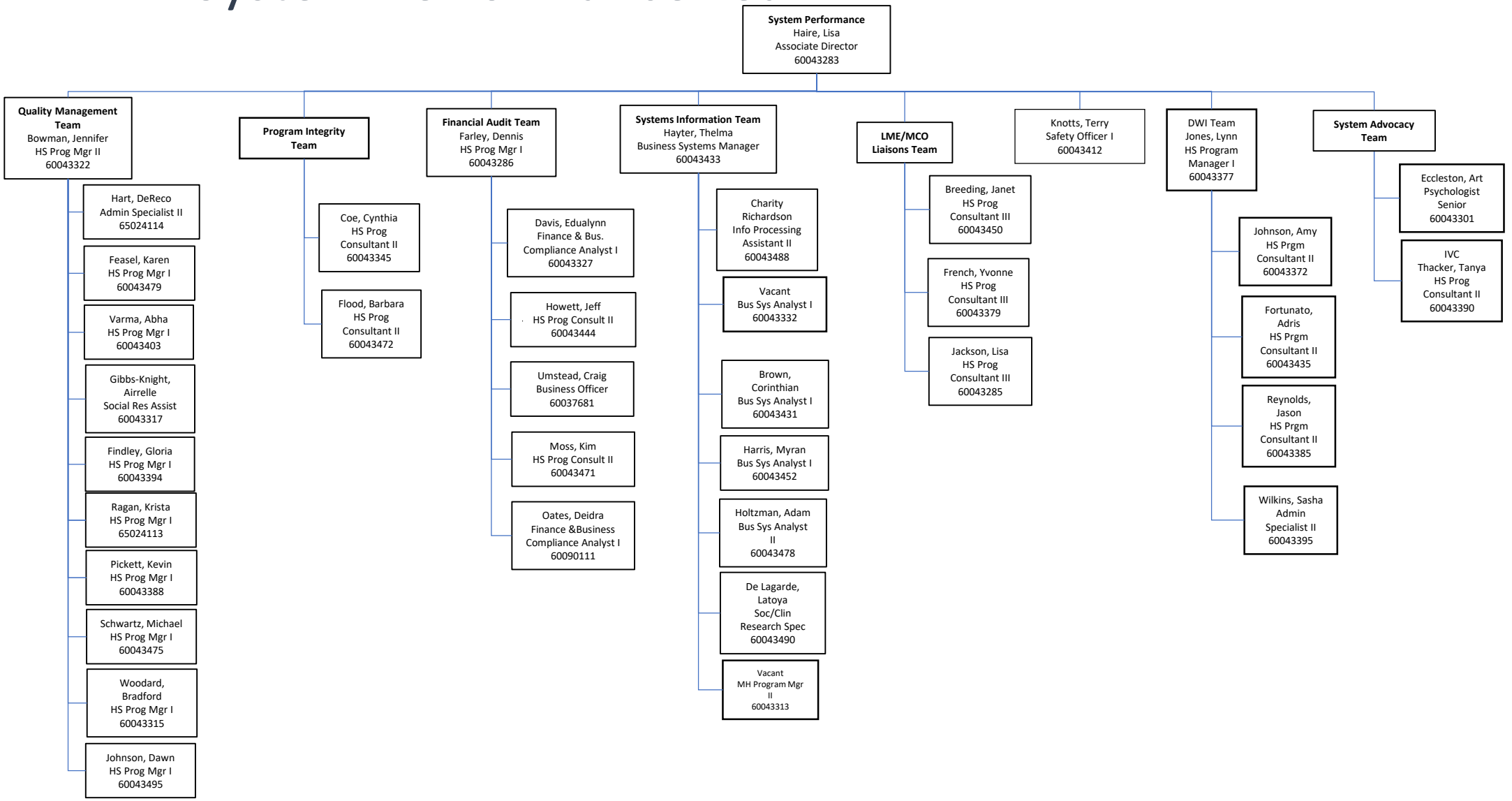
DMHDDSAS Executive Leadership Team



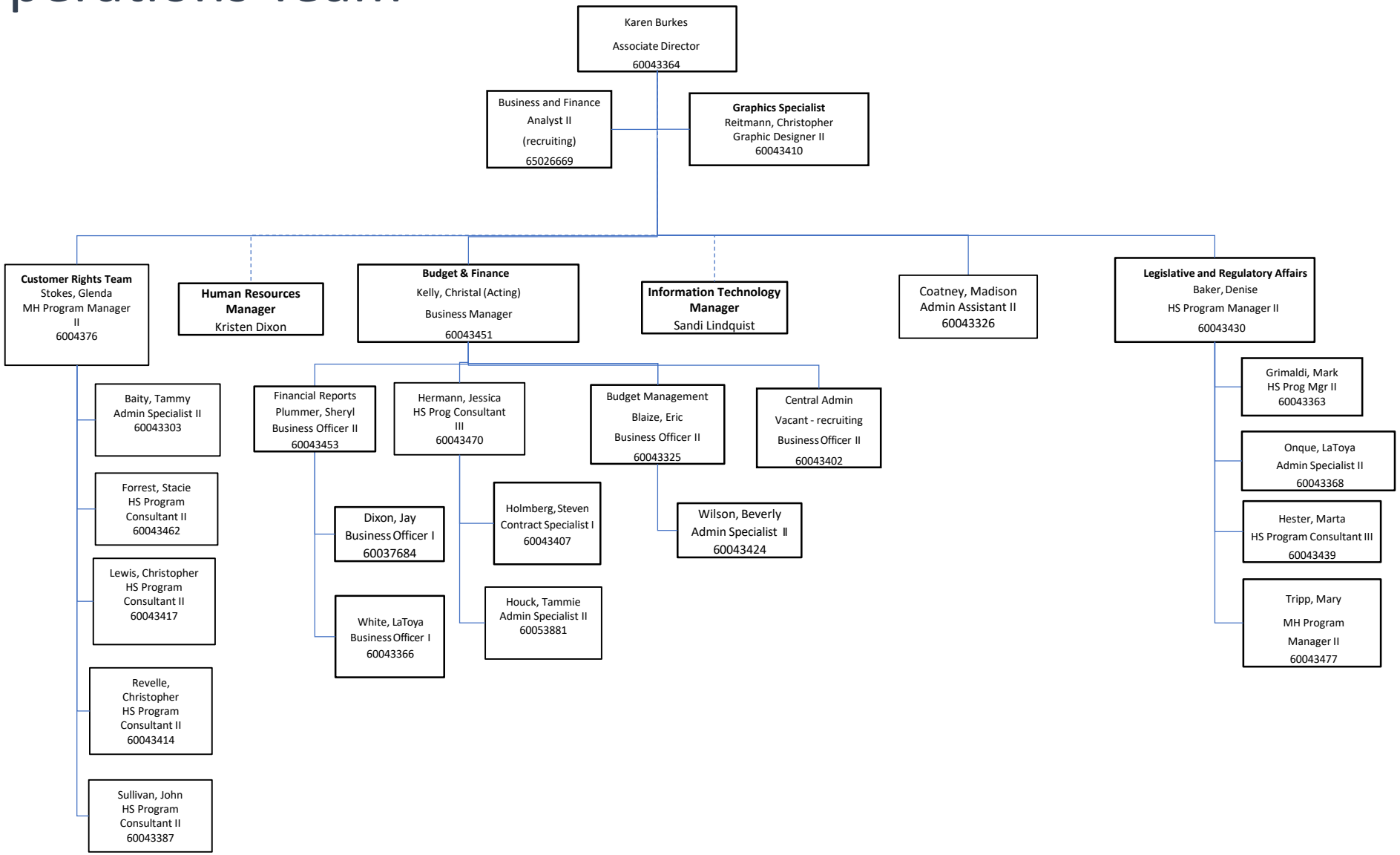
Policy and Program Management Team



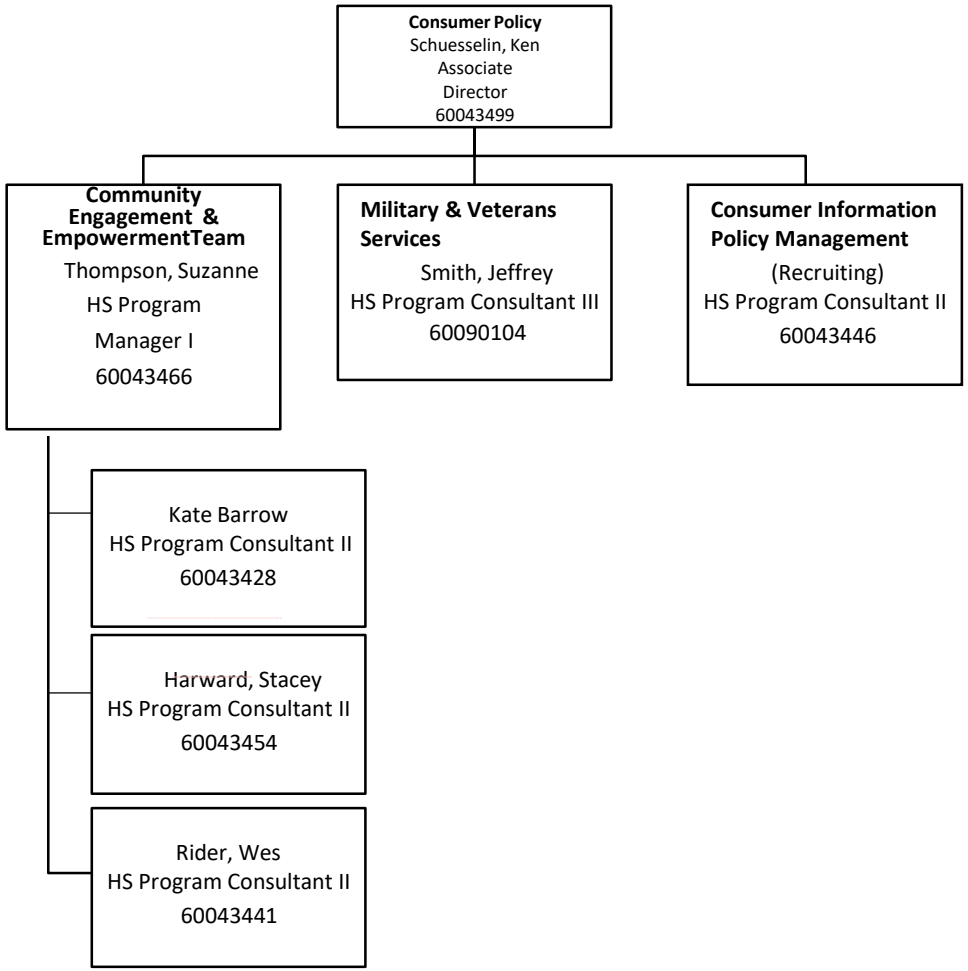
System Performance Team



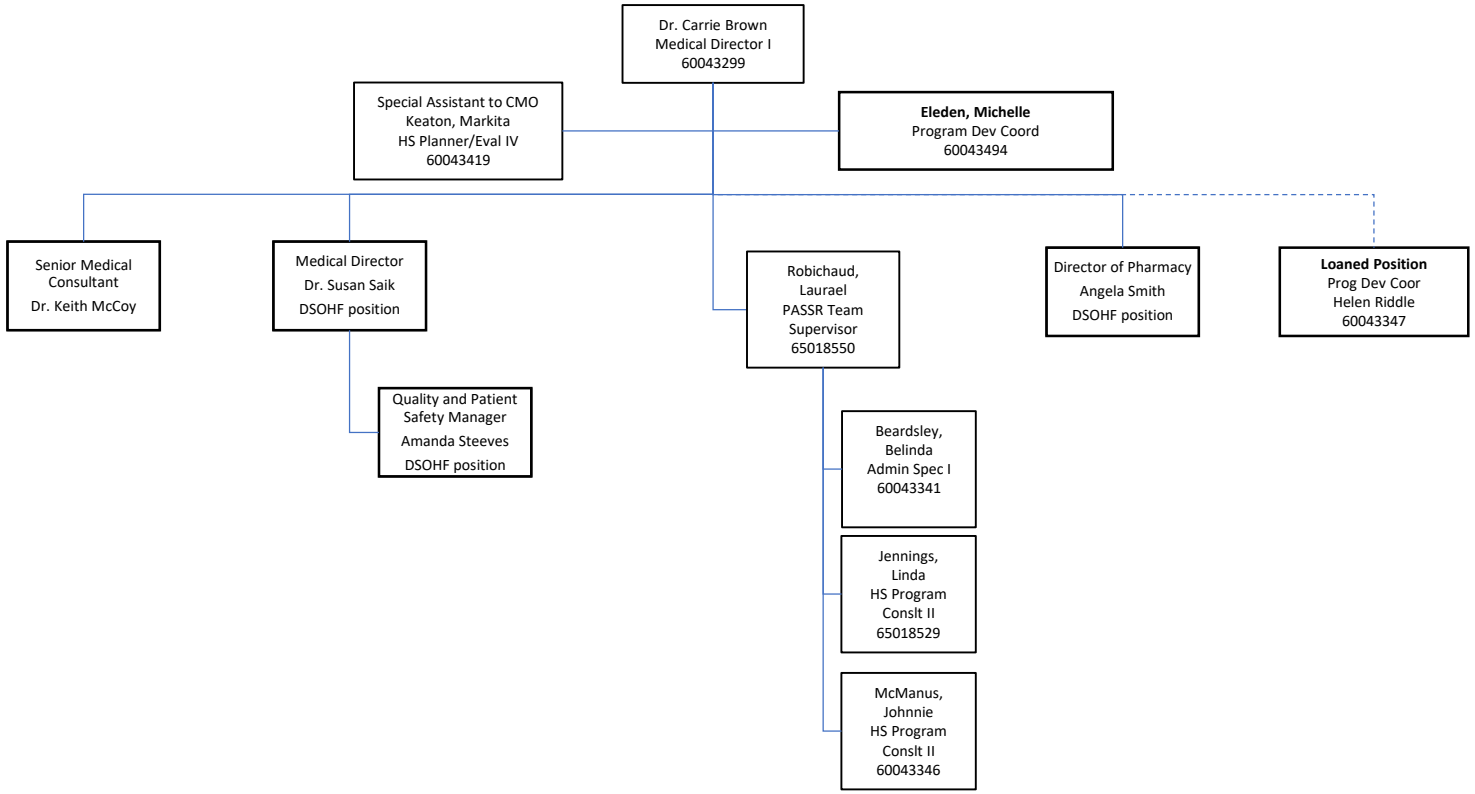
Operations Team



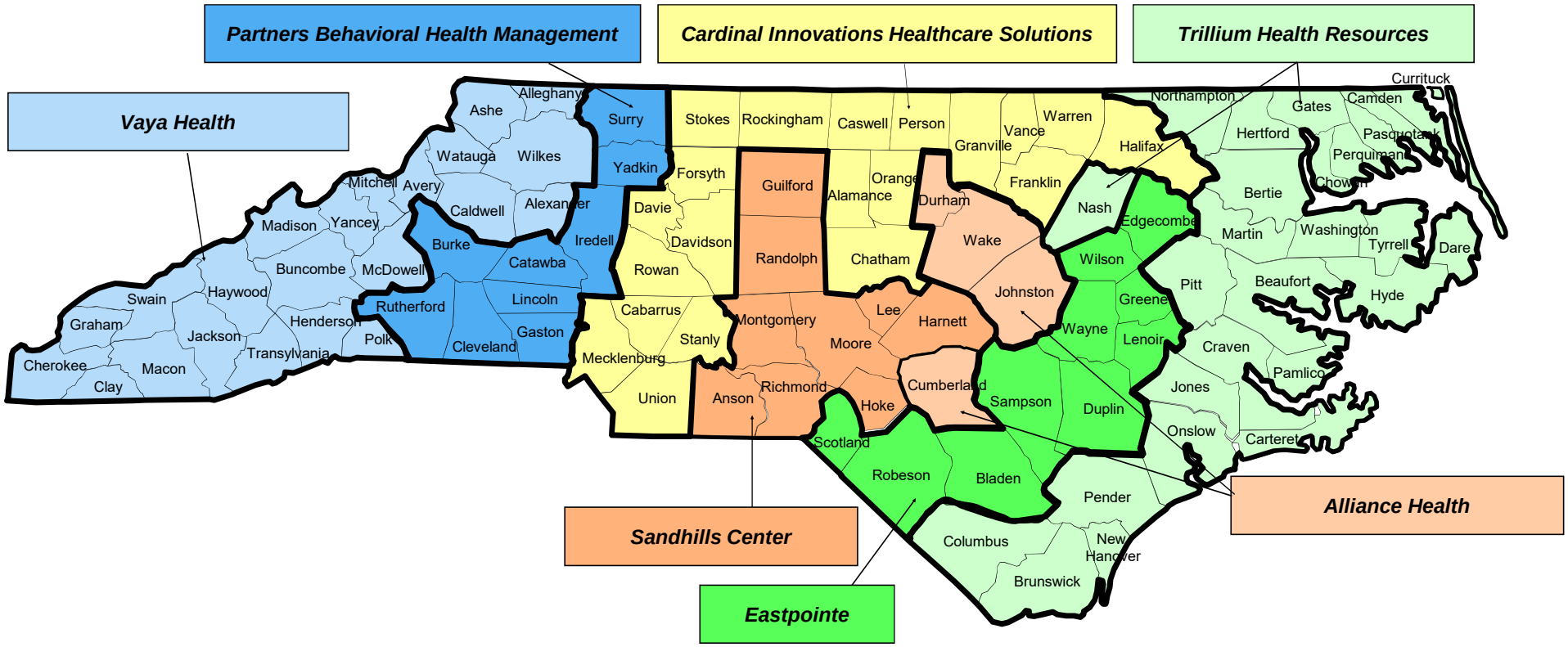
Engagement Team



Chief Medical Office for Behavioral Health and IDD



Local Management Entity - Managed Care Organizations (LME-MCOs)
DHHS currently has -- Seven- LME-MCOs operating under the 1915 b/c Waiver



- *Reflects LME-MCOs as of 7/1/19.*
- *Includes the Alliance Health name change (January 2019) and realignment of Rutherford County to Partners Behavioral Health Management on 7/1/19.*

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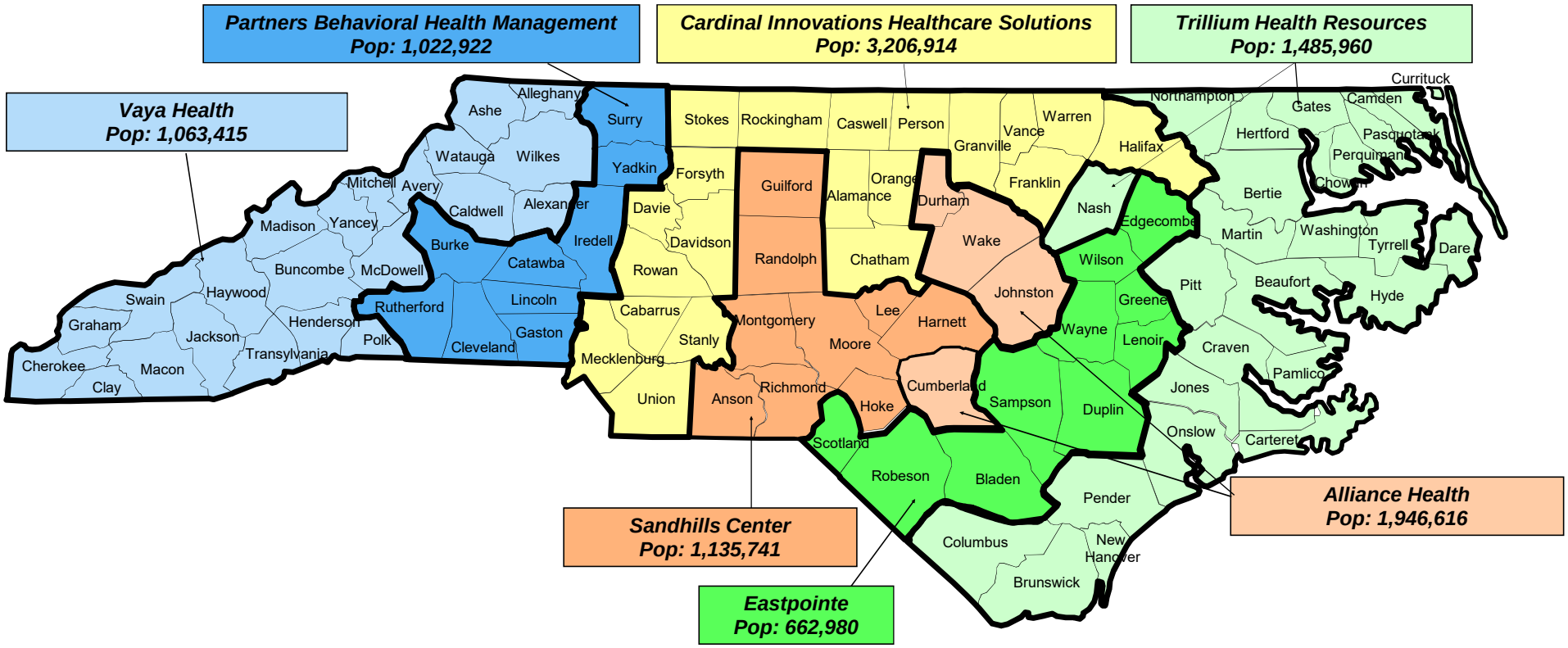

- *Reflects LME-MCOs and the population within their catchment area as of 7/1/19.*
- *Total NC population is 10,524,548. Source: NC OSBM July 2019 county single-age population estimates.*
- *Includes the Alliance Health name change (January 2019) and realignment of Rutherford County to Partners Behavioral Health Management on 7/1/19.*

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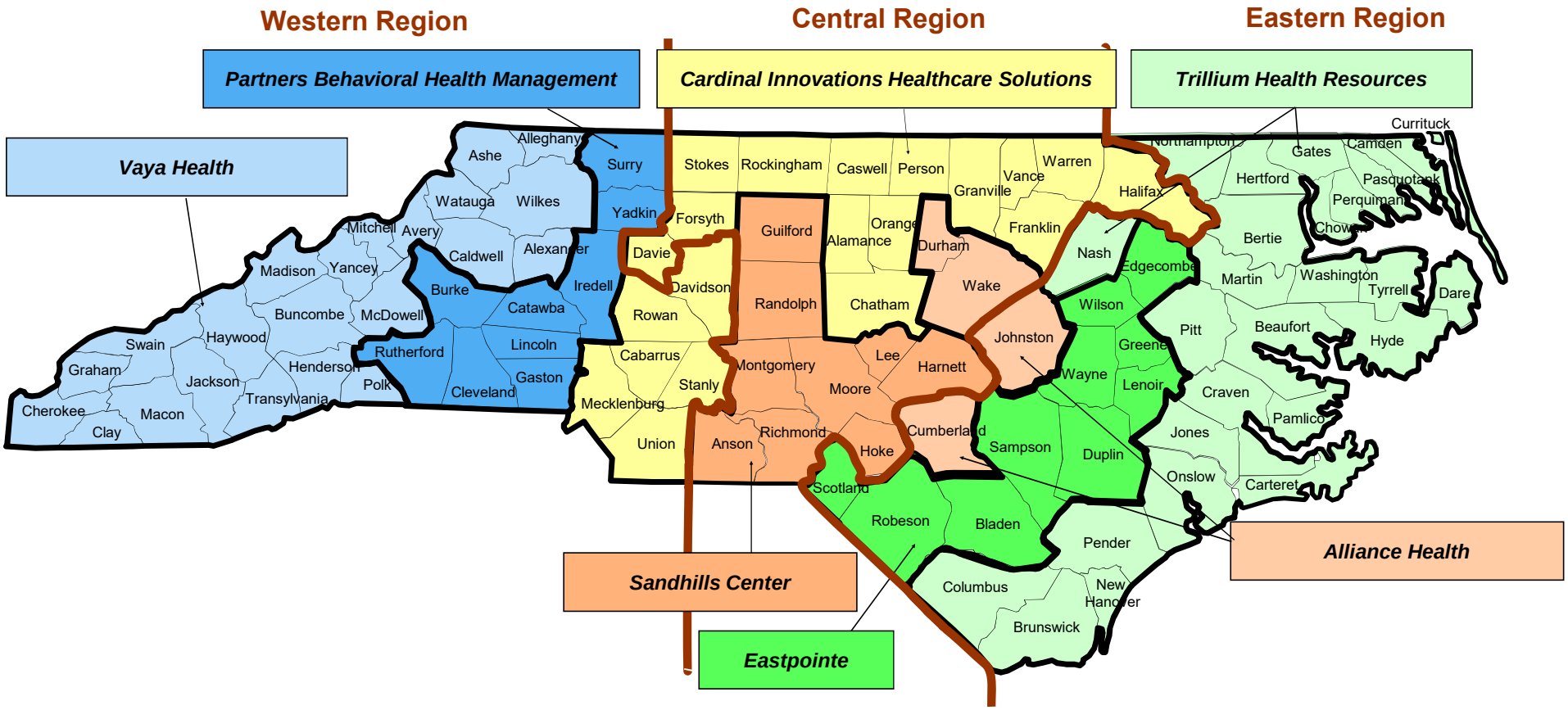

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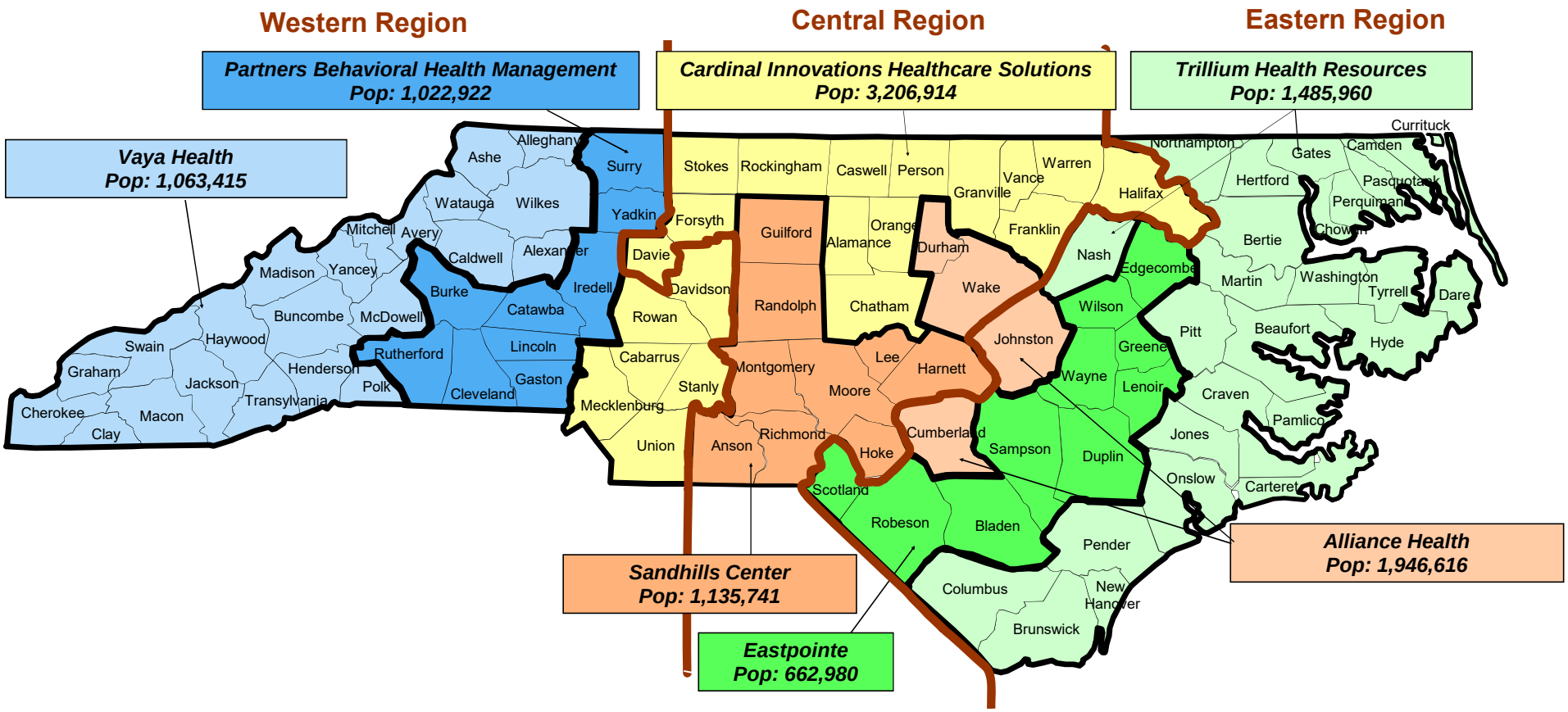

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North Carolina

Substance Use Disorder Implementation Plan Protocol

March 8, 2019

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Introduction

Like many states, North Carolina is facing an opioid crisis that has rapidly intensified in recent years. Opioid overdose deaths in North Carolina have increased from just over 100 deaths in 1999 to 1,384 in 2016, including a 39% increase in overdose deaths from 2015-2016.[1,2] Since 1999, over 13,000 North Carolinians have died from an opioid overdose. Despite significant efforts to turn the tide on the opioid crisis—including launching North Carolina's Opioid Action Plan, passing the bipartisan Strengthen Opioid Misuse Prevention (STOP) Act, and making changes to North Carolina's Medicaid program—the number of people dying from opioid overdoses each month continues to increase.

As part of its commitment to expand access to treatment for substance use disorders (SUDs), North Carolina's Department of Health and Human Services (the Department) is pursuing a Section 1115 demonstration to strengthen its SUD delivery system by:

- Expanding its SUD benefits to offer the complete American Society of Addiction Medicine (ASAM) continuum of SUD services;
- Obtaining a waiver of the Medicaid institution for mental diseases (IMD) exclusion for SUD services;
- Ensuring that providers and services meet evidence-based program and licensure standards;
- Building SUD provider capacity;
- Strengthening care coordination and care management for individuals with SUDs; and
- Improving North Carolina's prescription drug monitoring program (PDMP).

The following implementation plan provides an overview of North Carolina's current Medicaid SUD delivery system and then details North Carolina's strategic vision for comprehensive SUD delivery reform across six milestones identified by the Centers for Medicare & Medicaid Services (CMS).

Department Overview

The Department includes the following divisions that have significant roles in the delivery and regulation of SUD services for Medicaid enrollees:

- **Division of Health Benefits (North Carolina Medicaid).** The division within the Department responsible for implementing Medicaid transformation and managing the North Carolina (NC) Medicaid and Health Choice (CHIP) programs.
- **Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS).** The division that serves as the single state authority for the Substance Abuse and Mental Health Services Administration (SAMHSA) and administers state-funded mental health, developmental disability and substance abuse services.

[1] North Carolina's Opioid Action Plan, 2017-2021. Available at https://files.nc.gov/ncdhhs/NC%20Opioid%20Action%20Plan%208-22-2017.pdf.
[2] North Carolina Opioid Overdose Factsheet, June 2017. Available at https://files.nc.gov/ncdhhs/Opioid_Overdose_Factsheet_FINAL_06_27_17.pdf.

- **Division of Health Services Regulation (DHSR).** The division that certifies and monitors healthcare providers.
- **Division of State Operated Health Care Facilities (DSOHF).** The division that oversees and manages state-operated health care facilities that treat adults and children with mental illness, SUDs, intellectual and developmental disabilities (I/DDs) and neuro-medical needs.

Current SUD Delivery System

Today, North Carolina Medicaid contracts with seven local management entities–managed care organizations (LME-MCOs), which are prepaid inpatient health plans, to provide mental health, substance use, and I/DD services for Medicaid enrollees located within their catchment areas. Medicaid enrollees obtain physical health services, pharmacy, and most long-term services and support (LTSS) through Medicaid fee-for-service. Additionally, DMH/DD/SAS contracts with the LME-MCOs to manage state and federal block grant-funded mental health, I/DD and SUD services to serve the uninsured and underinsured populations living within their catchment areas. Certain populations that are excluded from LME-MCO enrollment, such as NC Health Choice or legal aliens, receive SUD services through Medicaid fee-for-service. NC Medicaid contracts with a vendor to perform utilization management functions for fee-for-service behavioral health services.

Medicaid Delivery System Transformation

In September 2015, the North Carolina General Assembly (General Assembly) enacted North Carolina Session Law 2015-245, which was amended by Session Laws 2016-121, 2017-57 and 2018-48, directing the transition of North Carolina's Medicaid program from a predominantly fee-for-service model to managed care beginning in 2019. Consistent with best practices, the Department will create integrated managed care products that cover the full spectrum of physical health, behavioral health, LTSS and pharmacy services for all enrollees. North Carolina will permit two types of prepaid health plan (PHPs) products: standard plans and behavioral health and intellectual and developmental disability (BH I/DD) tailored plans. The majority of Medicaid and NC Health Choice enrollees, including adults and children with lower-intensity behavioral health needs, will receive integrated physical health, behavioral health and pharmacy services through standard plans when managed care launches in November 2019. Individuals with significant behavioral health disorders, I/DDs, or traumatic brain injury (TBI) will be enrolled by July 2021 in BH I/DD tailored plans, which will be specialized managed care products that target the needs of these populations.

Both standard plans and BH I/DD tailored plans will cover SUD treatment and withdrawal management services, but the BH I/DD tailored plans will cover a more expansive set of SUD services targeting individuals with significant SUD needs. LME-MCOs will continue to provide all covered SUD treatment services for Medicaid enrollees in the period following approval of the state's 1115 demonstration until standard plan implementation in November 2019. Upon standard plan implementation and until the anticipated launch of BH I/DD tailored plans in July 2021, LME-MCOs will provide SUD services for Medicaid enrollees who are eligible to enroll in the BH I/DD tailored plans or who are delayed or excluded from managed care. Throughout the managed care transition and afterward, the Department will continue to provide the complete array of Medicaid-covered SUD treatment and withdrawal

services in fee-for-service for populations that will phase into managed care in later years of implementation or that will be exempt or excluded from managed care.[3]

[3] Federally recognized tribal members may choose to remain in the fee-for-service system and are not mandated to participate in managed care at any point, unless the mandate is for an Indian Managed Care Entity (IMCE).

Milestone 1: Access to Critical Levels of Care for SUD

North Carolina's Medicaid State Plan covers a wide range of SUD services for enrollees across outpatient, residential and inpatient care settings. While North Carolina's Medicaid program currently covers most services in the ASAM continuum of care, the state seeks to complete its coverage of the ASAM continuum by adding ASAM levels 3.1 (clinically managed low-intensity residential treatment services), 3.3 (clinically managed population-specific high-intensity residential programs), 2-WM (ambulatory withdrawal management with extended on-site monitoring) and 3.2-WM (clinically managed residential withdrawal management) to its State Plan, and expanding coverage of existing services such as ASAM levels 3.5 (clinically managed high-intensity residential services) and 3.7 (medically monitored intensive inpatient services) to include adolescents. The table below provides an overview of North Carolina Medicaid coverage for each ASAM level of care, as well as proposed changes.

ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
0.5	Early intervention	Screening, brief intervention and referral for treatment (SBIRT)	Physicians and physician extenders only	Currently covered for all	Expansion of providers that are eligible for reimbursement	Fee-for service, standard plans and BH I/DD tailored plans
1	Outpatient services	Psychiatric and biopsychosocial assessment; medication management; individual, group and family therapies; psychotherapy for crisis; and psychological testing for eligible enrollees based on clinical severity and function Service includes assisting the individual to achieve changes in his or her substance use or addictive	Direct-enrolled licensed behavioral health providers	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans

ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
		behaviors, serving as a step down from a more intensive level of care, care for an individual in the early stages of change, and care for ongoing monitoring and disease management				
2.1	Intensive outpatient services (substance abuse intensive outpatient program)	Structured program delivering 9–19 hours of services per week to meet complex needs of people with addiction and co-occurring conditions	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service and BH I/DD tailored plans
2.5	Partial hospitalization services (substance abuse comprehensive outpatient treatment)	Structured program delivering 20 or more hours of clinically intensive programming per week, with a planned format of individualized services	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans
3.1	Clinically managed low-intensity residential treatment services	SUD halfway-house services; supportive living environment with 24-hour staff and integration with clinical services; at least five hours of low-intensity treatment per week or more intensive outpatient care as indicated	DHSR-licensed facilities	No coverage	Will be covered for all enrollees meeting medical necessity criteria	Fee-for service and BH I/DD tailored plans
3.3	Clinically managed population-specific high-intensity	Clinically managed high-intensity SUD residential service for adults with cognitive impairment,	DHSR-licensed facilities	No coverage	Will be covered for all enrollees meeting medical	Fee-for service and BH I/DD

ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
	residential programs	including developmental delays, provided in a structured recovery environment			necessity criteria	tailored plans
3.5	Clinically managed high-intensity residential services (substance abuse non-medical community residential treatment)	Clinically managed high-intensity SUD residential services provided in a structured recovery environment	DHSR-licensed facilities	Currently covered for pregnant and parenting women	Will be covered for all enrollees, including adults and adolescents meeting medical necessity criteria	Fee-for service and BH I/DD tailored plans
3.7	Medically monitored intensive inpatient services (substance abuse medically monitored community residential treatment)	Medically monitored SUD inpatient treatment service with a structured regimen of 24-hour physician-directed evaluation, observation, medical monitoring and addiction treatment	DHSR-licensed specialty units in a community or psychiatric hospital	Currently covered for adult enrollees meeting medical necessity criteria	Will be covered for all enrollees, including adults and adolescents meeting medical necessity criteria	Fee-for service and BH I/DD tailored plans
4	Medically managed intensive inpatient services (inpatient behavioral health services)	Medically managed intensive inpatient services with 24-hour nursing care and daily physician care for severe, unstable problems in ASAM dimension: (1) acute intoxication and/or withdrawal potential; (2) biomedical conditions and complications; or (3) emotional, behavioral or cognitive conditions and complications	DHSR-licensed psychiatric hospitals and licensed community hospitals	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans

ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
		Counseling services also available				
OTP	Opioid treatment program (outpatient opioid treatment)	Service includes methadone or buprenorphine administration for treatment or maintenance; NC Medicaid is exploring creating an integrated service package that includes counseling and case management and other supportive services such as lab work in addition to methadone or buprenorphine	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans
1-WM	Ambulatory withdrawal management without extended on-site monitoring (ambulatory detoxification)	An organized outpatient withdrawal management service under the direction of a physician providing medically supervised evaluation, detoxification and referral services to treat mild withdrawal symptoms	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans
2-WM	Ambulatory withdrawal management with extended on-site monitoring	An organized outpatient withdrawal management service under the direction of a physician providing medically supervised evaluation, detoxification and referral services to treat moderate withdrawal symptoms with extended on-site monitoring	DHSR-licensed facilities	No coverage	Will be covered for all enrollees meeting medical necessity criteria	Fee-for service, standard plans and BH I/DD tailored plans

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ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
3.2-WM	Clinically managed residential withdrawal	An organized, clinically managed residential withdrawal management service for individuals who are experiencing moderate withdrawal symptoms and who require 24-hour supervision, observation and support; uses physician-approved protocols to identify individuals who require medical services beyond the capacity of the facility and to transfer these individuals to the appropriate levels of care	DHSR-licensed facilities	No coverage	Will be covered for all enrollees meeting medical necessity criteria	Fee-for service, standard plans and BH I/DD tailored plans
3.7-WM	Medically monitored inpatient withdrawal management (non-hospital medical detoxification)	An organized, medically monitored inpatient withdrawal management service under the supervision of a physician that provides 24-hour observation, monitoring and treatment for individuals who are experiencing severe withdrawal symptoms and require 24-hour nursing care	DHSR-licensed facilities	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans
n/a	Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization	An organized, medically monitored withdrawal management service under the supervision of a physician that provides 24 hour supervision in a permanent facility with inpatient beds; individuals served are often in crisis due to co-occurring severe mental disorders	DHSR-licensed facilities	Currently covered for adult beneficiaries meeting medical necessity criteria	Will be incorporated into ASAM 4.0-WM	Fee-for service, standard plans and BH I/DD tailored plans

ASAM Level of Care	Service Title	Description	Provider	Current Coverage	Future Coverage	Future Medicaid Delivery System
		and in need of short term, intensive evaluation, treatment intervention or behavioral management to stabilize the acute or crisis situation				
4-WM	Medically managed intensive inpatient withdrawal (inpatient behavioral health services)	An organized, medically managed inpatient service under the supervision of a physician that provides 24-hour, medically directed evaluation and withdrawal management for individuals who are experiencing severe, unstable withdrawal and require an acute care setting	Licensed psychiatric hospitals and licensed community hospitals	Currently covered for all enrollees meeting medical necessity criteria	No change expected	Fee-for service, standard plans and BH I/DD tailored plans

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The current North Carolina Medicaid coverage of ASAM-level SUD services, proposed changes and an implementation timeline are described in detail below. LME-MCOs currently are required to follow the Department's service definitions as described in the state's clinical coverage policies. Following managed care implementation, standard plans and BH I/DD tailored plans will be subject to these provisions in the clinical coverage policies when they launch on November 1, 2019, and July 1, 2021, respectively. The Department's service definitions will continue to apply to fee-for-service populations following the managed care transition.

Federal law prohibits federal financial participation (FFP) for services delivered to individuals ages 21 to 64 residing in IMDs. An IMD is defined as a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care or related services. One of the primary goals of the SUD-related portion of the 1115 demonstration is to waive this restriction and expand access to SUD treatment for individuals residing in IMDs. As detailed below, providers delivering the following types of services may be considered IMDs:

- ASAM level 3.1: Clinically managed low-intensity residential treatment services
- ASAM level 3.3: Clinically managed population-specific high-intensity residential programs
- ASAM level 3.5: Clinically managed high-intensity residential services
- ASAM level 3.7: Medically monitored intensive inpatient services
- ASAM level 4: Medically managed intensive inpatient services
- ASAM level 3.2-WM: Clinically managed residential withdrawal
- ASAM level 3.7-WM: Medically monitored inpatient withdrawal management
- Medically supervised or ADATC detoxification crisis stabilization
- ASAM level 4-WM: Medically managed intensive inpatient withdrawal

In addition, North Carolina has obtained approval to obtain FFP upon approval of this SUD Implementation Plan Protocol for the following non-residential services delivered to individuals residing in IMDs.

- ASAM level 2.1: Substance abuse intensive outpatient program
- ASAM level 2.5: Substance abuse comprehensive outpatient treatment program
- Opioid treatment program
- Office-based opioid treatment program

Level of Care: 0.5 (Early Intervention)

Current State

The Department provides coverage for several individual services around early intervention, including smoking cessation counseling and SBIRT. Physicians and physician extenders are the only providers who can currently bill LME-MCOs or Medicaid fee-for-service for these services. These services are available to all Medicaid-eligible enrollees without prior authorization.

Future State

North Carolina's Medicaid program plans to expand the types of providers that can bill this service to include direct-enrolled licensed behavioral health providers by updating the state's Medicaid management information system (MMIS) to add the taxonomies of the providers who would be eligible to bill these CPT codes. Additionally, NC Medicaid will post a Medicaid Bulletin informing the behavioral health providers of this change and any relevant clinical and billing criteria.

Summary of Actions Needed

- Implement MMIS modifications: September 2018 – April 2020

Level of Care: 1 (Outpatient Services)

Current State

The Department covers Medicaid-funded outpatient behavioral health services provided by direct-enrolled providers. These services are intended to determine an enrollee's SUD treatment needs and to provide the necessary treatment. Services focus on reducing symptoms of SUD and other BH disorders in order to improve the enrollee's functioning in familial, social, educational or occupational domains. Outpatient behavioral health services are available to eligible enrollees and often involve the participation of family members, significant others and legally responsible person(s) as applicable, unless contraindicated. Based on collaboration between the practitioner and the enrollee, and others as needed, the enrollee's needs and preferences determine the treatment goals and frequency, as well as measurable and desirable outcomes. Outpatient behavioral health services include:

- Comprehensive clinical assessment (CCA)
- Medication management
- Individual, group and family therapies
- Psychotherapy for crisis
- Psychological testing

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers, located here: https://files.nc.gov/ncdma/documents/files/8C_0.pdf.

Future State

The Department will amend the current Medicaid clinical coverage policies 8-A Diagnostic Assessment and 8-C to ensure a determination of ASAM level of care is included in the assessment information of enrollees diagnosed with SUDs. Enrollees with a SUD need will need to meet ASAM level 1 criteria to obtain this service.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policies 8-A Diagnostic Assessment and 8-C to reflect ASAM criteria: September 2018 – April 2020

- Submit SPA for 8A Diagnostic Assessment: September 2018 – April 2020

Level of Care: 2.1 (Intensive Outpatient Services)

Current State

The Department provides Medicaid coverage for substance abuse intensive outpatient program (SAIOP) services, which include structured individual and group SUD services that are provided in an outpatient program designed to assist adult and adolescent enrollees in beginning recovery and learning skills for recovery maintenance. The program is offered at least three hours a day, at least three days a week (no more than 19 hours of structured services per week), with no more than two consecutive days between offered services. SAIOP services include a structured program consisting of, but not limited to, the following services: individual, group and family counseling and support; biochemical assays to identify recent drug use; strategies for relapse prevention to include community and social support systems in treatment; life skills training; crisis contingency planning; disease management; and case management activities. Enrollees must meet the ASAM level 2.1 criteria to demonstrate medical necessity for these services.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here: https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

The Department will amend the current Medicaid clinical coverage policy 8-A to include the structured programming time frame of six to 19 hours for adolescents, reflect the 2013 ASAM criteria, require the presence of a full-time licensed professional, and permit this service to be reimbursed for individuals residing in an IMD. DHSR will update licensure rule 10A NCAC 27G .4400.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect 2013 ASAM criteria, add parameters for adolescents, require the presence of a full-time licensed professional, and permit the service to be reimbursed in an IMD: September 2018 – October 2020
- Update MMIS to permit this service to be reimbursed for individuals residing in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – October 2020
- Revise licensure rule: September 2018 – October 2022
- Revise LME-MCO contracts: September 2018 – October 2020

Level of Care: 2.5 (Partial Hospitalization Services)

Current State

The Department provides Medicaid coverage for substance abuse comprehensive outpatient treatment (SACOT), a time-limited periodic service with a multifaceted treatment approach for adults who require structure and support to achieve and sustain recovery. SACOT is a service that emphasizes the following: reduction in use of substances or continued abstinence; the negative consequences of substance use; the development of a social support network and necessary lifestyle changes; educational skills; vocational skills that focus on substance use as a barrier to employment; social and interpersonal skills; improved family functioning; understanding of addictive disease; and the continued commitment to a recovery and maintenance program. Enrollees must meet the ASAM level 2.5 criteria to demonstrate medical necessity for this service.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here: https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

The Department will update the current Medicaid clinical coverage policy 8-A to align with the 2013 ASAM criteria, require the presence of a full-time licensed professional and permit this service to be reimbursed for individuals residing in an IMD. The Department will also work with DHSR to update licensure rule 10A NCAC 27G .4500.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to align with ASAM criteria, require the presence of full-time licensed professional, and permit this service to reimbursed in an IMD: September 2018 – October 2020
- Update MMIS to permit this service to be reimbursed for individuals residing in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – October 2020
- Revise licensure rule: September 2018 – October 2022
- Revise LME-MCO contracts: September 2018 – October 2020

Level of Care: 3.1 (Clinically Managed Low-Intensity Residential Treatment Services)

Current State

North Carolina's Medicaid program does not currently cover ASAM level 3.1 clinically managed low-intensity residential treatment services, also called substance abuse halfway-house services. However, DMH/DD/SAS covers substance abuse halfway-house services under ASAM level 3.1 in its state-funded service array. Additionally, North Carolina has a current licensure rule under 10A NCAC 27G .5600 for the services provided in this type of facility.

Future State

The Department will submit a state plan amendment (SPA) to add substance abuse halfway-house services to its State Plan for all enrollees. North Carolina is has obtained expenditure authority to deliver the service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for substance abuse halfway-house services provided to individuals residing in IMDs.

The Department will promulgate a new Medicaid clinical coverage policy for substance abuse halfway-house services. This service will provide a supportive living environment with 24-hour staff and at least five hours of low-intensity treatment per week (i.e., individual, group and/or family therapies; psycho-education) or a more intensive level of outpatient care such as ASAM 2.1 as medically necessary. Additionally, DHSR will work to create a new stand-alone licensure rule to align with ASAM criteria. Enrollees will need to meet the ASAM level 3.1 criteria to access these services.

Summary of Actions Needed

- Develop a Medicaid clinical coverage policy: September 2018 – October 2020
- Create a licensure rule waiver process: September 2018 – October 2020
- Create licensure rule: September 2018 – October 2022
- Implement MMIS modifications: September 2018 – October 2020
- Submit SPA: September 2018 – October 2020

Level of Care: 3.3 (Clinically Managed Population-Specific High-Intensity Residential Programs)

Current State

The Department does not currently cover ASAM level 3.3 clinically managed population-specific high-intensity residential programs in Medicaid.

Future State

The Department will submit a SPA to add clinically managed population-specific high-intensity residential programs to its State Plan for all enrollees meeting the medical necessity criteria. North Carolina has obtained expenditure authority to deliver the service to individuals receiving the service in facilities that meet the definition of an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, and the finalization of new licensure rules, North Carolina will be able to provide Medicaid reimbursement for clinically managed population-specific high-intensity residential services provided to individuals residing in IMDs.

The Department will promulgate a new Medicaid clinical coverage policy that will reflect the 2013 ASAM criteria for this level of care. These programs will provide clinically managed high-intensity SUD residential services in a structured recovery environment to adults with cognitive impairment, including

developmental delays. Additionally, working across divisions, the Department will create a licensure rule for this service. Enrollees will need to meet the ASAM level 3.3 criteria to access these services.

Summary of Actions Needed

- Develop a Medicaid clinical coverage policy: September 2018 – October 2020
- Create a licensure rule waiver process: September 2018 – October 2020
- Create licensure rule: September 2018 – October 2022
- Implement MMIS modifications: September 2018 – October 2020
- Submit SPA: September 2018 – October 2020

Level of Care: 3.5 (Clinically Managed High-Intensity Residential Services)

Current State

The Department currently covers ASAM level 3.5 clinically managed high-intensity residential services for pregnant and parenting women at facilities that do not meet the definition of an IMD. Clinically managed high-intensity residential services, also called non-medical community residential treatment (NMCRT), is a 24-hour, professionally supervised residential recovery program that provides trained staff to work intensively with adults with SUDs who provide or have the potential to provide primary care for their minor children.

NMCRT rehabilitation facilities provide planned programs of professionally directed evaluation, care and treatment for the restoration of functioning of enrollees with an addiction disorder. These programs include assessment, referral, individual and group therapy, family therapy, recovery skills training, disease management, symptom monitoring, medication monitoring and self-management of symptoms, after-care, follow-up, access to preventive and primary healthcare including psychiatric care, and case management activities. NMCRT facilities do not provide 24-hour medical nursing or monitoring. Enrollees must meet the ASAM level 3.5 criteria to demonstrate medical necessity for these services.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here: https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

North Carolina has obtained expenditure authority to deliver these services to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to reimburse NMCRT provided to Medicaid enrollees in IMDs.

The Department will revise the current Medicaid clinical coverage policy 8-A to reflect the 2013 ASAM criteria, add adolescents who meet medical necessity as a population eligible to receive this service, include IMDs as eligible service providers, and extend coverage for treatment services provided in a therapeutic community. Working across divisions, the Department will revise the licensure rules 10A NCAC 27G .4100 and 10A NCAC 27G .4300 and create a new licensure rule for both adults and

adolescents. The Department will also need to submit a SPA in light of the changes to this clinical coverage policy.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect 2013 ASAM criteria, add adolescents as a population eligible to receive service, include IMDs as eligible service providers, and extend coverage for treatment services provided in a therapeutic community: September 2018 – October 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – October 2020
- Revise existing licensure rules and create new licensure rules: September 2018 – October 2022
- Revise LME-MCO contracts: September 2018 – October 2020
- Submit SPA: September 2018 – October 2020

Level of Care: 3.7 (Medically Monitored Intensive Inpatient Services)

Current State

The Department currently covers ASAM level 3.7 medically monitored intensive inpatient services for adults only at facilities that do not meet the definition of an IMD. Medically monitored intensive inpatient service providers, also called medically monitored community residential treatment (MMCRT) providers, are non-hospital rehabilitation facilities for adults, with 24-hour medical or nursing monitoring, that provide a planned program of professionally directed evaluation, care and treatment for the restoration of functioning of enrollees with alcohol and other drug problems or addiction. Enrollees must meet the ASAM level 3.7 criteria to demonstrate medical necessity for these services.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here: https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

North Carolina has obtained expenditure authority to deliver these services to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for MMCRT delivered to individuals residing in IMDs. North Carolina is planning to make these services available to both adolescents and adults who demonstrate medical necessity.

The Department will revise the current Medicaid clinical coverage policy 8-A to reflect the 2013 ASAM criteria, add adolescents who meet medical necessity as a population eligible to receive this service and add IMDs as eligible service providers. Working across divisions, the Department will create a new

licensure rule for this level of care that aligns with the ASAM criteria. The Department will also need to submit a SPA in light of the changes to this clinical coverage policy.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect ASAM criteria, add adolescents as a population eligible to receive service, and include IMDs as eligible service providers: September 2018 – October 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – October 2020
- Revise and create licensure rules: September 2018 – October 2022
- Revise LME-MCO contracts: September 2018 – October 2020
- Submit SPA: September 2018 – October 2020

Level of Care: 4 (Medically Managed Intensive Inpatient Services)

Current State

Since July 2016, LME-MCOs have had the authority to reimburse for inpatient services delivered in an IMD in lieu of settings covered by the NC State Plan.

North Carolina Medicaid currently provides coverage for ASAM level 4 medically managed intensive inpatient services at facilities that do not meet the definition of an IMD. Medically managed intensive inpatient services are behavioral health services provided in a hospital setting 24 hours a day along with supportive nursing and medical care provided under the supervision of a psychiatrist or a physician. These services are designed to provide continuous treatment for enrollees with acute psychiatric or substance use problems. They are appropriate for enrollees whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care. Enrollees who are admitted with an SUD must meet the ASAM level 4 criteria to demonstrate medical necessity for these services.

Additional coverage, code and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-B, Inpatient Behavioral Health Services, located here: https://files.nc.gov/ncdma/documents/files/8B.pdf.

Future State

North Carolina has obtained expenditure authority to deliver these services to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for medically managed intensive inpatient services delivered to individuals residing in IMDs.

The Department will revise the current Medicaid clinical coverage policy 8-B to reflect the 2013 ASAM criteria and include IMDs as eligible service providers for SUD treatment. Working across divisions, the Department will revise the 10A NCAC 27G .6000 licensure rule to align with ASAM criteria.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-B to reflect ASAM criteria and include IMDs as eligible service providers for SUD treatment: September 2018 – July 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Revise LME-MCO contracts: September 2018 – July 2020

Level of Care: OTP (Opioid Treatment Programs)

Current State

The Department currently covers office-based opioid treatment and opioid treatment programs at the ASAM OTP level of care.

Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone

The clinical coverage policy 1A-41 for office-based opioid treatment outlines the requirements for providers who prescribe buprenorphine and the buprenorphine-naloxone combination product for the treatment of opioid use disorders (OUDs) in office-based settings. The Drug Addiction Treatment Act of 2000 (DATA 2000) permits providers who meet certain qualifications to dispense or prescribe narcotic medications that have a lower risk of abuse, such as buprenorphine and the buprenorphine-naloxone combination product, and that are approved by the Food and Drug Administration (FDA) for OUDs in settings other than an OTP, such as a provider's office. This program allows enrollees who need the opioid agonist treatment to receive this treatment in a qualified provider's office, provided certain conditions are met.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy 1A-41, Office-Based Opioid Treatment: Use of Buprenorphine and Buprenorphine-Naloxone, located here: https://files.nc.gov/ncdma/documents/files/1A-41_4.pdf?ANpMLgJ7MIhEyt4r38bYvXinBFTk1h23.

Outpatient Opioid Treatment

Outpatient opioid treatment is a service designed to offer the enrollee an opportunity to effect constructive changes in his or her lifestyle by receiving, via a licensed OTP, methadone or other drugs approved by the FDA for the treatment of an OUD, in conjunction with rehabilitation and medical services. North Carolina Medicaid covers methadone- and buprenorphine-assisted treatment at this service level. Enrollees must meet the ASAM OTP criteria to demonstrate medical necessity for this service.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhance Mental Health and Substance Use Services, located here: https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

The Department will revise the current Medicaid clinical coverage policy 8-A to reflect that the 2013 ASAM criteria, permit this service to be reimbursed in an IMD, and to develop an integrated service model for outpatient opioid treatment that includes medication, medication administration, counseling, laboratory tests and case management activities. Working across divisions, the Department will revise the 10A NCAC 27G .3600 licensure rule.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect ASAM criteria, permit service to be reimbursed in an IMD, and create integrated service model: September 2018 – April 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 – April 2020
- Revise licensure rule: September 2018 – October 2022
- Submit SPA: September 2018 – April 2020
- Revise LME-MCO contracts: September 2018 – April 2020

Level of Care: 1-WM (Ambulatory Withdrawal Management Without Extended On-Site Monitoring)

Current State

The Department currently provides coverage for ASAM level 1-WM ambulatory withdrawal management without extended on-site monitoring. Ambulatory detoxification is an organized outpatient service delivered by trained clinicians who provide medically supervised evaluation, detoxification and referral services in regularly scheduled sessions. The services are designed to treat the enrollee's level of clinical severity, to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol), and to effectively facilitate the enrollee's transition into ongoing treatment and recovery. Enrollees must meet the ASAM level 1-WM criteria to demonstrate medical necessity for this service.

Additional coverage and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here**:** https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

The Department will need to submit a SPA for 1-WM ambulatory withdrawal management services to reflect the proposed changes to the service based on the ASAM criteria. The Department will

promulgate a new Medicaid clinical coverage policy that will reflect the ASAM criteria for this level of care and will work with DHSR to revise the 10A NCAC 27G .3300 licensure rule

Summary of Actions Needed

- Develop new Medicaid clinical coverage policy to align with ASAM criteria: September 2018 – July 2020
- Develop a licensure rule waiver process: September 2018 – July 2020
- Revise licensure rules: September 2018 – October 2022
- Submit SPA: September 2018 – July 2020
- Revise LME-MCO contracts: September 2018 – July 2020

Level of Care: 2-WM (Ambulatory Withdrawal Management With Extended On-Site Monitoring)

Current State

The Department does not currently provide coverage for ASAM level 2-WM ambulatory withdrawal management with extended on-site monitoring.

Future State

The Department will need to submit a SPA for ambulatory withdrawal management services to reflect that, going forward, the state will cover ambulatory withdrawal management with extended on-site monitoring for all enrollees who meet the medical necessity criteria. The Department will promulgate a new Medicaid clinical coverage policy that will reflect the 2013 ASAM criteria for this level of care. This service will provide enrollees with an organized outpatient withdrawal management service under the direction of a physician providing medically supervised evaluation, detoxification and referral services to treat moderate withdrawal symptoms with extended on-site monitoring. Enrollees must meet the ASAM level 2-WM criteria to demonstrate medical necessity for this service. Additionally, NC Medicaid will work with DHSR to revise the 10A NCAC 27G .3300 licensure rule to include ambulatory withdrawal management with extended on-site monitoring.

Summary of Actions Needed

- Develop a Medicaid clinical coverage policy: September 2018 – July 2020
- Develop a licensure rule waiver process: September 2018 – July 2020
- Create licensure rule: September 2018 – October 2022
- Implement MMIS modifications: September 2018 – July 2020
- Submit SPA: September 2018 – July 2020
- Revise LME-MCO contracts: September 2018 – July 2020

Level of Care: 3.2-WM (Clinically Managed Residential Withdrawal)

Current State

Federal restrictions preclude the Department from obtaining FFP for withdrawal services delivered in an IMD to Medicaid enrollees between the ages of 21 and 64.

North Carolina Medicaid does not currently provide coverage for ASAM level 3.2-WM clinically managed residential withdrawal.

Future State

The Department will submit a SPA to add clinically managed residential withdrawal services to its State Plan. North Carolina is also seeking expenditure authority to deliver the service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, and the finalization of new licensure rules, North Carolina will be able to provide Medicaid reimbursement for clinically managed residential withdrawal services, also called social setting detoxification services, that are delivered to individuals residing in IMDs.

The Department will promulgate a new Medicaid clinical coverage policy that will reflect the 2013 ASAM criteria for this level of care and include IMDs as eligible providers. This policy will provide adults with an organized clinically managed residential withdrawal service that offers 24-hour supervision, observation and support for enrollees who are experiencing moderate withdrawal symptoms and who require 24-hour support utilizing physician-approved protocols. Enrollees must meet the ASAM level 3.2-WM criteria to demonstrate medical necessity for this service.

Working across divisions, the Department will revise the 10A NCAC 27G .3200 licensure rule.

Summary of Actions Needed

- Develop a Medicaid clinical coverage policy: September 2018 – July 2020
- Develop a licensure rule waiver process: September 2018 – July 2020
- Revise licensure rule: September 2018 – October 2022
- Implement MMIS modifications: September 2018 – July 2020
- Submit SPA: September 2018 – July 2020
- Revise LME-MCO contracts: September 2018 – July 2020

Level of Care: 3.7-WM (Medically Monitored Inpatient Withdrawal Management)

Current State

The Department currently covers ASAM level 3.7-WM medically monitored inpatient withdrawal management services at facilities that do not meet the definition of an IMD. Non-hospital medical detoxification, the Department's name for this service, is an organized service delivered by medical and nursing professionals, which provides 24-hour, medically supervised evaluation and withdrawal

management in a permanent facility affiliated with a hospital or in a free-standing facility. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols. Enrollees must meet the ASAM level 3.7-WM criteria to demonstrate medical necessity for this service.

Additional coverage, code and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here**:** https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

North Carolina has obtained expenditure authority to deliver the service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for medically monitored inpatient withdrawal management services delivered to individuals residing in IMDs.

The Department will revise the current clinical coverage policy 8-A to reflect the 2013 ASAM criteria and include IMDs as eligible service providers. Working across divisions, the Department will revise the 10A NCAC 27G .3100 licensure rule.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-A to reflect ASAM criteria and include IMDs as eligible service providers: September 2018 – July 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Develop a licensure rule waiver process: September 2018 –July 2020
- Revise licensure rule: September 2018 – October 2022
- Submit SPA: September 2018 – July 2020
- Revise LME-MCO contracts: September 2018 – July 2020

Level of Care: Medically Supervised or ADATC Detoxification Crisis Stabilization

Current State

The Department currently covers medically supervised or ADATC detoxification crisis stabilization services.. Medically supervised or ADATC detoxification crisis stabilization is an organized service, delivered by medical and nursing professionals, that provides for 24-hour medically supervised evaluation and withdrawal management in a licensed permanent facility with 16 beds or less. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols. Beneficiaries are often in crisis due to co-occurring severe substance related mental disorders (e.g. acutely suicidal or severe mental health problems and co-occurring SUD) and are in need of short term intensive evaluation, treatment intervention or behavioral management to stabilize the acute or crisis situation.

Additional coverage, code and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-A, Enhanced Mental Health and Substance Abuse Services, located here**:** https://files.nc.gov/ncdma/documents/files/8A_1.pdf.

Future State

North Carolina has obtained expenditure authority to deliver the service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for medically supervised or ADATC detoxification crisis stabilization services delivered to individuals residing in IMDs.

Coverage for detoxification services delivered in ADATCs will be incorporated into the Medicaid and Health Choice Clinical Coverage Policy 8-B for Inpatient Behavioral Health Services, which will be updated to align with 2013 ASAM level 4.0-WM criteria and include IMDs as eligible service providers. .

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-B to reflect ASAM criteria: September 2018 – July 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019

Level of Care: 4-WM (Medically Managed Intensive Inpatient Withdrawal)

Current State

Federal restrictions preclude the Department from obtaining FFP for medically managed intensive inpatient withdrawal services delivered in an IMD to Medicaid enrollees between the ages of 21 and 64. Since July 2016, LME-MCOs have had the authority to reimburse for inpatient services delivered to individuals residing in an IMD in lieu of services or settings covered by the Medicaid State Plan.

The Department currently provides Medicaid coverage for ASAM level 4-WM medically managed intensive inpatient withdrawal services at facilities that do not meet the definition of an IMD. Inpatient behavioral health services provide treatment in a hospital setting 24 hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for enrollees with acute psychiatric or substance use problems. It is appropriate for enrollees whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care. Enrollees must meet the ASAM level 4-WM criteria to demonstrate medical necessity for this service.

Additional coverage, code and billing details can be found in Medicaid and Health Choice Clinical Coverage Policy No. 8-B, Inpatient Behavioral Health Services, located here**:** https://files.nc.gov/ncdma/documents/files/8B.pdf.

Future State

North Carolina has obtained expenditure authority to deliver this service to individuals ages 21 to 64 residing in an IMD. Following CMS approval of NC's 1115 demonstration, SPA and SUD Implementation Plan Protocol, North Carolina will be able to provide Medicaid reimbursement for medically managed intensive inpatient withdrawal services to individuals residing in IMDs.

The Department will revise the current clinical coverage policy 8-B to reflect the 2013 ASAM criteria and include IMDs as eligible service providers. Working across divisions, the Department will revise the 10A NCAC 27G .6000 licensure rule.

Summary of Actions Needed

- Amend current Medicaid clinical coverage policy 8-B to reflect ASAM criteria and include IMDs as eligible service providers: September 2018 – July 2020
- Implement MMIS modifications to permit this service to be reimbursed in an IMD: September 2018 – April 2019
- Revise LME-MCO contracts: September 2018 – July 2020

Summary of Actions Needed Across All Service Levels

Action	Implementation Timeline
Current Services[4]	
Revise Medicaid clinical coverage policies to reflect 2013 ASAM criteria and expand coverage to adolescents, as indicated	September 2018 – October 2020
Develop a licensure rule waiver process to incorporate ASAM criteria	September 2018 – October 2020
Revise licensure rules to align with ASAM criteria	September 2018 – October 2022
Implement MMIS modifications	September 2018 – October 2020
Submit SPAs, as necessary	September 2018 – October 2020
Revise LME-MCO contracts	September 2018 – October 2020
New Services	
Standard and BH I/DD Tailored Plan Services	
Develop Medicaid clinical coverage policies	September 2018 – July 2020
Develop a licensure rule waiver process	September 2018 – July 2020
Create licensure rules	September 2018 – October 2022
Implement MMIS modifications	September 2018 – July 2020
Submit SPAs	September 2018 – July 2020
Revise LME-MCO contracts	September 2018 – July 2020
BH I/DD Tailored Plan Services Only	
Develop Medicaid clinical coverage policies	September 2019 – October 2020
Create licensure rules	September 2020 – October 2020
Implement MMIS modifications	September 2019 – October 2020
Submit SPAs	September 2019 – October 2020

Milestone 2: Use of Evidence-Based SUD-Specific Patient Placement Criteria

North Carolina has robust, evidence-based policies in place to ensure that enrollees have access to appropriate SUD services according to their diagnosis and ASAM level of care determination .Over the course of the 1115 demonstration, North Carolina will strengthen its assessment and person-centered planning policies, which are prerequisites for obtaining most SUD services, by requiring that all SUD providers conducting assessments document their training with respect to the ASAM criteria.

Enrollee Assessments

Current State

As part of its Medicaid 8-A and 8-C clinical coverage policies, NC Medicaid requires behavioral health providers to complete an assessment before an enrollee can receive behavioral health services, except

[4] For some services, actions will be complete prior to October 2020 as detailed earlier in this section.

for selected crisis services. Providers use their clinical expertise to choose between two types of assessments:

1. **Diagnostic assessments:** NC Medicaid requires that a team of at least two licensed professionals interview and assess an enrollee and, based on the assessment, write a joint report recommending the services appropriate for the enrollee. For enrollees with SUDs, at a minimum this team must include (1) a certified clinical supervisor or licensed clinical addiction specialist; and (2) a medical doctor (MD), doctor of osteopathy (DO), nurse practitioner (NP), physician assistant (PA) or licensed psychologist. The clinical coverage policy for diagnostic assessments recommends a level of placement using the ASAM criteria for enrollees with SUD diagnoses, but does not require its use.
2. **Comprehensive clinical assessments (CCA):** Licensed professionals perform the CCA, a clinical evaluation that provides the necessary data and recommendations that form the basis of the enrollee's treatment or person-centered plan, as described in the next section. NC Medicaid does not have a prescribed format for the CCA; providers can tailor the CCA based on the enrollee's clinical presentation.

Diagnostic assessments and CCAs must include the following elements:

- Description of the presenting problems, including source of distress, precipitating events, and the associated problems or symptoms.
- Chronological general health and behavioral health history (including both mental health and substance abuse) of the enrollee's symptoms, treatment and treatment response.
- Current medications (for both physical and psychiatric treatment).
- A review of the biological, psychological, familial, social, developmental and environmental dimensions to identify strengths, needs and risks in each area.
- Evidence of the enrollee's and the legally responsible person's (if applicable) participation in the assessment.
- Analysis and interpretation of the assessment information with an appropriate case formulation.
- DSM-5 diagnosis, including mental health, SUDs or intellectual/developmental disabilities, as well as physical health conditions and functional impairment.
- Recommendations for additional assessments, services, support or treatment based on the results of the CCA.
- Signature of the licensed professional completing the assessment and the date.

Future State

The Department will update clinical coverage policies 8-A and 8-C to require an ASAM determination as part of the diagnostic assessment and CCA. The Department will require all professionals administering diagnostic assessments and CCAs to obtain training in the ASAM criteria..

Upon their launch in 2019 and 2021, respectively, standard plans and BH I/DD tailored plans will be required to follow the provisions related to behavioral health assessments included in Medicaid clinical coverage policies 8-A and 8-C.

Summary of Actions Needed

- Revise clinical coverage policies to require that (1) an ASAM determination is part of the diagnostic assessment and CCA and (2) licensed providers providing SUD services or assessments document their training with respect to the ASAM criteria: September 2018 – April 2020
- Contractually require standard plans to comply with the provisions related to behavioral health assessments included in Medicaid clinical coverage policies 8-A and 8-C: Completed
- Contractually require BH I/DD tailored plans to comply with the provisions related to behavioral health assessments included in Medicaid clinical coverage policies 8-A and 8-C: September 2018-July 2021

Person-Centered Plan

Current State

Person-centered planning is a guiding principle that must be embraced by all who are involved in the SUD service delivery system. Person-centered thinking and individualized service planning are the hallmarks of the provision of high-quality services in meeting the unique needs of each person served. Each plan is driven by the individual, utilizing the results and recommendations of a comprehensive clinical assessment, and is individually tailored to the preferences, strengths and needs of the person seeking services.

As detailed in the clinical coverage policies for behavioral health services, a person-centered plan is required in order for an enrollee to receive the covered SUD treatment services listed in Milestone 1, with the exception of all detoxification services, outpatient treatment and early intervention services. When a person-centered plan is not required, a plan of care, service plan or treatment plan, consistent with and supportive of the service provided and within professional standards of practice, is required on or before the day the service is delivered. The person-centered plan must be developed and written by a qualified professional or a licensed professional according to the requirements of the specific policy and in collaboration with the individual receiving services, family members (when applicable) and other service providers, in order to maximize unified planning. The person responsible for developing the person-centered plan should present the results and recommendations of the plan as an integral part of the person-centered planning discussions and should incorporate them into the plan as appropriate and as agreed upon by the individual and/or his or her legally responsible person.

The person-centered plan is effective for the 12-month period following the date the qualified or licensed professional signs it, unless there is a change that requires an updated plan. The person-centered plan includes service orders for behavioral health services other than ASAM level 1.0 (outpatient services) that demonstrate medical necessity and are based on an assessment of each enrollee's needs. Service orders are valid for one year from the date of the person-centered plan. At least annually, the LME-MCOs must review medical necessity for the services, and providers must issue a new service order for services to continue. An event such as a hospitalization may trigger a new assessment and a person-centered plan revision.

Future State

Upon their launch in 2019 and 2021, respectively, standard plans and BH I/DD tailored plans will be required to follow the person-centered planning provisions included in current Medicaid clinical coverage policies prior to authorizing SUD services. As noted above, the Medicaid clinical coverage policies will continue to apply to SUD services delivered through fee-for-service. This means that the process described above related to the development and use of the person-centered plan will continue to occur as it does today.

Summary of Actions Needed

- Contractually require standard plans to comply with the provisions related to person-centered planning included in Medicaid clinical coverage policies 8-A and 8-C: Completed
- Contractually require BH I/DD tailored plans to comply with the provisions related to person-centered planning included in Medicaid clinical coverage policies 8-A and 8-C: September 2018-July 2021

Utilization Management

Current State

NC Medicaid requires LME-MCOs to establish a utilization management program that includes a written plan that addresses procedures used by LME-MCOs to review and approve requests for medical services, and that identifies the clinical criteria used by LME-MCOs to evaluate the medical necessity of the service being requested. Additionally, LME-MCOs are required to ensure consistent application of the review criteria and consult with requesting providers when appropriate. LME-MCOs must conduct an annual appraisal that assesses adherence to the utilization management plan and identifies the need for changes. LME-MCOs are permitted to establish utilization management requirements for behavioral health services that are different from, but not more restrictive than, Medicaid State Plan requirements. NC Medicaid requires LME-MCOs to use the ASAM criteria to determine medical necessity of SUD services.

NC Medicaid requires providers, except those in outpatient, SAIOP and SACOT programs, to obtain prior approval from an enrollee's LME-MCO before providing certain SUD services. For all services, the LME-MCOs performs utilization management. The LME-MCOs follow the requirements listed below, although they have the flexibility to establish their own utilization management criteria, provided they are not more restrictive than the requirements listed below.

For populations receiving SUD services through fee-for-service, the NC Medicaid's behavioral health vendor performs utilization management, which includes prior authorization for selected services, in accordance with NC Medicaid's clinical coverage policy requirements detailed below. The vendor does not have the flexibility to establish its own utilization management criteria.

Medicaid clinical coverage policies:

- **ASAM Level 1: Outpatient services.** For children and adolescents under the age of 21, initial coverage is limited to 16 unmanaged outpatient visits per year, with additional visits requiring

prior authorization. For adult enrollees, coverage is limited to eight unmanaged outpatient visits per year, with additional visits requiring prior authorization.

- **ASAM Level 2.1: SAIOP.** The initial 30 calendar days of treatment do not require a prior authorization. Services provided after this initial 30-day "pass-through" period require authorization from the LME-MCO or the Department's approved behavioral health vendor. This pass-through is available only once per treatment episode and only once per state fiscal year. The amount, duration and frequency of SAIOP services must be included in an enrollee's authorized person-centered plan. Services may not be delivered less frequently than noted in the structured program set forth in the service description described in Milestone 1. Reauthorization shall not exceed 60 calendar days. Under exceptional circumstances, one additional reauthorization up to two weeks can be approved. All utilization review activity shall be documented in the enrollee's person-centered plan.
- **ASAM Level 2.5: SACOT.** The initial 60 calendar days of treatment do not require a prior authorization. Services provided after this initial 60-day pass-through period require authorization from the LME-MCO or the Department's approved behavioral health vendor. This pass-through is available only once per treatment episode and only once per state fiscal year. The amount, duration and frequency of SACOT services, as well as all utilization review activities, must be included in an enrollee's authorized person-centered plan. Reauthorization shall not exceed 60 calendar days.
- **ASAM Levels 3.5 and 3.7: NMCRT and MMCRT.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization shall not exceed 10 days, and reauthorization shall not exceed 10 days. This service and all utilization review activity shall be included in the enrollee's person-centered plan. Utilization management must be performed by the LME-MCO or the Department's approved behavioral health vendor.
- **ASAM Level 4: Medically managed intensive inpatient services.** Authorization from the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization is limited to seven calendar days.
- **Outpatient opioid treatment.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization shall not exceed 60 days. Reauthorization shall not exceed 180 days. All utilization review activity shall be documented in the enrollee's person-centered plan.
- **ASAM Level 1-WM: Ambulatory detoxification.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization is limited to seven days. Reauthorization is limited to three days, as there is a 10-day maximum for this service. This service must be included in an enrollee's person-centered plan.
- **ASAM Level 3.7-WM: Medically monitored inpatient withdrawal management.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization shall not exceed 10 days. Reauthorization shall not exceed 10 days. This service must be included in an enrollee's person-centered plan. All utilization review activity shall be documented in the enrollee's person-centered plan.
- **Medically supervised or ADATC detoxification crisis stabilization.** Authorization by the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization shall not exceed 5 days. This is a short-term service that cannot be billed for more than 30 days in a 12-month period. All utilization review activity shall be included in an enrollee's person-centered plan.

- **ASAM Level 4-WM: Medically managed withdrawal management services.** Authorization from the LME-MCO or the Department's approved behavioral health vendor is required. Initial authorization is limited to seven calendar days.

Future State

For all newly added SUD services—halfway house for individuals with an SUD, clinically managed population-specific high-intensity residential services, ambulatory detoxification services with extended on-site monitoring, and social setting detoxification services—the Department will establish prior authorization and utilization management requirements consistent with ASAM standards of care to ensure the appropriateness of patient placement. The clinical coverage policies for these new services will include these prior authorization and utilization management requirements. As described in Milestone 1, the Department will submit SPAs to add these four services to its Medicaid State Plan.

Following the managed care transition in November 2019, and consistent with its utilization management approach for LME-MCOs, the Department will permit standard plans and BH I/DD tailored plans (beginning at their launch in July 2021) to establish utilization management requirements for behavioral health services that are different from, but not more restrictive than, Medicaid State Plan requirements. Standard plans and BH I/DD tailored plans will be required to use the ASAM criteria to review the medical necessity of SUD services versus a "fail first" approach and will ensure that patient placements are appropriate as detailed in the LME-MCO and PHP contracts.

Approximately one to two years following BH I/DD tailored plan launch, the Department will solicit feedback from enrollees and providers, as well as standard plans and BH I/DD tailored plans, on utilization management approaches for SUD services, to determine whether to allow plans greater flexibility to establish their own utilization management approach. The clinical coverage policies will continue to apply to the fee-for-service population.

The Department understands the importance of ensuring that the length of SUD treatment authorized is aligned with an individual's specific needs. The National Institute on Drug Abuse (NIDA) notes that a program of fewer than 90 days of residential or outpatient treatment has shown limited or no effectiveness and recommends a 12-month minimum length of treatment for methadone maintenance.[5] Individuals with SUDs may require treatment that continues over a period of years and for multiple episodes. Client retention and engagement in treatment are critical components of recovery.

Summary of Actions Needed

Action	Implementation Timeline
Revise clinical coverage policies to require that (1) an ASAM determination is part of the diagnostic assessment and CCA and (2) licensed providers providing SUD services or assessments document	September 2018 – April 2020

[5] National Institute on Drug Abuse. (n.d.). 7: Duration of treatment. Retrieved April 12, 2018, from https://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iii/6-duration-treatment.

their training with respect to the ASAM criteria	
Submit SPAs as needed to reflect updated utilization management requirements	September 2018 – October 2020
Update LME-MCO contracts, as necessary	September 2018 – October 2020
Require standard plans to follow clinical coverage policies 8-A and 8-C	Completed
Require BH I/DD tailored plans to follow clinical coverage policies 8-A and 8-C	September 2018 – July 2021

Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

DHSR licenses and regulates outpatient, residential and inpatient SUD providers. The current licensure rules for SUD treatment providers include standards around the services that must be offered, program hours and staff credentials. Today, the degree of alignment between licensure rules for SUD providers and the ASAM criteria varies across provider type. The Department, through cross-division collaboration, intends to update nearly all of the licensure rules for SUD providers to align with the 2013 ASAM criteria and ensure that residential treatment providers either provide medication-assisted treatment (MAT) on-site or facilitate access to off-site MAT providers within a specified distance. The Department will also conduct more robust monitoring of SUD treatment providers to ensure compliance with the ASAM criteria.

Provider Licensure

Current State

Today, DHSR's Mental Health Licensure & Certification Section (MHLC) licenses and regulates non-acute residential facilities and outpatient programs pursuant to NC General Statute 122C. DHSR's Acute and Home Care Section licenses and regulates hospitals and psychiatric hospitals that provide acute inpatient and withdrawal management services. Four outpatient services and five residential services that provide an ASAM level of care are considered to be non-acute residential facilities and outpatient programs. With the exception of ASAM level 2.1 (substance abuse intensive outpatient program) and 2.5 (substance abuse comprehensive outpatient program) providers, none of the licensure rules for covered SUD treatment providers, including residential treatment providers, were written to reflect the ASAM criteria. The table below displays the SUD outpatient programs and the residential and inpatient services that North Carolina Medicaid covers today or intends to add to the State Plan; North Carolina's administrative rule that applies to each service; and the alignment between the current provider qualifications and the ASAM criteria.

The licensing standards for each covered service are memorialized in the 10 NCAC 27G Administrative Code, located here: http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2027%20-%20mental%20health,%20community%20facilities%20and%20services/subchapter%20g/subchapter%20g%20rules.pdf.

ASAM Level of Care	ASAM Title for Level of Care	North Carolina Licensure Rule	Section of NC Administrative Code (10A NCAC 27G)	Current Provider Qualifications
Outpatient Services				
2.1	Intensive outpatient services	Substance abuse intensive outpatient program	.4400	Reflect ASAM criteria with regard to types of services offered, hours of clinical care for adults and credentials of staff
2.5	Partial hospitalization services	Substance abuse comprehensive outpatient treatment	.4500	Reflect ASAM criteria with regard to types of services offered, hours of clinical care for adults and credentials of staff
OTP	Opioid treatment program	Outpatient opioid treatment	.3600	Do not reflect ASAM criteria
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Outpatient detoxification for substance abuse	.3300	Do not reflect ASAM criteria
2-WM	Ambulatory withdrawal management with extended on-site monitoring	N/A	N/A	New service; will require revision of the .3300 licensure rule
Residential Services				
3.1	Clinically managed low-intensity residential treatment services	Supervised-living halfway house	.5600	Will require new stand-alone licensure rule
3.2-WM	Clinically managed residential withdrawal	Social setting detoxification for substance abuse	.3200	Do not reflect ASAM criteria
3.3	Clinically managed population-specific high-intensity residential programs	N/A	N/A	New service; will require new licensure rule

ASAM Level of Care	ASAM Title for Level of Care	North Carolina Licensure Rule	Section of NC Administrative Code (10A NCAC 27G)	Current Provider Qualifications
3.5	Clinically managed high-intensity residential services	Residential recovery programs for individuals with substance abuse disorders and their children	.4100	Do not reflect ASAM criteria
		Therapeutic community	.4300	Do not reflect ASAM criteria
		Non-medical community residential treatment services (adults and adolescents)	N/A	New service; will require new licensure rule
3.7	Medically monitored intensive inpatient services	Residential treatment for individuals with substance abuse disorders	.3400	Do not reflect ASAM criteria
3.7-WM	Medically managed inpatient withdrawal	Non-hospital medical detoxification	.3100	Do not reflect ASAM criteria
N/A	Medically supervised or ADATC detoxification crisis stabilization	N/A	N/A	Do not reflect ASAM criteria
Inpatient Services				
4	Medically managed intensive inpatient services	Psychiatric hospital	.6000	Do not reflect ASAM criteria
		Psychiatric unit, hospital	10A NCAC 13B .5200	
4-WM	Medically managed intensive inpatient withdrawal	Psychiatric hospital	.6000	Do not reflect ASAM criteria
		Psychiatric unit, hospital	10A NCAC 13B	

Future State

DHSR, in collaboration with other divisions of the Department, will develop a licensure rule waiver process to expedite the process of aligning its provider qualifications for SUD outpatient programs and residential treatment services with ASAM criteria within the next 24 months. DHSR will also leverage the state's administrative rulemaking process to update its licensure rules for SUD outpatient programs and residential treatment services to align with the ASAM criteria. DHSR will continue to evaluate whether it needs to revise its licensure rules for inpatient services to align with ASAM criteria. When developing licensure rules for new services or new populations that will be able to access a service (e.g., adolescents), DHSR will ensure that they reflect ASAM's specifications regarding service definitions, hours of clinical care provided and program staff credentialing.

Summary of Actions Needed

- Develop a licensure rule waiver process to incorporate ASAM criteria: September 2018 – October 2020
- Revise existing licensure rules to align provider qualifications with 2013 ASAM criteria: September 2018 – October 2022

Monitoring of SUD Treatment Providers

Current State

To ensure that high-quality SUD treatment services are delivered in accordance with state licensure rules, DHSR regularly monitors outpatient OTPs and residential treatment providers. DHSR's monitoring of residential and OTP providers includes annual surveys, complaint investigations and follow-up surveys to determine compliance with the North Carolina administrative rules regarding services offered, hours of clinical care and program staffing. DHSR does not conduct annual surveys of outpatient treatment providers other than OTPs, but investigates complaints and conducts follow-up surveys to ensure that the provider has addressed the cited deficiencies.

Future State

DHSR will incorporate questions assessing compliance with the ASAM criteria, as memorialized in the state's updated licensure rules, into its annual surveys of licensed SUD treatment providers. In addition, DHSR will begin surveying ASAM level 2.1, 2.5 and 1-WM providers annually for compliance with the licensure rules. DHSR, in collaboration with other divisions of the Department, will train its inspectors to ensure they are equipped on how to monitor providers for compliance with ASAM standards. As part of these education efforts, DHSR will also revise its Survey Process Guide, which includes written instructions for surveyors regarding how to consistently assess compliance with administrative rules. These actions are expected to be completed by October 2020.

Summary of Actions Needed

- Revise DHSR MHLC's annual survey process to provide the ability to assess compliance with 2013 ASAM standards: September 2018 – October 2020

Requirement That Residential Treatment Providers Offer MAT On-Site or Facilitate Access to Off-Site Providers

Current State

DMH/DD/SAS currently requires state-funded ASAM level 3.5 (clinically managed high-intensity residential services) providers, many of which may be Medicaid providers as well, to provide MAT on-site or coordinate care with a licensed OTP or office-based opioid treatment (OBOT) provider. ASAM level 3.7 (medically monitored intensive inpatient services) providers are not subject to a similar requirement, although some ASAM 3.7 providers may offer MAT on-site if the individual was receiving MAT prior to seeking care at the residential facility and/or if the physicians at the facility have completed buprenorphine training required under DATA 2000.

To ensure that all residential treatment providers either offer MAT on-site or facilitate access to MAT off-site, North Carolina is conducting two different assessments of MAT capacity. First, the state is working to identify which residential treatment providers offer MAT on-site today. Second, the state is plotting the locations of licensed OBOT providers and OTPs that currently provide MAT services and comparing them to the locations of residential treatment providers to understand access to OBOT and OTP.

Future State

The Department will require residential treatment providers that do not provide MAT on-site to have the ability to link individuals to a licensed OBOT or OTP located within a minimum number of miles or minutes. The Department will develop this requirement based on the results of its analysis of the geographic locations of residential treatment providers compared with OBOT providers and OTPs. This standard may vary for residential treatment facilities located in urban and rural areas of the state. To ensure provider compliance with this requirement, the Department will conduct outreach and additional training, as well as provide technical assistance to residential treatment providers.

Summary of Actions Needed

- Develop requirement for residential treatment providers to be able to refer patients to MAT within a minimum number of miles or minutes: September 2018 – October 2020

Summary of Actions Needed

Action	Implementation Timeline
Develop a licensure rule waiver process to incorporate ASAM criteria	September 2018 – October 2020
Revise existing licensure rules to align provider qualifications with 2013 ASAM criteria	September 2018 – October 2022
Revise DHSR MHLC's annual survey process to provide the ability to assess compliance with 2013 ASAM standards	September 2018 – October 2020
Develop requirement for residential treatment providers to be able to refer patients to MAT within a minimum number of miles or minutes	September 2018 – October 2020

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care, Including for Medication-Assisted Treatment for OUD

Today, LME-MCOs manage SUD provider networks and are required to comply with NC Medicaid choice and time and distance standards for all covered Medicaid services. Rural areas, in particular, face ongoing staffing shortages at critical levels of SUD care, including with respect to OTPs and residential treatment services. To ensure that Medicaid enrollees, whether they receive services through the LME-MCOs or fee-for-service, have access to SUD treatment providers at critical levels of care, the Department will conduct an assessment of all Medicaid-enrolled providers. As part of this assessment, the Department will identify providers that are accepting new patients. The Department will use the results of the assessment to target network development efforts for LME-MCOs, standard plans and BH I/DD tailored plans.

Current State

The Department tasks the LME-MCOs with overseeing the development and management of a qualified SUD provider network in accordance with community needs. LME-MCOs are responsible for the enrollment, disenrollment, credentialing, and assessment of qualifications and competencies of providers, in accordance with applicable state and federal regulations. The LME-MCOs are subject to the following network adequacy standards for Medicaid covered behavioral health services:

Provider Type	Urban Standard	Rural Standard[6]
Outpatient Services[7]	≥ 2 providers of each outpatient service within 30 minutes or 30 miles of residence	≥ 2 providers of each outpatient service within 45 minutes or 45 miles of residence
Location-Based Services[8]	≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence	≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence
Crisis Services[9]	≥ 1 provider of each crisis service within each LME-MCO region	
Specialized Services[10]	≥ 1 provider of each service within each LME-MCO region	
Inpatient Services	≥ 1 provider of each service within each LME-MCO region	

LME-MCOs endeavor to ensure that enrollees have a choice of providers within time and distance requirements set forth by the Department. LME-MCOs must ensure a provider directory is made available to the enrollees to support their selection of a provider. In the event of limited services, LME-MCOs may request an exception for a specific access-to-care gap. The Department determines whether to grant an exception by examining service utilization, provider availability and the LME-MCO's plan for ensuring enrollees have access to the required service. In addition, the LME-MCO must have a plan for meeting the network adequacy requirement in the future.

Each LME-MCO is required to conduct an annual gap analysis and needs assessment of its provider network that incorporates data analysis of access to and choice of providers, as well as input from enrollees, family members, providers and other stakeholders. LME-MCOs review all services, identify service gaps, and prioritize strategies to address any gaps or weaknesses identified. The assessment takes into consideration the characteristics of the population in the entire catchment area and includes input from individuals receiving services and their family members, the provider community, local public agencies, and other local system stakeholders. Each LME-MCO assesses the adequacy, accessibility, and availability of its current provider network and creates a network development plan to meet identified community needs, following the Department's published gap analysis requirements.

Notwithstanding the LME-MCOs' robust time and distance standards, there are gaps in provider access in rural areas of North Carolina across all ASAM levels. Recent gap analyses have

[6] For the purposes of the state's network adequacy standards, "urban" is defined as "non-rural counties," or counties with an average population density of 250 or more people per square mile. This includes 20 counties categorized by the North Carolina Rural Economic Development Center (the Rural Center) as "regional cities or suburban counties" or "urban counties." These 20 counties include 59% of the state's population. "Rural" is defined as counties with a population density below 250 people per square mile. Per the Rural Center, 80 counties in North Carolina meet this definition; these counties are home to 41% of the state's population. See more at http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf.

[7] Outpatient services include behavioral health services provided by direct enrolled providers such as psychiatrists.

[8] Location-based services include ASAM levels 2.1 (SAIOP), 2.5 (SACOT) and OTPs.

[9] Detoxification services include ASAM levels 1-WM (ambulatory detoxification services without extended on-site monitoring), and 3.7-WM (non-hospital medical detoxification). For medically supervised or ADATC detoxification crisis stabilization, each LME-MCO is required to contract with all three ADATCs in the state.

[10] Specialized services include ASAM levels 3.5 (NMCRT) and 3.7 (MMCRT).

highlighted gaps in access to OTPs, ASAM level 2.5 (SACOT) providers, residential treatment programs and withdrawal management services.

To ensure that enrollees in fee-for-service have sufficient access to services, NC Medicaid enrolls any willing provider, reviews the adequacy of its network on a service-level basis, and collaborates with stakeholders to expand its network for services where shortages exist.

Future State

Within 12 months of the demonstration approval, the Department will complete its statewide assessment of the availability of enrolled Medicaid and state-funded providers, which will include identifying those who are accepting new patients at the critical levels of care. This assessment will also identify providers delivering state-funded services at ASAM level 3.1 (substance abuse halfway house) and ASAM level 3.2-WM (social setting detoxification services), which will be added to the Medicaid service array.

Summary of Actions Needed

- Conduct an assessment of all Medicaid-enrolled providers, to include the identification of providers that are accepting new patients at the critical levels of care: September 2018 – October 2019

Network Adequacy Standards for LME-MCOs, Standard Plans and BH I/DD Tailored Plans

As described above, LME-MCOs are subject to a strong set of SUD network adequacy standards today. Standard plans and BH I/DD tailored plans will also be expected to maintain and monitor a robust network of SUD providers beginning at their launches in November 2019 and July 2021, respectively.

The Department will develop a monitoring system to ensure compliance with all applicable network adequacy standards for LME-MCOs, standard plans and BH I/DD tailored plans. In alignment with the final federal Medicaid managed care rule, the Department will monitor the following indicators from the report "Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability." North Carolina will also use consumer experience to verify and monitor access to care and adjust time and distance standards, if necessary. The state will monitor appropriate service use through performance measure indicators that align with HEDIS measures.

Indicators of Provider Network Adequacy and Service Availability

Availability	Accessibility	Accommodation	Acceptability	Realized Access
Provider Capacity	**Timely Access to Care**	**Cultural Competency & Operating Hours**	**Customer Service**	**Appropriate Service Use**
Number of providers accepting new Medicaid enrollees	Percentage of consumers living within 30 minutes/30 miles for urban and 45 minutes/45 miles for rural areas	Availability and delivery of services in a culturally competent manner regardless of cultural and ethnic backgrounds;	Consumer perception of care surveys Number of appeals, grievances and	Critical performance indicators: Follow-up after care

Availability	Accessibility	Accommodation	Acceptability	Realized Access
Provider Capacity	**Timely Access to Care**	**Cultural Competency & Operating Hours**	**Customer Service**	**Appropriate Service Use**
	Percentage of consumers able to be seen within maximum wait time for emergent, urgent and routine care	disabilities; and gender, sexual orientation or gender identity	complaints	Readmissions Initiation and engagement Physical healthcare visits

As part of its managed care design process, the Department has developed the following time and distance standards for proposed SUD services that will be covered by standard plans. These services include one of the new services at ASAM level 2-WM (ambulatory detoxification with extended on-site monitoring). The Department will develop network adequacy standards for BH I/DD tailored plans in the coming year.

Standard Plan Network Adequacy Standards for Behavioral Health Services

Provider Type	Urban Standard	Rural Standard
Outpatient Services[11]	≥ 2 providers of each outpatient service within 30 minutes or 30 miles of residence	≥ 2 providers of each outpatient service within 45 minutes or 45 miles of residence
Location-Based Services[12]	≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence	≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence
Crisis Services[13]	≥ 1 provider of each crisis service within each standard plan region	
Inpatient Services	≥ 1 provider of each crisis service within each standard plan region	

Building Capacity for New Services

The state intends to support LME-MCOs, standard plans and BH I/DD tailored plans in building network capacity for new or expanded services that will be covered through fee-for-service as well.

[11] Outpatient services include behavioral health services provided by direct-enrolled providers such as psychiatrists.
[12] Location-based services include ASAM levels 2.1 (SAIOP), 2.5 (SACOT) and OTPs.
[13] Crisis services include ASAM levels 1-WM (ambulatory detoxification services without extended on-site monitoring), 2-WM (ambulatory detoxification with extended on-site monitoring), and 3.7-WM (non-hospital medical detoxification). For medically supervised or ADATC detoxification crisis stabilization, the standard plan will be required to contract with all three ADATCs in the state.

- **Expand service offerings to include ASAM level 2-WM.** The Department plans to work with the LME-MCOs to encourage their ASAM level 1-WM providers to expand their service offerings to include ASAM level 2-WM.
- **Leverage state-funded networks for ASAM levels 3.1, 3.7 and 3.2-WM.** The Department plans to work with LME-MCOs to enroll in Medicaid their current state-funded providers for ASAM levels 3.1 and 3.2-WM, in order to build Medicaid provider networks for these services. In addition, the state will work with LME-MCOs to enroll in Medicaid their state-funded providers serving adolescents for ASAM level 3.7 (medically monitored community residential treatment).
- **Engage with stakeholders for ASAM level 3.3.** To build sufficient networks for ASAM level 3.3 (clinically managed population-specific high-intensity residential programs), the state will engage with disability advocates representing individuals with TBI or I/DD as well as LME-MCOs, in order to identify providers that may be interested in offering this service.
- **Provide training for new Medicaid SUD providers.** The Department will educate and require the LME-MCOs, standard plans and BH I/DD tailored plans to provide training for new Medicaid SUD providers, to orient them to Medicaid and managed care, including topics such as utilization management, credentialing and billing.

Strategies to Ensure Adequate Capacity Post-Managed Care Transition

While standard plans and BH I/DD tailored plans will be required to meet minimum standards set by the Department, they will be given sufficient flexibility to innovate to improve quality and efficiency of care. In the event a service gap is identified, the standard plan or BH I/DD tailored plan may request an exception for a specific access-to-care gap in a specific region, consistent with current LME-MCO practice. The Department will determine if an exception is granted by looking at service utilization, the availability of providers, history of complaints, and the plan's short- and long-term plans for meeting ASAM level of care needs.

Standard plans and BH I/DD tailored plans will be allowed to develop their own telemedicine policies to ensure access to needed services, consistent with departmental guidance and approval. However, plans will not be permitted to use telemedicine to meet the state's network adequacy standards (unless the state has approved a request for an exception that involves telemedicine). When a Medicaid enrollee requires a medically necessary service that is not available within a standard plan's or BH I/DD tailored plan's network, the plan may offer the service, if applicable and clinically appropriate, through telemedicine, in addition to providing access to an out-of-network provider of the needed service. In these instances, the enrollee will have a choice between out-of-network provider and telemedicine and will not be forced to receive services through telemedicine. Medicaid enrollees receiving services through fee-for-service will be able to access telemedicine services consistent with the Department's clinical coverage policies. The Department is also exploring additional ways to leverage telemedicine for SUD treatment. As discussed in greater detail in Milestone 5 below, the state is supporting an expansion of Project Extension for Community Healthcare Outcomes (ECHO) to expand access to MAT in underserved and rural communities.

Standard plans and BH I/DD tailored plans will be required to submit an Access Plan annually to the Department, which will be reviewed and monitored by department staff. The Access Plan will

demonstrate that the plans have the capacity to serve the expected enrollment in their service area in accordance with the Department's network requirements and network adequacy standards. NC Medicaid will review each Access Plan to ensure the standard plan or BH I/DD tailored plan meets all the expectations and requirements and provides a reasonable approach to a plan's oversight and management of its providers and networks.

NC Medicaid will continue to ensure that it is has an adequate network of SUD providers in its fee-for-service program.

Expanding Access to MAT

The state has identified approximately 800 certified OBOT providers across North Carolina, and is working to determine the composition of active and non-active MAT prescribers. A robust network of active OBOT providers can complement the growing network of 65 OTPs licensed across the state. To build the network of active OBOT providers, the state intends to provide ongoing training programs and technical support to prescribers on the following:

- Implementing safe prescribing practices.
- Collaborating with pharmacists as part of a care team.
- Incorporating component services including counseling into the practice.
- Billing the PHP for component services (e.g., prescription, laboratory and counseling services).

Summary of Actions Needed

Action	Implementation Timeline
Conduct an assessment of all Medicaid-enrolled providers, to include the identification of providers that are accepting new patients at the critical levels of care	September 2018 – October 2019
Work to build Medicaid provider networks for new Medicaid levels of care	September 2018 – October 2020
Develop BH I/DD tailored plan network adequacy standards for SUD treatment services, taking into account results of provider assessment	September 2018 – October 2019

Milestone 5: Implementation of Comprehensive Strategies to Address Prescription Drug Abuse and Opioid Use Disorders

North Carolina has intensified its efforts over the past year to address the opioid crisis. As described below, the state developed and is making progress on an Opioid Action Plan outlining statewide goals and priorities for tackling the epidemic. Recent state legislation implementing opioid prescribing guidelines and expanding access to naloxone, Medicaid pharmacy program initiatives, the state's requirements for PHPs and a federal 21st Century Cures Act grant of $31 million have also bolstered North Carolina's efforts.

The North Carolina Opioid Action Plan

In June 2017, North Carolina announced North Carolina's Opioid Action Plan, which outlines the key actions the state and its partners are taking to combat the epidemic and calls for measuring and assessing the effectiveness of the strategies. The Opioid Action Plan was developed through collaboration among state agencies and various health, law enforcement, education, business, nonprofit and government partners. It aims to reduce opioid addiction and overdose deaths in the period from 2017 to 2021 by implementing the following key strategies:

- Create a coordinated infrastructure between the state, stakeholders and local coalitions.
- Reduce oversupply of prescription opioids.
- Reduce diversion of prescription drugs and flow of illicit drugs.
- Increase community awareness and prevention.
- Make naloxone widely available, and link overdose survivors to care.
- Expand treatment and recovery-oriented systems of care.
- Measure impact and revise strategies based on results.

The Department has thus far conducted numerous activities in support of the Opioid Action Plan. In October 2017, the Department purchased nearly 40,000 units of nasal naloxone to make the overdose reversal drug more widely available and thus help reduce the number of unintentional opioid-related deaths. The naloxone has been distributed to partners across the state that work with individuals at high risk of opioid overdose, including OTPs and other treatment providers, EMS agencies, Oxford House, and other community partners. The Department established a North Carolina Payers Council to bring together healthcare payers across the state to partner on benefit design, member services, and pharmacy policies to reduce opioid overuse and overdose. The Department also made important changes to the Medicaid program in order to increase access to treatment by removing prior-approval requirements for suboxone.

Strengthen Opioid Misuse Prevention Act

In June 2017, North Carolina's General Assembly passed and Governor Roy Cooper signed the STOP Act, North Carolina Session Law 2017-57, Senate Bill 257. The STOP Act seeks to reduce drug addiction and overdoses through smarter prescribing practices by doctors and dentists, restrictions on pharmacies dispensing opioids, expanding the availability of naloxone, and strengthening the state's Controlled Substance Reporting System (CSRS). STOP Act provisions apply broadly across the state; they are not specific to the Medicaid program.[14] North Carolina will require standard plans and BH I/DD tailored plans to incorporate STOP Act requirements into their opioid misuse programs. Key provisions, most of which became effective immediately, include:

Prescriber Provisions

- **Reduce unused, misused and diverted pills with five-day limit on initial prescriptions for acute pain.** A prescriber may not prescribe more than a five-day supply of a controlled substance (or a

[14] STOP Act, https://www.ncleg.net/gascripts/billlookup/billlookup.pl?Session=2017&BillID=H243.

seven-day supply after surgery) when first treating a patient for acute pain, effective January 1, 2018.[15]

- **Reduce doctor shopping and improve care with required scan of state prescription database.** Before prescribing controlled substances, a doctor, dentist or other prescriber must check the CSRS to learn of a patient's other prescriptions, effective upon completion of certain upgrades to the CSRS.[16]
- **Reduce fraud through e-prescribing.** A prescriber must electronically prescribe controlled substances to reduce fraud stemming from stolen prescription pads or forged prescriptions—except for drugs administered by the prescriber or drugs administered in a healthcare or residential facility, effective January 1, 2020.
- **Reduce diversion of veterinary drugs.** Veterinarians who dispense controlled substances must register and report to CSRS to enable detection of drug diversion by pet owners, effective January 1, 2019.
- **Tighter supervision.** PAs and NPs must consult their supervising physicians the first time they prescribe controlled substances and every 90 days thereafter, effective July 1, 2017.

Pharmacy Provisions

- **Implement universal registration and reporting.** All pharmacies dispensing controlled substances must register for and report to CSRS—consistent with the current practice of most pharmacies.
- **Enable near-time reporting to detect and stop doctor-shopping.** Pharmacies dispensing controlled substances must report to CSRS within 24 hours of each transaction—down from the current requirement of 72 hours but consistent with the current practice of many pharmacies, effective September 1, 2017.
- **Detect fraud, misuse and diversion.** Pharmacies must consult the CSRS before dispensing a controlled substance when there is reason to suspect fraud, misuse or diversion, and must consult the prescriber when there is reason to believe the prescription is fraudulent or duplicative. Pharmacies are required to remedy missing or incomplete data upon request, effective upon completion of certain upgrades to the CSRS.

Provisions Expanding Access to Community-Based Treatment and Naloxone

- **Improve health and save money by investing in local treatment and recovery services.** The STOP Act appropriates $10 million for FY 2017-18 and $10 million for FY 2018-19 for community-based treatment and recovery services for substance use disorders, including MAT.
- **Reverse overdoses and save lives.** The STOP Act facilitates wider distribution of the overdose-reversal drug naloxone by clarifying that standing orders cover not only individuals at risk, family members, law enforcement and local health departments, but also community health groups. In addition, the act underscores that no state funds may be used to support needle exchange programs, but that does not preclude a local government from supporting such a program in its community.

Other Provisions

[15] This requirement does not apply to cancer care, palliative care, hospice care or MAT for substance use disorders.
[16] This scan is allowed but not required for cancer treatment, palliative care, hospice care, drugs administered in a healthcare or residential facility, or prescriptions for five or fewer days (or seven or fewer days after surgery).

- **Stronger oversight.** The Department will audit doctor, dentist and other prescriber use of the CSRS and will report violations to the appropriate licensing boards, effective upon completion of certain upgrades to the CSRS.
- **Better data use.** The STOP Act expands use of data to detect and prevent fraud and misuse.
- **More secure funding.** The STOP Act creates a non-reverting special revenue fund to support the CSRS.

Medicaid Pharmacy Program

The NC Medicaid pharmacy program has worked to (1) update clinical coverage criteria for the use of opioids for pain management based on the Centers for Disease Control and Prevention (CDC) guideline "Prescribing Opioids for Chronic Pain"; (2) align clinical coverage criteria for prescription of opioids with strategies targeted toward reducing the oversupply of prescription opioids available for diversion and misuse; (3) strengthen its enrollee lock-in program; and (4) expand access to suboxone.[17] The Medicaid pharmacy program has also adopted the STOP Act provisions, as applicable.

In 2010, North Carolina established the NC Medicaid Enrollee Lock-In Program to establish a "prescription gatekeeper" for enrollees deemed to have potential for misuse of their prescription benefits.[18] In March 2017, the state strengthened its Medicaid lock-in program by increasing the number of enrollees subject to the lock-in from 200 to 600 per month and by lengthening the duration of enrollment in the program to two years. Next, in May 2017, Medicaid increased the early refill threshold for all opioids and benzodiazepine prescriptions from 75% to 85%, meaning that an enrollee cannot refill a prescription for one of these drugs until less than 15% of his or her current supply remains.

Effective June 1, 2018, NC Medicaid limited the prior authorization threshold for opioids to 90 mg of morphine equivalents per day. In addition, NC Medicaid began to require prior approval for opioid prescriptions exceeding the maximum daily dosage; for opioid prescriptions that are for longer than five or seven days, consistent with the STOP Act; or for any non-preferred opioid product.[19] The state requires opioid prescribers to consult the CSRS, review the CDC chronic pain guidelines for prescribing opioids and, if applicable, explain the need to exceed daily dosage limits prior to prescribing opioids. Finally, the Medicaid program eliminated the prior authorization requirements for suboxone as of November 1, 2017, to provide timely access to opioid withdrawal treatment.

New Medicaid Managed Care Provisions

North Carolina recognizes that a strong partnership with standard plans and BH I/DD tailored plans is necessary to build on its ongoing efforts to combat the opioid epidemic. To that end, the Department

[17] NC Division of Medical Assistance. Outpatient Pharmacy Prior Approval Criteria Opioid Analgesics, available at https://www.nctracks.nc.gov/content/dam/jcr:45fd795f-2681-4fab-b59c-07b350801d6b/Criteria-Opioid%20Analgesics%2090mme%20and%20III%20and%20IV.pdf.

[18] Today, the program restricts enrollees who meet at least one of the following criteria to a single prescriber and pharmacy: enrollees with six claims of opiates, benzodiazepines and certain anxiolytics; beneficiaries receiving prescriptions for these drugs from more than three prescribers in two consecutive months; or referral from a provider, NC Medicaid or Community Care of North Carolina (CCNC). NCHC enrollees are not subject to lock-in provisions. Source: NC Outpatient Pharmacy Clinical Coverage Policy.

[19] North Carolina Medicaid Pharmacy Newsletter, June 2017.

will require its PHPs to implement a comprehensive opioid misuse prevention program. To monitor potential abuse or inappropriate utilization of prescription medications, the Department will give plans the choice of either participating in the NC Medicaid Enrollee Lock-In Program or develop their own lock-in program consistent with state law and subject to Department approval. PHPs will provide care coordination for enrollees in the lock-in program in conjunction with the enrollee's primary care provider. Plans will be required to report to the Department lock-in program outcomes including, but not limited to, changes in emergency department visits and changes in opioid misuse, to inform monitoring efforts and identify the need for further interventions.

Additionally, plans will be required to implement a maximum morphine milligram equivalent dose for opioid prescriptions as point-of-service edits, as well as drug utilization review programs to address opioid misuse.

Opioid Initiatives Supported by the 21st Century Cures Act Grant

North Carolina is using a $31 million grant received through the 21st Century Cures Act in May 2017 to expand access to prevention, treatment and recovery supports to reduce opioid-related deaths over the next two years.[20] It will also be used to purchase 6,600 naloxone kits statewide to be distributed to law enforcement, paramedics and OTPs. The state expects to serve approximately 1,500 individuals annually over the two-year period through the grant as a whole. In addition to expanding treatment services, funding will be available for prevention, education and outreach; screening/triage/referral; recovery supports; and provider education and development. Two specific examples of current projects funded by this grant follow:

- **Project Extension for Community Healthcare Outcomes (ECHO)** The Department is using its 21st Century Cures Act grant to expand training on MAT and associated barriers for providers and interdisciplinary clinical teams through the University of North Carolina's (UNC) research initiative, Project ECHO, in collaboration with the University of New Mexico Project ECHO. The core goals of the UNC ECHO for MAT demonstration project are to (1) increase understanding about how known barriers to the implementation of MAT in primary care can be overcome; (2) evaluate strategies to overcome those barriers; and (3) simultaneously expand access to MAT in rural and underserved counties, reducing the risk of accidental overdose deaths through a multilayered provider and practice engagement strategy. Additional ECHOs may focus on highlighting best practices and evidence-based care, as well as building treatment capacity for pregnant women or mothers, individuals with OUD who are also HIV positive or hepatitis C positive, and/or for individuals with OUD in North Carolina prisons.
- **Training on ASAM Levels of Care.** During March and April 2018, the state used funds from its 21st Century Cures Act grant to offer and subsidize the cost of eight two-day and four one-day trainings on the ASAM criteria, primarily targeting medical professionals and clinical staff employed at OTPs and OBOT programs across the state. The training provided participants with a comprehensive overview of the ASAM criteria, including:
    - Services that are part of the ASAM continuum of care.
    - ASAM's six dimensions used to complete a holistic, biopsychosocial assessment that evaluates an individual's substance use and withdrawal history; health history and

[20] Governor Cooper Announces $31 Million Grant to Fight Opioid Epidemic in NC.

current physical condition; readiness to change; and emotional, behavioral or cognitive conditions, among others.
- ASAM's continued stay and discharge criteria for residential SUD services.

North Carolina has been a leader in the fight against the opioid crisis. By deploying these initiatives, the state has made and will continue to make progress in curbing this nationwide epidemic.

Summary of Actions Needed

Action	Implementation Timeline
Continue implementation of the STOP Act provisions on an ongoing basis.	September 2018 – October 2020

Milestone 6: Improved Care Coordination and Transitions Between Levels of Care

Care Coordination

Current State

Today, LME-MCOs are responsible for providing care coordination for Medicaid enrollees, including those with special healthcare needs and those who meet the state's definition of being "at risk," but cannot duplicate case management functions that enrollees receive as part of select behavioral health services. The population with special healthcare needs includes the following individuals with SUDs:

- Individuals with an SUD diagnosis and current ASAM patient placement criteria (PPC) of at least level 3.7 or 3.2-WM.
- Adults who reported use of drugs by injection.
- Children with a mental health or SUD diagnosis, who are currently residing or have resided in the past 30 days in a facility operated by the Department of Juvenile Justice or the Department of Corrections, an inpatient hospital setting, a therapeutic group home, or a psychiatric residential treatment facility.
- Individuals with co-occurring SUD and mental illness or I/DD as follows:
    - Individuals with both a mental illness diagnosis and a substance use diagnosis and a current LOCUS/CALOCUS of V or higher, or current ASAM PPC level of 3.5 or higher.
    - Individuals with both an I/DD and an SUD diagnosis and current ASAM PPC level of 3.3 or higher.

Medicaid defines at-risk individuals as those enrollees who:
- Do not appear for scheduled appointments and are at risk for inpatient or emergency treatment.
- Receive a crisis service as their first service, in order to facilitate engagement with ongoing care.
- Are discharged from an inpatient psychiatric unit or hospital, a psychiatric residential treatment facility, or a facility-based crisis or general hospital unit following admission for a mental health, SUD or I/DD condition.

LME-MCOs' care coordination responsibilities for the populations listed above include the following:

- Identifying enrollees' clinical needs.
- Determining level of care through case review.
- Arranging assessments.
- Linking enrollees to necessary psychological, behavioral, educational and physical evaluations.
- Engaging in clinical discussions with enrollees' treatment providers.
- Conducting deliberate organization of care activities.
- Facilitating appropriate delivery of healthcare services and connecting enrollees to the appropriate level of care.
- Addressing support services and resources.
- Assisting enrollees with obtaining referrals and arranging appointments.
- Educating enrollees about other available supports as recommended by clinical care coordinators.
- Monitoring enrollees' attendance in treatment.
- Identifying and addressing enrollees' needs and barriers to treatment engagement.
- Developing engagement strategies for individuals with special healthcare needs.
- Coordinating and linking all Medicaid-funded services for the enrollee, as appropriate.
- Assisting with developing a person-centered treatment plan in consultation with the enrollee and his or her primary care provider.

In addition to the care coordination functions performed by the LME-MCOs, case management is provided as part of select SUD services. In particular, SAIOP and SACOT services include case management components to arrange, link, or integrate across multiple types of SUD services and supports.

The state's fee-for-service behavioral health contractor provides care coordination services to populations excluded from the LME-MCOs. Care coordinators provide the following care coordination functions telephonically:

- Information intake;
- Evaluation;
- Referral to inpatient providers or to appropriate level of care;
- Utilization review;
- Quality assurance;
- Discharge and aftercare planning; and
- Monitoring.

Transitions of Care

Current State

Among their care coordination functions, LME-MCOs are required to coordinate and monitor services provided to enrollees during transitions of care. Responsibilities include assisting hospitals, facilities and other institutional providers with discharge planning for short-term and long-term hospital and institutional stays when the admission is primarily based on the enrollee's behavioral health diagnosis.

Transitional care coordination performed by LME-MCOs cannot duplicate inpatient facilities' requirements for discharge planning. The inpatient facility must involve the patient, family, staff members and referral sources in discharge planning. If a patient is being referred to another facility for further care, appropriate documentation of the patient's current status must be forwarded with the patient within 48 hours of discharge. The discharge summary must include the reasons for referral, the diagnosis, functional limitations, services provided, the results of services, referral action recommendations, and activities and procedures used by the patient to maintain and improve functioning.

Future State

Upon their launches in 2019 and 2021, respectively, the standard plans and BH I/DD tailored plans will be responsible for care coordination and care management for enrollees with SUDs, including managing transitions between levels of care. LME-MCOs will continue to manage care coordination and care transitions for certain Medicaid enrollees with SUDs until BH I/DD tailored plans launch. For populations that will remain in fee-for-service, the state will develop care coordination protocols that include transitions of care across service levels. In developing the care coordination and care management approaches for these new managed care products, North Carolina has prioritized the establishment of specific requirements related to serving enrollees with SUDs as described below.

Standard Plans: Care Coordination and Care Management

When standard plans launch in November 2019, they will be responsible for overseeing, funding and organizing all aspects of care management in a way that improves health outcomes and manages the total cost of care for their enrollees. They will be required to complete care needs screenings and to perform claims analysis and risk scoring to identify enrollees at risk; stratify their populations by level of need; perform comprehensive assessments for those identified as part of "priority populations"; and perform localized care management at the site of care, in the home or in the community, where face-to-face interaction is possible.

Standard plans will be required to establish policies and procedures to deliver care to and coordinate services for all enrollees regardless of risk or needs. As part of their care coordination for all enrollees, standard plans will be required to do the following:

- Establish policies and procedures for coordination between physical and behavioral health providers, and between mental health and substance use providers.
- Establish policies and procedures to coordinate enrollee transitions from LME-MCOs or Medicaid fee-for-service into standard plans and from one standard plan to another, or between delivery systems.
- Design an evidence-based tool to conduct a care needs screening that can identify enrollees' behavioral health needs, incorporating the ASAM criteria to screen for opioid usage and other SUDs.
- Make best efforts to conduct a care screening of every enrollee within 90 days of enrollment as required by the managed care rule, to identify enrollees with unmet healthcare needs (including SUDs) who may require a comprehensive assessment for care management.

Additionally, standard plans will designate enrollees with SUDs as meeting the state's definition of special healthcare needs, and thereby as a high-priority population for receiving care management.

All care management must include coordination of physical health, behavioral health, pharmacy and social services. In addition, the Department will require that all care managers receive training on integrated and coordinated physical and behavioral healthcare, and care managers serving individuals with behavioral health needs will also receive training on behavioral health crisis response.

Standard Plans: Transitions of Care

Among their care coordination responsibilities for all enrollees, including those with SUDs, standard plans will manage transitions of care for all enrollees moving from one clinical setting to another, to prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes. Following standard plan contracting, standard plans will be required to share with the Department their transitional care management policies and procedures, the experience and qualifications of care managers performing transitional care management, and how their transitional care management approach relates to the staffing and contracting approach for high-need enrollees' care management.

In order to identify enrollees in transition who are at risk of readmissions and other poor outcomes, standard plans shall develop a methodology that considers the frequency, duration and acuity of inpatient, skilled nursing facility (SNF), and LTSS admissions or emergency department visits; discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised treatment centers or alcohol drug abuse treatment centers; and neonatal intensive care unit (NICU) discharges. In addition, the standard plan may target enrollees for transitional care management by severity of condition, medications and other factors the standard plan may prioritize.

Standard plans will ensure that the entity conducting transitional care management performs the following functions:

- Conducts outreach to the member's advanced medical home/primary care provider and all other medical providers.[21]
- Facilitates clinical handoffs, including those to behavioral health providers.
- Obtains a copy of the discharge plan/summary, and verifies that the enrollee's care manager receives and reviews the discharge plan with the enrollee and the facility.
- Ensures that a follow-up outpatient and/or home visit is scheduled, within a clinically appropriate time window.
- Conducts medication reconciliation and support medication adherence.
- Ensures that a care manager is assigned to manage the transition.
- Rapidly follows up with the enrollee via the assigned care manager following discharge.
- Develop a protocol for determining the appropriate timing and format of such outreach.

[21] The AMH program will be the framework under which providers can choose to take primary responsibility for care management, either at the individual practice level or in a contractual relationship with a care management/population management entity (e.g., a Clinically Integrated Network)—and receive higher reimbursement for such responsibility—or choose to coordinate with PHPs' care management approaches.

BH I/DD Tailored Plans: Care Coordination and Care Management

By design, BH I/DD tailored plans will serve a high-cost population with complex needs. BH I/DD tailored plan enrollees will have a significant need for robust, whole-person care management services that will address their physical health, mental health, substance use, I/DD, TBI, pharmacy, community support and social needs. Specifically, care management for BH I/DD tailored plan enrollees will take into account the following:

- Future BH I/DD tailored plan enrollees are closely engaged with mental health, SUD, I/DD and TBI providers with whom they have frequent interaction and trusting relationships, and conflict-free care management services should be provided at these sites or in primary care settings that have expertise in serving populations with significant BH or I/DD needs to the maximum extent possible.
- Care management services for populations that will enroll in BH I/DD tailored plans, including individuals with SUDs, should generally be more intensive than those provided to the standard plan population and should occur face-to-face for all BH I/DD tailored plan enrollees.
- Care managers serving BH I/DD tailored plan enrollees must have specialized expertise, including training in mental health, SUD, I/DD and/or TBI care; experience managing physical and behavioral healthcare and I/DD co-morbidities; and specialized clinical supervision experience to support the coordination of care between physical and behavioral healthcare.

The BH I/DD tailored plan care management model will meet federal standards for health home services, and North Carolina anticipates submitting a health home SPA prior to the BH I/DD tailored plan launch. Health home funds will flow to BH I/DD tailored plans. Given that BH I/DD tailored plans will not launch until July 2021, the Department is still in the process of establishing the full set of BH I/DD care management requirements.

BH I/DD Tailored Plans: Transitions of Care

Among their care management responsibilities, entities delivering health home care management services will be required to provide comprehensive transitional care management services, including all standard plan transitional care services. Additional responsibilities will include:

- Instituting evidence-based care transition programs directed toward individuals with mental health disorders SUDs and I/DD.
- Developing relationships with local hospitals, nursing homes, SUD residential treatment facilities, SUD rehabilitation providers and inpatient psychiatric facilities to promote smooth care transitions.
- Developing working relationships with the justice system and the Division of Social Services to support transitions back to the community.

The Department recognizes the importance of ensuring that standard plan enrollees who meet the BH I/DD tailored plan level of need or require a service that will only be covered by BH I/DD tailored plans are transitioned as quickly and smoothly as possible. To that end, these enrollees will be able to transfer across standard plans and BH I/DD tailored plans throughout the coverage year.

Summary of Actions Needed

Action	Implementation Timeline
Incorporate care management provisions into standard plan contracts	January 2019 – November 2019
Incorporate care management provisions into BH I/DD tailored plan contracts	January 2021 – July 2021
Submit a health home SPA to authorize the creation of behavioral health homes	July 2019 – March 2020

SUD HIT Plan: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
1. Enhanced interstate data sharing in order to better track patient-specific prescription data	▪ North Carolina's PDMP, which is called the CSRS, enables practitioners to see patient prescription history of 24 states, Washington DC, Puerto Rico and the Military Health System using National Associations of Boards of Pharmacy's (NABP) PMP Interconnect (PMPi). The states are: Alabama, Arizona, Arkansas, Connecticut, Delaware, Florida, Georgia, Idaho, Maine, Minnesota, Mississippi, New Jersey, New Mexico, New York, North Dakota, Ohio, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, and West Virginia.	▪ The state will update its HIT plan as more states are included in PMPi sharing. ▪ By September 2019, 11,250 prescriber and 580 pharmacies will be approved for integration. ▪ Two-way data sharing will be established between North Carolina and all other states.	▪ Review necessary steps to join RxCheck. ▪ Enhance interstate data sharing (ex. KY) through connection with the RxCheck hub, and continue to reach out to remaining states (provided funds are available). **Timeline:** September 2018 – April 2020
2. Enhanced "ease of use" for prescribers and other state and federal stakeholders.	▪ In order to facilitate ease for prescribers, DMH/DD/SAS successfully updated the CSRS platform in September 2018 ▪ North Carolina launched new efforts to integrate CSRS and other states' PDMP data into clinical workflows in November 2018. ▪ At this time, 3,213 prescribers have been approved for integration. ▪ Forty-three pharmacies are currently approved to be integrated.	▪ North Carolina has a CSRS integration plan that includes a variety of EHR platforms, including the state's HIE as an option in the event an EHR vendor is not willing to participate. ▪ The state has developed a prioritization matrix based on healthcare entities' geographic location, specialty, past	▪ Continue to approve additional prescribers and pharmacies for integration with the CSRS, as well continue its integration efforts with the HIE. **Timeframe:** September 2018 - September 2019

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	▪ The state's Health Information Exchange (HIE), NC HealthConnex, is expected to complete integration by September 2019. ▪ The UNC Health Care System integrated independent of the state's effort in the Summer of 2018. ▪ Large pharmacy chains, such as CVS (367 stores), Walmart (229), Kroger (125), Kmart (14), Costco (8), Harris Teeter (8) and Walgreens (474) have integrated independently as well.	prescribing practices, and overdose rates in their area. ▪ Integration goals are 11,250 prescribers and 580 pharmacies by September 2019. ▪ Ultimately, all NC prescribers and dispensers will have CSRS data integrated into their daily workflows (December 2023, contingent on availability of funds).	
3. Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange.	▪ The Department is working to connect the CSRS with the state's HIE, known as NC HealthConnex. ▪ In May 2018, the Department executed a contract with a vendor to use PMP Gateway to develop an interface between the CSRS and NC HealthConnex .	▪ Transmissions between the CSRS and the HIE will be bi-directional and occur in real time. ▪ The interface with NC HealthConnex is expected to be complete in September 2019, following NC HealthConnex's migration to a new platform.	▪ Complete the interface with HealthConnex in September 2019. **Timeframe**: September 2018 - September 2019
4. Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns (see also "Use of PDMP" #6, below).	▪ On a quarterly basis, DMH/DD/SAS is providing the NC Medical Board, Nursing Board and Board of Pharmacy with advanced analytics collected through the CSRS, based on criteria established by each board aimed at flagging providers with potentially questionable prescribing patterns.	▪ DMH/DD/SAS plans to partner with additional state licensing boards, such as the NC Board of Podiatry Examiners and the NC State Board of Dental Examiners, to identify prescribers with questionable prescribing patterns.	▪ Continue to partner with Medical, Nursing and Pharmacy Boards to refine reports. ▪ Establish partnerships with additional state licensing boards. ▪ Deploy clinical alerts in

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	▪ The licensing boards use these reports to identify prescribers for investigation. ▪ In addition to quarterly reports to the licensing boards, the system utilizes threshold reports to notify prescribers directly when a patient has exceeded established thresholds of a number of prescribers and pharmacies visited in a 90-day period.	▪ DMH/DD/SAS will work with new partners to develop a process for reporting. ▪ Additionally, DMH/DD/SAS will improve reporting sensitivity by improving identity resolution for patients, prescribers and dispensers in the CSRS. ▪ In September 2019, "clinical alerts" will be deployed, which will enable any prescriber to see these threshold alerts when a patient is queried. Current threshold reports are only visible to the practitioner who wrote the prescription.	September 2019. **Timeframe**: September 2018 - September 2019
Current and Future PDMP Query Capabilities			
5. Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e., the Entity Resolution [ER] strategy with regard to PDMP queries).	▪ The CSRS' current approach to matching patients with prescriptions to patients in the CSRS involves first examining patients' first and last names, dates of birth, and street addresses. ▪ Based upon that review, the CSRS identifies cases where records with similar names used to fill multiple opioid prescriptions are likely a single patient, or separates records when it identifies that two different patients have used the same identifying information to fill	▪ DMH/DD/SAS plans to continue its efforts to improve identity resolution among prescribers, patients and dispensers, including leveraging the HIE's MPI capabilities.	▪ Prescriber and dispenser Entity Resolution is moving forward using DEA and NPI data in routine system auditing in addition to the Entity Resolution plan. ▪ Continue partnership with GDAC and expand scope of work to include making the business case to other state agencies to

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	their prescriptions. ▪ Since 2017, DMH/DD/SAS has partnered with the state's Government Data Analytics Center (GDAC) to facilitate data sharing to improve patient, prescriber and dispenser identity resolution. ▪ The CSRS is also using data from the U.S. Drug Enforcement Agency (DEA) to improve identity resolution for patients, prescribers and dispensers. ▪ Finally, DMH/DD/SAS is working to identify additional data sources that can further improve the resolution of patient identity.		obtain permissions and consult with GDAC on defining the methodology for patient and prescriber entity resolution. ▪ Begin discussions with the HIE Authority on additional strategies to coordinate NC HealthConnex and CSRS information. **Timeframe**: September 2018 - September 2021
Use of PDMP – Supporting Clinicians with Changing Office Workflows			
6. Develop enhanced provider workflow/business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance, to address the issues that follow.	▪ DMH/DD/SAS co-chairs the Department's Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC), which is focused on implementing the state's Opioid Action Plan, as described in Milestone 5. ▪ As part of the Opioid Action Plan, the Department aims to expand clinicians' access and use of the CSRS as a tool to combat the opioid epidemic. ▪ The Department recommends that a patient's report is queried within 48 hours of a patient's initial visit. ▪ The CSRS integration plan simplifies	▪ All HCEs using EHRs and PMS will have CSRS data integrated into their workflows	▪ Continue to collaborate with vendor to integrate EHR/PMS and CSRS data and acquire additional licenses for pharmacies and prescribers. **Timeframe**: November 2018 - December 2023 (Contingent upon available funds)

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	providers' abilities to query the report while a patient is in clinic without interrupting the clinician's workflow. ▪ For those entities that are not integrated, state law permits delegate access to the system for querying patients' prescription history on behalf of the practitioner. ▪ Practitioners use the CSRS separate from their EHR and Pharmacy Management Systems (PMS) to acquire patient controlled substance prescription history. ▪ The state is in the process of integrating CSRS and EHR data for individual Healthcare Entities (HCEs)		
7. Develop enhanced supports for clinician review of patient CSRS data prior to prescribing a controlled substance	▪ PDMP users currently use NarxCare analytics, available since September 2018 to review prescription history. ▪ In addition to the information provided in #6, the new CSRS platform includes additional supports for clinical decision-making by providing visualization of the history and overdose risk scores. ▪ The SAMHSA MAT locator is embedded in the system along with links to printable Centers for Disease Control and Prevention (CDC) pamphlets to help practitioners discuss topics with their patients.	▪ The state will enhance educational resources available to users on effective NarxCare usage	▪ Extend NarxCare funding to continue availability of NarxCare analytics to CSRS users. **Timeline**: September 2018 - December 2019

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	▪ CSRS also provides a morphine milligram equivalent (MME) or lorazepam milligram equivalent (LME) to assist prescribers in identifying risky behavior.		
Master Patient Index/Identity Management			
8. Enhance patient and prescriber profiles by leveraging other state databases in support of SUD care delivery.	▪ DMH/DD/SAS is in the early stages of Entity Resolution. ▪ The CSRS' current approach to matching patients is detailed above, under #5, "Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP."	▪ Collaborate with GDAC to mirror the current database and use other databases (e.g., Division of Motor Vehicles, Department of Public Safety, HIE Authority) that GDAC has access to, with proper permissions, to better link prescriptions and identify patients and prescribers.	▪ Continue partnership with GDAC and expand scope of work to include making the business case to other state agencies to obtain permissions. ▪ Consult with GDAC on defining the methodology for patient and prescriber Entity Resolution. **Timeframe**: September 2018 - September 2021
Overall Objective for Enhancing PDMP Functionality & Interoperability			
9. Leverage the above functionalities/capabilities /supports (in concert with any other state health IT, technical assistance or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing and to ensure that Medicaid does not inappropriately	▪ DMH/DD/SAS has started a pilot project with NC Medicaid to minimize the risk of inappropriate opioid overprescribing and to ensure that Medicaid does not inappropriately pay for opioids. ▪ Through this pilot, DMH/DD/SAS and NC Medicaid match CSRS data with Medicaid claims data to identify Medicaid prescribers who may be overprescribing opioids, as well as patients who may be at risk of developing or have OUDs.	▪ DMH/DD/SAS and NC Medicaid will work to expand the pilots and run reports analyzing all Medicaid claims for opioid prescriptions on a monthly basis. ▪ Following the managed care transition, standard plans (as of November 2019) and BH I/DD tailored plans (as of July 2021) will be required to submit pharmacy encounter	▪ Expand pilots to run reports analyzing all Medicaid claims for opioid prescriptions on monthly basis. ▪ DMH/DD/SAS and NC Medicaid will meet to plan for: (1) cleaning and processing data received from standard plans and BH I/DD tailored plans, and (2) sharing

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
pay for opioids.		data to the Department on a weekly basis. ▪ Once NC Medicaid receives the encounter data, it will clean and process the data to identify opioid prescriptions and share with DMH/DD/SAS to identify (1) prescribers who are overprescribing opioids, and (2) patients who have or may be at risk of developing OUDs.	information on prescribers who may be overprescribing opioids and patients who have or may be at risk of developing OUDs. **Timeframe**: September 2018 - July 2021

10. North Carolina has sufficient health IT infrastructure at every appropriate level (i.e., state, delivery system, health plan/MCO and individual provider) to achieve the goals of this demonstration.

11. North Carolina's SUD Health IT Plan is aligned with the State's broader State Medicaid Health IT Plan (SMHP).

12. The Department will include appropriate standards referenced in the ONC Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B in subsequent PHP contract amendments or PHP re-procurements.

Attachment A, Section II—Implementation Administration

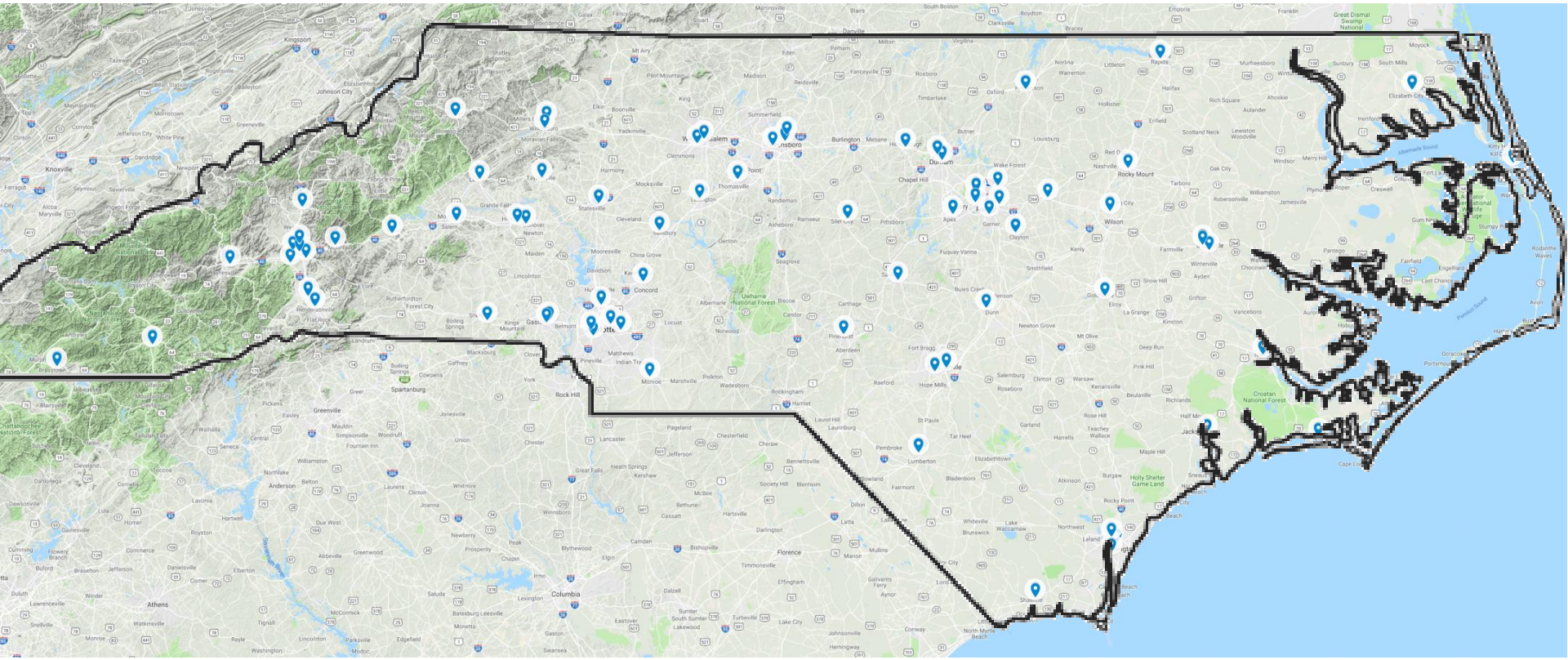
Please provide the contact information for the state's point of contact for the SUD Health IT Plan.

Name and Title: Katherine Nichols, Assistant Director, DMH/DD/SAS
Telephone Number: 919-715-2027
Email Address: Katherine.Nichols@dhhs.nc.gov

Attachment A, Section III—Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

Opioid Treatment Programs in North Carolina



Urban areas may have fewer capacity issues, but there isn't sufficient funding.

Rural areas struggle with both capacity and funding restricting access to quality care.

NORTH CAROLINA'S OPIOID ACTION PLAN

Updates and Opportunities

June 2017

Governor Roy Cooper launched the NC Opioid Action Plan.

Since the launch of the Opioid Action Plan, we've advanced many strategies:

- ✓ Received over **$54 million in federal funding** which provided **treatment for over 12,000 people.**
- ✓ Increased the number of **Syringe Exchange Programs,** and served over 5,000 people annually through them.
- ✓ **Trained over 3,000 providers** on clinical issues related to the epidemic, include safe prescribing of opioids and pain treatment.
- ✓ Funded **peer support specialists** with lived experience in emergency departments to connect people with substance use disorders (SUDs) to ongoing services and supports.
- ✓ Launched **a medical residency training** project that will give over 400 prescribers their DATA 2000 waiver to prescribe buprenorphine, and work with over 20 residency programs to incorporate the DATA 2000 waiver into their curriculum ongoing.

- ✓ **Funded 34 local organizations** to implement action plan strategies in their communities.
- ✓ **Enhanced the Controlled Substances Reporting System (CSRS)** to provide data visualizations so providers can make informed decisions at the point of care.
- ✓ **Integrated CSRS with electronic health records** and established data exchange with 29 states.
- ✓ **Convened a Payers Council** which made recommendations for insurance payers to respond to the opioid epidemic.
- ✓ **Raised awareness of safe drug storage**, disposal and drug take backs.
- ✓ Developed **model healthcare worker diversion prevention** protocols.
- ✓ Collected and incinerated over 100,000 pounds of medications through **Operation Medicine Drop.**
- ✓ Created a publicly accessible **data dashboard** to monitor progress.
- ✓ Established an opioid research consortium and created a **NC Opioid Research Agenda.**
- ✓ Launched multiple **public education campaigns.**

THE RESULT

Since the launch of the Plan:

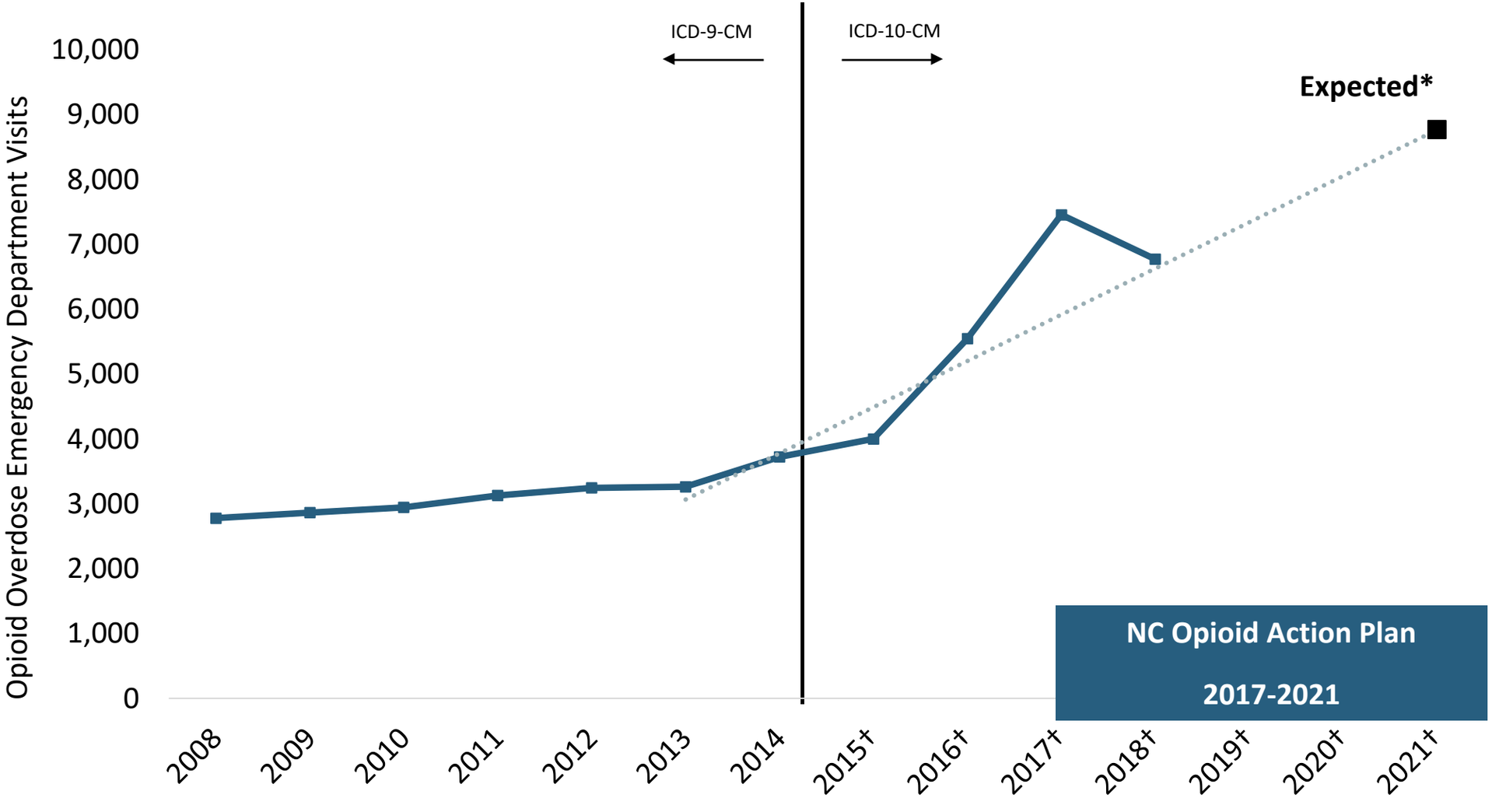
Opioid dispensing has **decreased by 24%**

Buprenorphine dispensing has **increased 15%**

Uninsured and Medicaid beneficiaries who have received opioid use disorder treatment has **increased by 20%**

Buprenorphine is an FDA-approved medication for the treatment of opioid use disorder.

Opioid overdose emergency department visits have declined for the first time in over a decade.



*Data are preliminary and subject to change

Source: NC Division of Public Health, Epidemiology Section, NC DETECT, 2009-2018 Q3

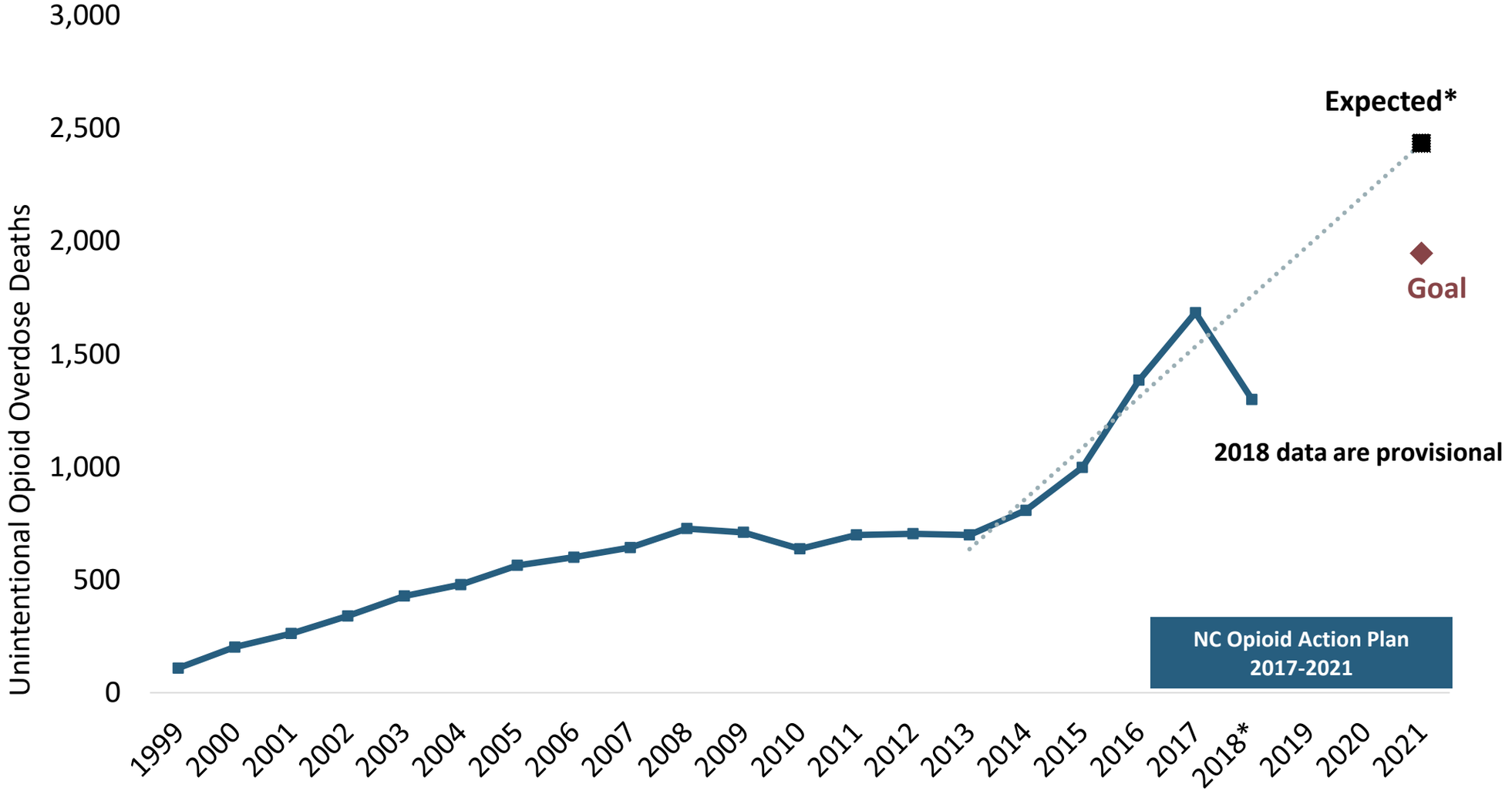
BUT THERE IS STILL MUCH MORE WORK TO DO …

NORTH CAROLINA'S OPIOID ACTION PLAN

Updates and Opportunities

Version 2.0

The Opioid Action Plan continues the goal to reduce expected opioid overdose deaths **by 20% by 2021.**

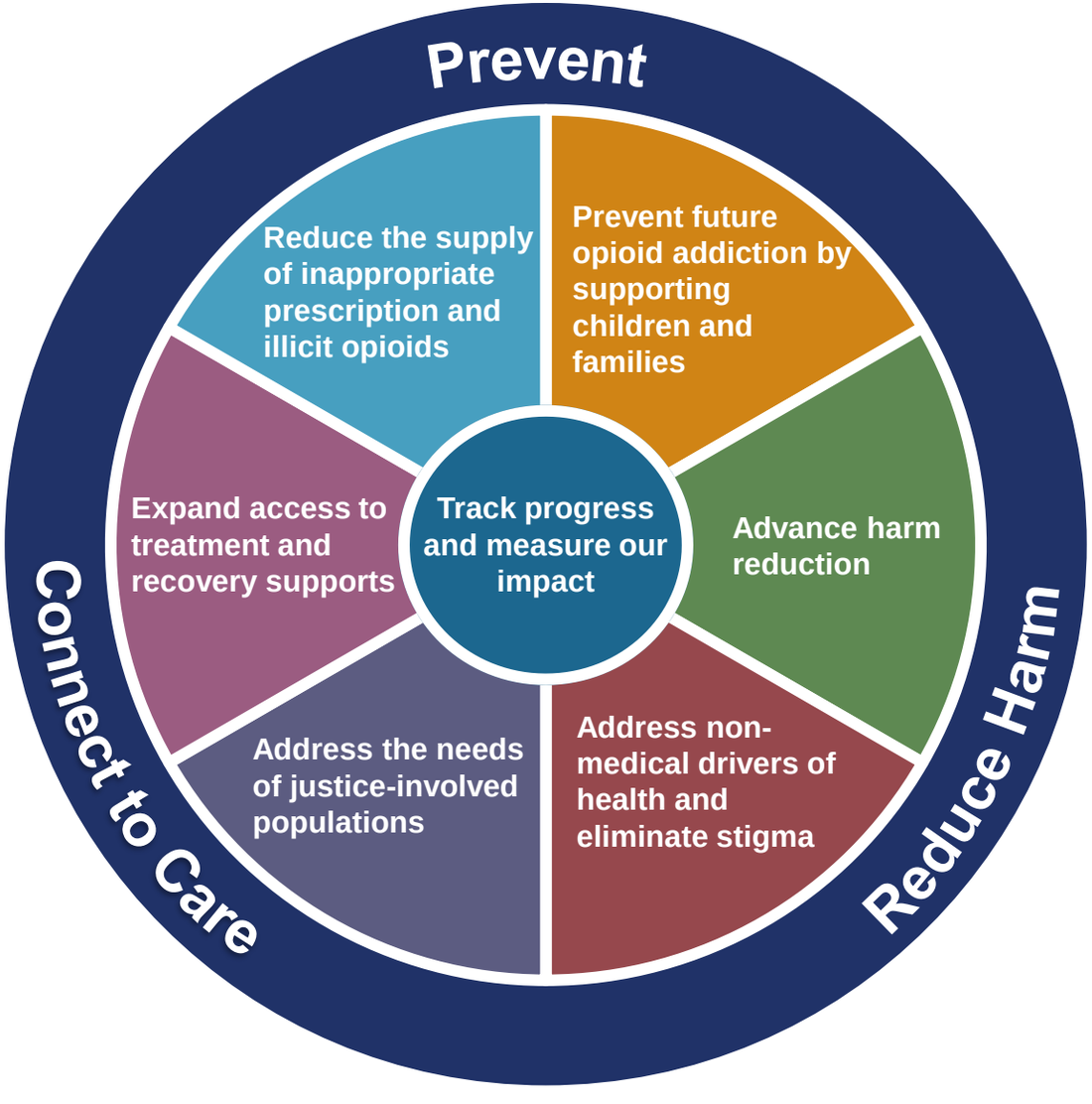


*Data are preliminary and subject to change

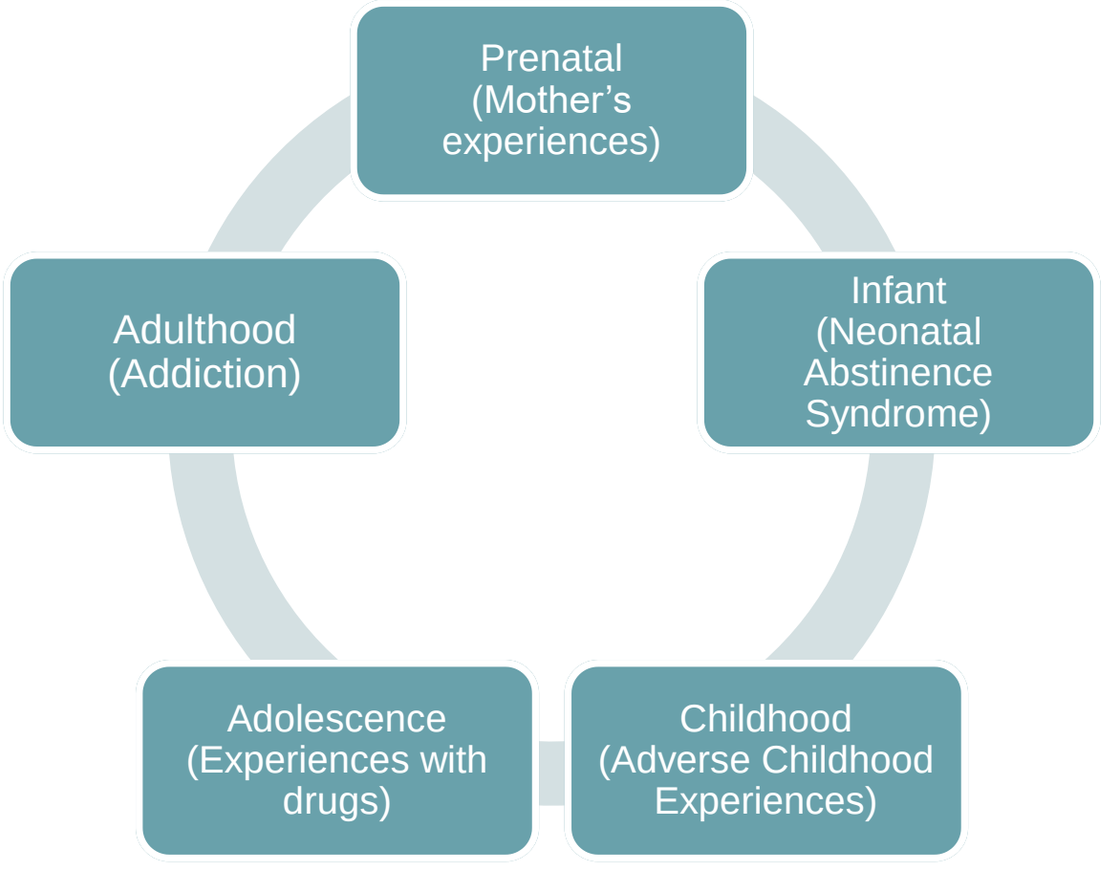
Source: NC State Center for Health Statistics, Vital Statistics-Deaths, ICD10 coded data, includes NC Resident deaths occurring out of state, 1999-2018 Q2

The Opioid Action Plan 2.0 aims to identify impactful, feasible strategies to **reduce opioid overdoses** in North Carolina and **prevent the next wave** of the epidemic.

Opioid Action Plan Version 2.0



Prevent



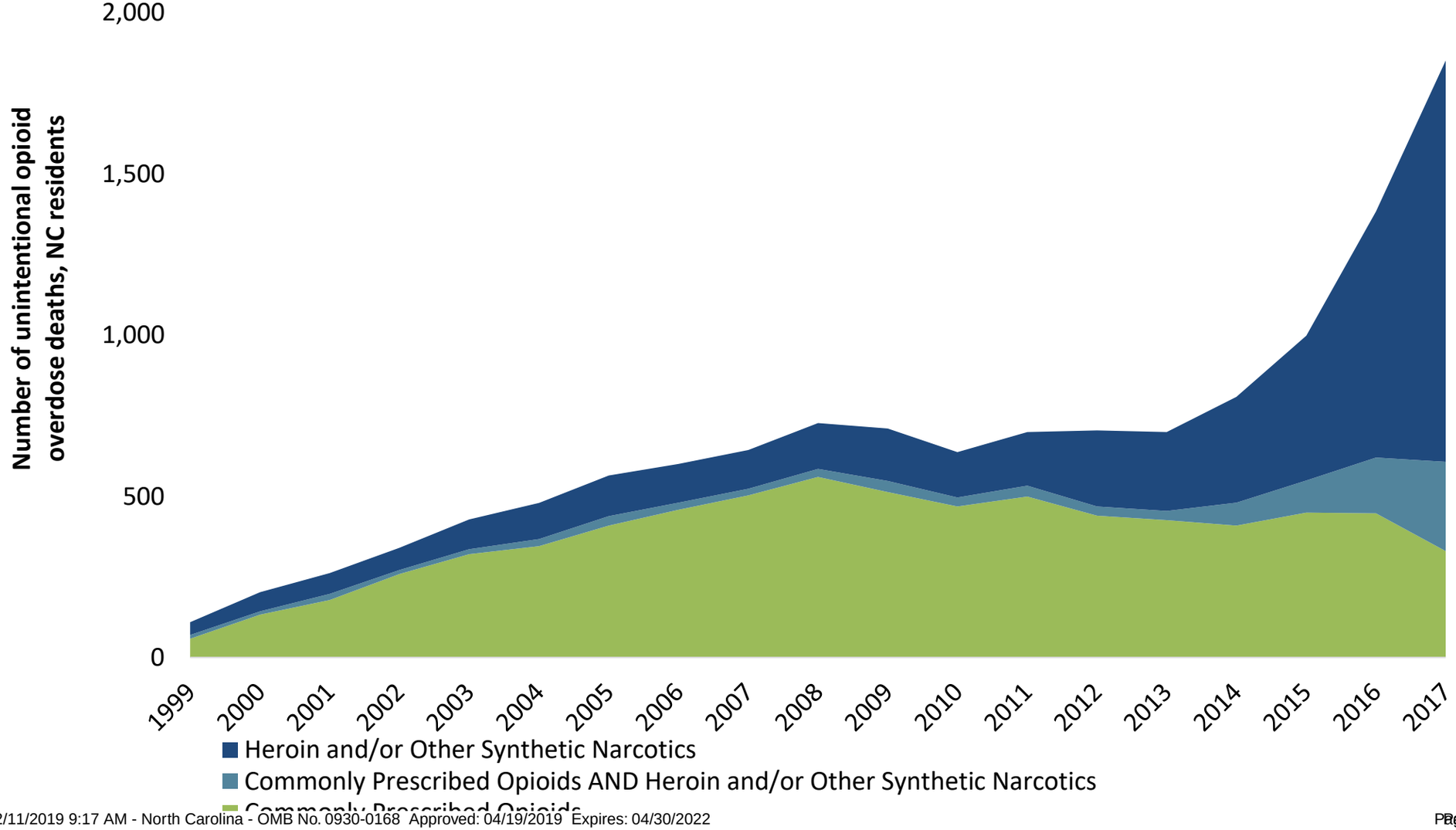
The epidemic is part of an intergenerational cycle of trauma and harm.

Prevent: Plan Priorities

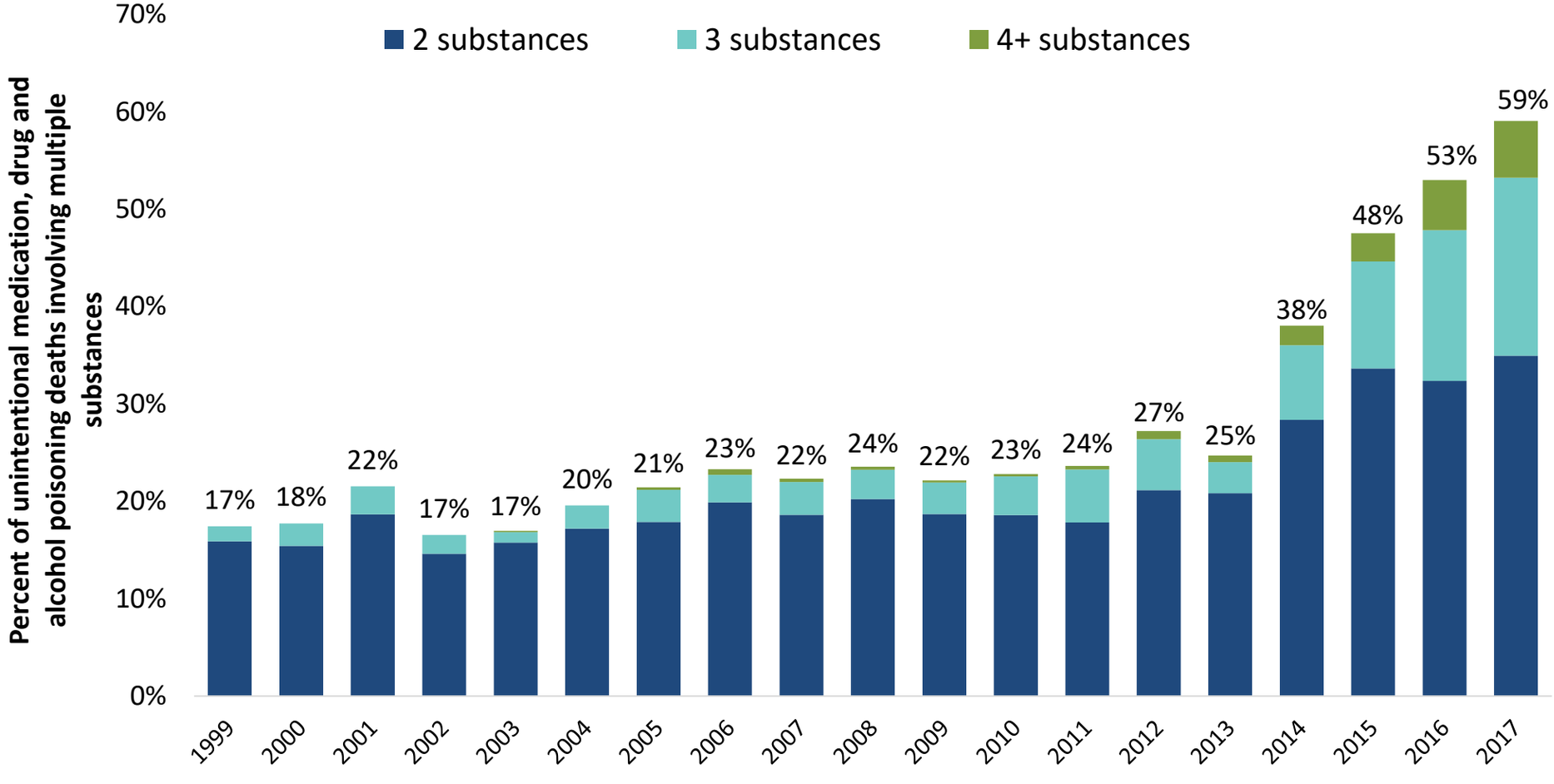
- Increase judicious opioid prescribing and the use of **non-opioid pain treatments.**
- Prevent youth misuse by **addressing the upstream causes** of substance use disorders, including trauma and adverse childhood experiences (ACEs).

Reduce Harm

Over 80% of unintentional opioid overdose deaths now involve illicit opioids.



Most overdose deaths now involve multiple substances.



STIGMA KILLS PEOPLE

Reduce Harm: Plan Priorities

- Prevent overdoses by reducing the harms associated with drug use through **expansion of syringe exchange programs and naloxone access.**
- Focus on **non-medical drivers of health** for people with substance use disorders and **eliminate stigma.**

Connect to Care

AN ESTIMATED **89% OF PEOPLE DON'T RECEIVE** THE SUBSTANCE USE DISORDER TREATMENT THEY NEED.

PEOPLE ARE **40 TIMES MORE LIKELY TO DIE OF AN OVERDOSE** IN THE TWO WEEKS POST INCARCERATION THAN THE GENERAL POPULATION.

Connect to Care: Plan Priorities

- Expand **access to treatment and recovery supports** by piloting an alternative payment model, developing low-threshold buprenorphine guidelines, and training the next generation of doctors to provide substance use disorder treatment.
- Address the needs of high-risk populations including **justice-involved persons.**

STRATEGIES

Prevent: Reduce the supply of prescription and illicit opioids

Increase the use of opioid-sparing pain treatment

- Increase adoption of model safe opioid prescribing policies in hospitals and health systems.
- Identify and educate high opioid prescribers on safe opioid prescribing practices.
- Develop provider trainings on multi-modal evidence-based pain treatment for different populations including the elderly and people with substance use disorders.

Use the Controlled Substances Reporting System (CSRS) to reduce opioid overprescribing

- Register 100% of eligible prescribers and dispensers in the CSRS.
- Report data to NC professional boards so they can investigate aberrant prescribing or dispensing of opioids.

Reduce the supply of diverted and illicit opioids

- Provide tools to community coalitions about safe storage and disposal of opioids.
- Conduct trafficking investigation and enforcement to curb the flow of diverted prescription drugs and illicit drugs.

Prevent: Avert future opioid addiction by supporting youth and families

Reduce youth misuse of drugs

- Launch a youth-oriented campaign to reduce drug and medication misuse.
- Identify and disseminate evidence-based curriculum to address mental health needs in youth, including emotional modulation and resiliency.

Prevent trauma, including ACEs, and increase resiliency to trauma

- Increase publicly-funded behavioral healthcare integration, and early identification, screening and referral for social resource needs.
- Prevent Adverse Childhood Experiences (ACEs) and increase resiliency by supporting the NC Perinatal Strategic Health Plan and the NC Early Childhood Action Plan.
- Pilot a new program to address the impact of family substance use on children by working with families with children in foster care or at risk of having children placed out of the home. This program would connect parents to evidence-based substance use disorder treatment, recovery support services, peer support, and other services such as transportation and housing.

Improve prenatal, maternal and infant care for women with substance use disorders

- Train providers who work with pregnant women on substance use disorder treatment, eliminating stigma, and implementing plans of safe care.

Reduce Harm: Advance harm reduction

Increase access to harm reduction services

- Support the creation or expansion of 30 syringe exchange programs, and build the capacity of syringe exchange programs to provide education, testing and referral to care.
- Train health systems and pharmacists to provide and refer people to harm reduction services.

Make naloxone widely available

- Increase the number of naloxone kits distributed to communities with high overdose rates.
- Increase naloxone co-prescribing and dispensing to people who are at risk of an overdose.

Reduce Harm: Address social determinants of health and eliminate stigma

Address determinants of health and eliminate stigma for people who use drugs

- Create a training program on Housing First principles and harm reduction for housing providers, including homeless shelters and emergency housing.
- Convene an advisory council of current and former opioid users and others in recovery to guide Opioid Action Plan components and implementation.
- Expand employment support services for people with substance use disorders, and increase workplace policies and employment assistance programs that support people with substance use disorders.
- Run a stigma reduction education campaign about substance use disorders and people who use drugs.

Connect to Care: Expand access to treatment and recovery supports

Increase coverage of treatment

- Close the Medicaid coverage gap.
- Increase the number of people who receive substance use disorder treatment and recovery supports.
- Pilot alternative payment models that support improved care coordination for patients.

Increase linkages to treatment and recovery supports

- Develop model inpatient, emergency department and discharge policies for people with substance use disorder.
- Support 10 counties in creating post overdose response teams that link overdose victims to treatment and support.
- Increase the number of community-based recovery supports, including community-based recovery supports that are inclusive of medication-assisted treatment (MAT).

Expand treatment capacity and improve treatment quality

- Ensure every medical school in North Carolina provides addiction training to students.
- Incorporate waiver trainings into 25 residencies, nurse practitioners, or physicians assistant training programs, and increase opportunities to work with patients with substance use disorders during training.
- Develop a best practices guide for low-barrier buprenorphine treatment in different healthcare settings.
- Increase buprenorphine dispensing by 20%.
- Explore opportunities to utilizing telehealth and telemedicine to increase rural access to treatment.

Connect to Care: Address the needs of justice-involved populations

Increase pre-arrest diversion of low-level offenders

- Support counties in adopting pre-arrest diversion programs to divert low-level offenders to community-based programs and services.
- Maintain and enhance therapeutic (mental health, recovery and veteran) courts.

Provide overdose prevention education and medication-assisted treatment (MAT) during incarceration and upon release.

- Identify model policies to screen for substance use disorders and connect to overdose prevention education and treatment during incarceration or upon release
- Work with at least six jails to screen for substance use disorders, use FDA-approved medications for treatment, and provide overdose prevention education and connections to care upon release.

Expand supports for people after release

- Train community corrections and Treatment Accountability for Safer Communities (TASC) offices on substance use disorders and connecting to naloxone, harm reduction resources and treatment.
- Increase education opportunities for those with criminal history by working with institutions of higher education to not screen people out based on criminal records alone.
- Reduce barriers to employment for those with a criminal history, and provide information on education options, career paths and licensures that are available to people with different classes of convictions.

Track and Measure: Track progress and measure our impact

Improve data infrastructure

- Improve publicly accessible data dashboard of key metrics for data dissemination to monitor impact of this plan based on stakeholder feedback.
- Create data warehouse of aggregate opioid data to facilitate data collaborations and external sharing with data partners.
- Create a case definition for overdose clusters to alert EMS, law enforcement, health care providers and others.
- Establish a standardized data collection system to track law enforcement, EMS, and community administered naloxone reversal attempts.

Research and evaluation

- Continue the opioid research consortium of state agencies and research institutions, and use the research agenda to inform future work and evaluate existing work.

Track outcome data

- Continue to track key metrics.

Track progress and measure our impact

To track our progress in combatting the epidemic, North Carolina will monitor these 12 metrics as part of the North Carolina's Opioid Action Plan 2.0.

Metrics*	2016	2017	2018
Track progress and measure our impact			
Number of unintentional opioid-related deaths of NC Residents (ICD-10)	1,407	1,884	Data pending^
Number of ED visits that received an opioid overdose diagnosis (all intents)	5,546	7,455	6,772
Reduce the supply of prescription and illicit opioids			
Total number of opioid pills dispensed	580,144,900	530,604,800	453,977,900
Percent of opioid deaths involving heroin or fentanyl/fentanyl analogues	59%	75%	80%
Prevent overdoses by advancing harm reduction, reducing stigma, and addressing non-medical drivers of health			
Number of community naloxone reversals	3,684	4,176	3,943
Number of newly-diagnosed acute hepatitis C cases	203	188	185
Raise community awareness and increase community prevention and response efforts			
Percent of children in foster care due to parental substance use disorder	37%	39%	42%
Number of hospitalizations associated with drug withdrawal in newborns	1,278	1,392	Data pending
Expand access to treatment and recovery supports			
Number of buprenorphine prescriptions dispensed	478,744	568,233	637,840
Number of uninsured individuals and Medicaid beneficiaries with an opioid use disorder served by treatment programs	28,968	31,758	34,310
Address the needs of justice-involved populations			
Number of law enforcement agencies carrying naloxone	136	193	252
Number of opioid overdoses deaths among recently released population	Data Pending	Data Pending	Data Pending

***Data are continually updated as additional cases, visits, claims, and other data points are finalized in each system.**

Getting It Done

Legislatively mandated by SL-2015-241.

The **Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC)** serves as the primary convening group to advance this work.

OPDAAC members represent a wide variety of agencies and fields including but not limited to: local health departments, healthcare organizations, law enforcement, substance abuse prevention, the recovery community, mental health treatment, harm reduction, emergency medicine, regulatory boards.

All are welcome to join the OPDAAC.

For more information, visit our website.

Getting It Done

To respond to this epidemic, it is critical that we support local stakeholders in responding to the epidemic in their communities.

The **Menu of Local Actions** identifies impactful strategies that can be implemented at the local level and provides information and resources on each strategy.

Local stakeholders can select strategies from the menu based on the needs and resources of their community.

The menu will continue to be updated with information and resources as more become available.

SIMPLE SCREENING INSTRUMENT FOR INFECTIOUS TUBERCULOSIS (TB)

	Yes	No	Comments
1. Has it been more than three (3) months since you've seen a doctor or health care provider?			
2. Have you or do you now live in a shelter or on the street?			
3. Have you been in jail or prison in the past year?			
4. Has it been more than one (1) year since you've had a TB skin test? What were the results?			
5. Have you ever been told you have TB?			
6. Have you ever been treated for TB?			
7. Within the past thirty (30) days have you had any of the following symptoms for two (2) or more weeks: • Fever			
• Drenching night sweats			
• Productive cough			
• Coughing up blood			
• Shortness of breath			
• Lumps or swollen glands in the neck or armpits			
• Unexplained weight loss			
• Diarrhea lasting more than a week			
8. Has anyone you know or lived with been told they have TB in the past year?			
9. Do you live with anyone who has had either of these symptoms: coughing up blood or drenching night sweats?			

_____ _____

Signature Date

SIMPLE SCREENING INSTRUMENT FOR INFECTIOUS TUBERCULOSIS (TB) - GUIDANCE

The following questions in this screening instrument are worded so that an answer of "yes" may indicate an increased risk of infection of tuberculosis. Referral to a local health department should be made when an increased risk is identified. Following each question is background information pertaining to the question and the rationale for its conclusion.

1. Has it been more than three (3) months since you've seen a doctor or other health care provider?
(This question is a lead-in intended to put the interviewee at ease.)

2. Have you or do you now live in a shelter or on the streets?
(This question is asked because there is an increase in the incidence of TB among homeless individuals that is related to their crowded conditions and limited access to medical care.)

3. Have you been in jail or prison in the past year?
(In certain areas, there is an increased risk of TB exposure among individuals who have been incarcerated. This is related to crowded conditions and to the common occurrence of sexual assault among prison inmates).

4. Has it been more than one (1) year since you had a TB skin test?
(This question is intended to identify individuals with latent TB who are, as a consequence, at risk for active TB. Although most individuals with positive TB skin tests do not have active TB, individuals in outreach populations who have been screened previously and found to have positive skin tests should be referred for evaluation to determine whether they have active TB or should receive preventive chemotherapy).

5. Have you ever been told you have TB?
(This question is intended to identify individuals with TB who are not already in contact or have fallen out of touch with their treatment facility. In the non HIV- infected population, the highest risk of developing active TB occurs within the first year after exposure and infection. In the HIV-infected population, however, development of active disease does not diminish dramatically with subsequent years.)

6. Have you ever been treated for TB?
(This question is intended to determine if an individual has ever tested positive for and been treated for active TB.)

7. Within the last 30 days, have you had any of the following symptoms for two (2) or more weeks: fever; drenching night sweats that were so bad you had to change your clothes or the sheets on the bed; productive cough; coughing up blood; shortness of breath; lumps or swollen glands in the neck or armpits; losing weight without meaning to; diarrhea lasting more than a week?
(Although the first four symptoms above are common among individuals with active TB, they are nonspecific and are also consistent with other diagnoses, including bacterial pneumonia, acute bronchitis, cancer of the lung, HIV-related lung disease and others. Other symptoms include lumps or swollen glands in the neck or armpits, which may be present in individuals with extrapulmonary TB or AIDS-related conditions. Unintentional weight loss may identify individuals with latent or active TB or HIV infection; these are very nonspecific symptoms however, and multiple other diagnoses are possible. Diarrhea lasting more than a week may identify persons with HIV infection but is also nonspecific).

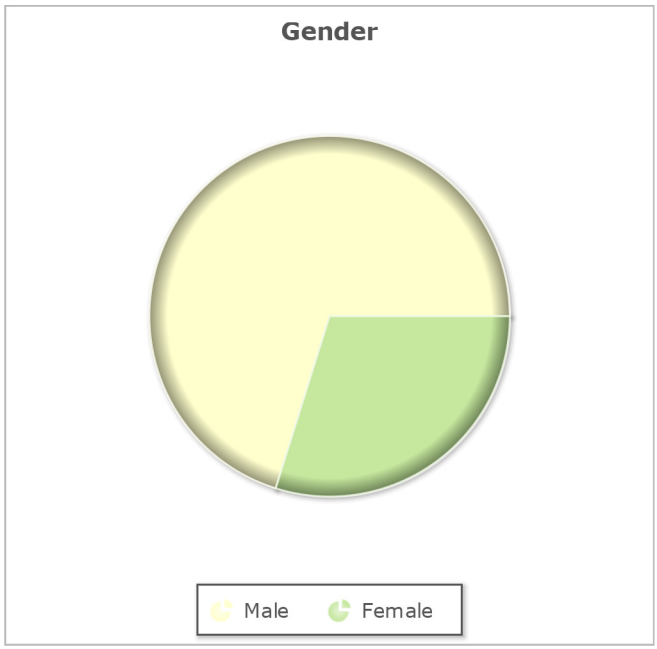
8. Has anyone you know or lived with been told they have TB in the past year?
(This question is intended to identify individuals who may be in contact with someone who has TB.)

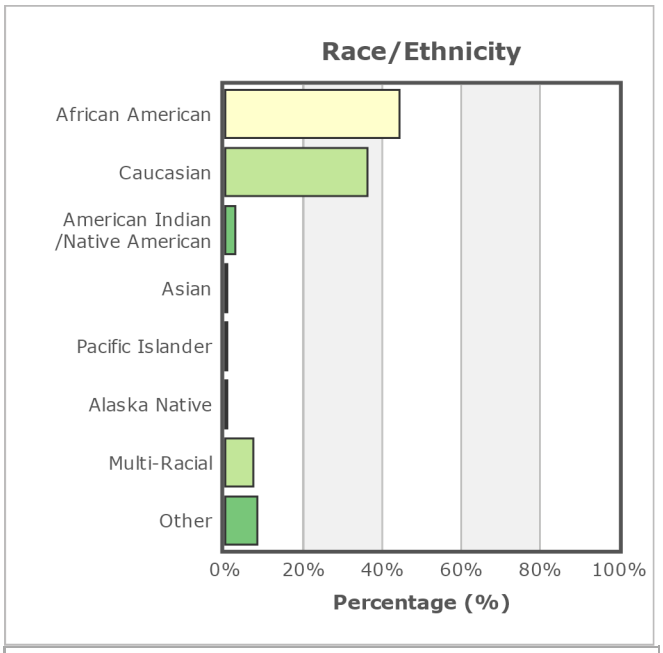
9. Do you live with anyone who has had either of these symptoms: coughing up blood or drenching night sweats?
(This question is intended to identify individuals who have been in contact with someone who has TB and who thereby have an increased risk of developing latent or active TB. These symptoms have been selected from those in number 7 as being somewhat more specific and more likely to indicate a high degree of infectious risk).

NC-TOPPS Simple Query Report

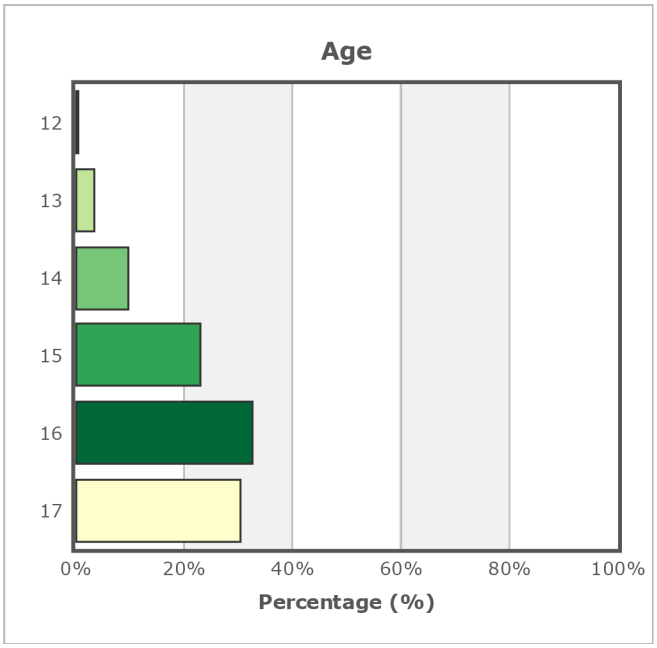
Alliance Health
Cardinal Innovations
Eastpointe
Partners Behavioral Health Management
Sandhills
Trillium Health Resources
Vaya Health
Adolescent Substance Use Disorder Consumers
Episode Completion Interviews started *Saturday, July 1, 2017* through *Saturday, June 30, 2018*
Number of Episode Completion Interviews: 1,056

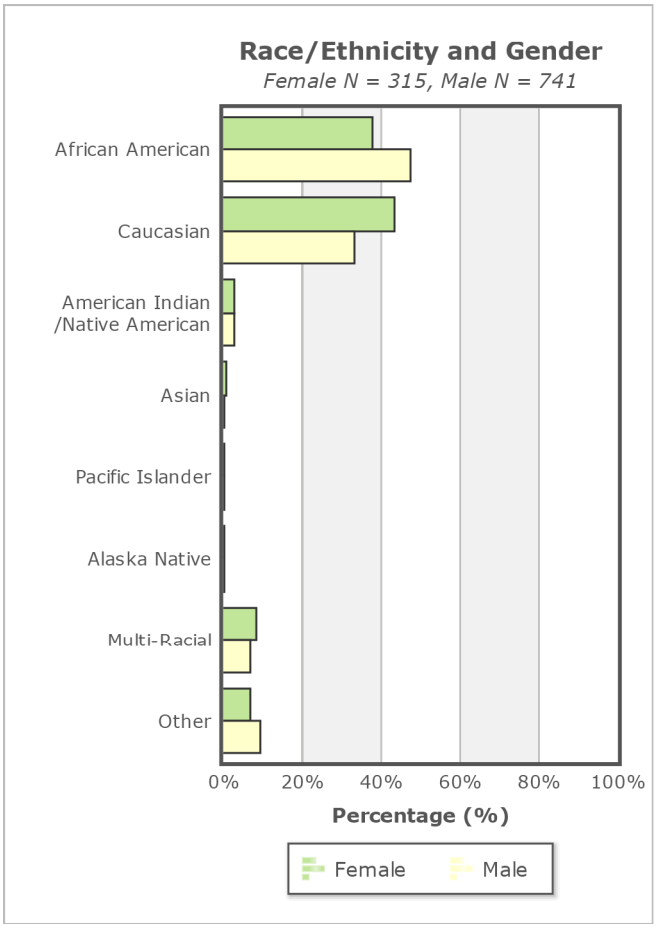
Demographics

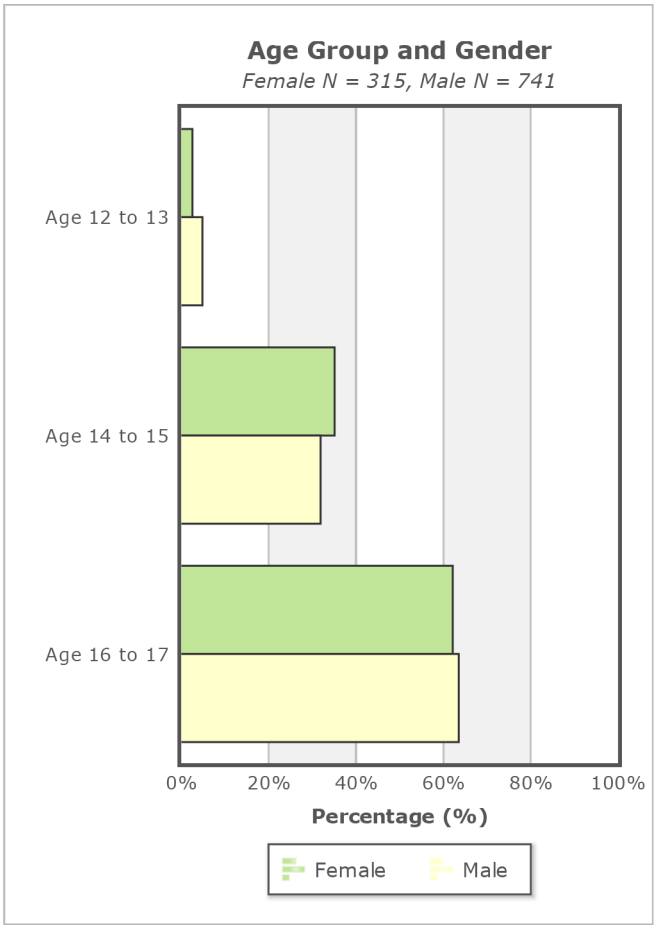




139 *(13.2%)* consumer(s) indicate that they are of Hispanic, Latino, or Spanish origin.


Age
12
13
14
15
16
17
0%
20%
40%
60%
80%
100%
Percentage (%)


Race/Ethnicity and Gender
Female N = 315, Male N = 741
African American
Caucasian
American Indian /Native American
Asian
Pacific Islander
Alaska Native
Multi-Racial
Other
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male


Age Group and Gender
Female N = 315, Male N = 741
Age 12 to 13
Age 14 to 15
Age 16 to 17
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male

Services

Periodic Services	Initial	EC
90832-90838 - Psychotherapy	23.1%	21.6%
90846 - Family Therapy without Patient	3.1%	3.5%
90847 - Family Therapy with Patient	10.2%	10.7%
90849 - Group Therapy (multiple family group)	4.5%	4.2%
90853 - Group Therapy (non-multiple family group)	15.2%	15.0%
H0004 - Behavioral Health Counseling - Individual Therapy	9.2%	9.8%
H0004 HQ - Behavioral Health Counseling - Group Therapy	6.7%	7.5%
H0004 HR - Behavioral Health Counseling - Family Therapy with Consumer	3.7%	3.8%
H0004 HS - Behavioral Health Counseling - Family Therapy without Consumer	0.3%	0.3%
YP831 - Behavioral Health Counseling (non-licensed provider)	0.0%	0.0%
YP832 - Behavioral Health Counseling - Group Therapy (non-licensed provider)	0.3%	0.3%
YP833 - Behavioral Health Counseling - Family Therapy with Consumer (non-licensed provider)	0.7%	0.8%
YP834 - Behavioral Health Counseling - Family Therapy without Consumer (non-licensed provider)	0.2%	0.2%
H0005 - Alcohol and/or Drug Group Counseling	10.2%	10.1%
YP835 - Alcohol and/or Drug Group Counseling (non-licensed provider)	1.7%	2.3%

Community Based Services	Initial	EC
H0015 - Substance Abuse Intensive Outpatient Program (SAIOP)	22.6%	23.0%
H2022 - Intensive In-Home Services (IIH)	14.9%	15.2%
H2033 - Multisystemic Therapy Services (MST)	10.8%	11.6%
H2035 - Substance Abuse Comprehensive Outpatient Treatment (SACOT)	0.5%	0.6%
YP630 - Individual Placement and Support (IPS) Supported Employment	0.0%	0.0%
H2023 U4 - Supported Employment	0.0%	0.0%
H2026 U4 - Ongoing Supported Employment	0.0%	0.1%

Facility Based Day Services	Initial	EC
H0035 - Mental Health - Partial Hospitalization	0.4%	0.3%
H2012 HA - Child and Adolescent Day Treatment	8.0%	9.0%

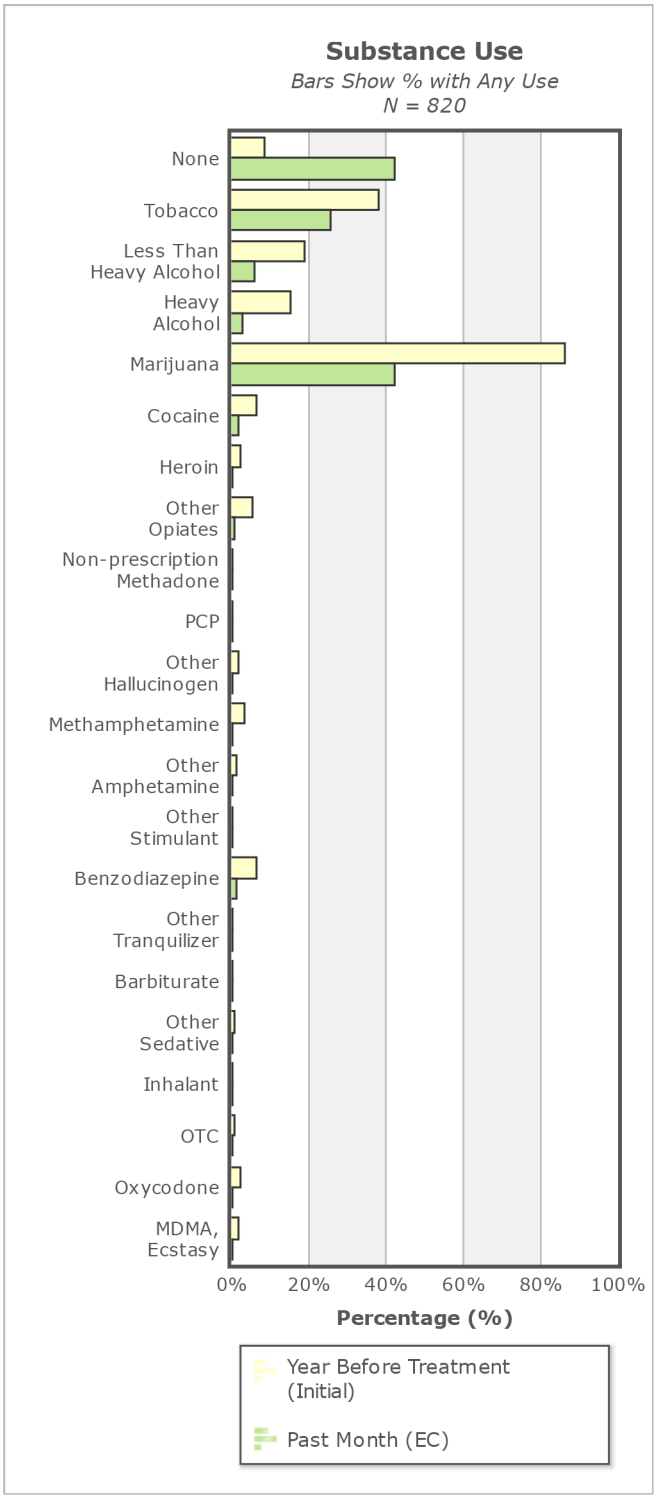
Residental Services	Initial	EC
H0013 - SA Medically Monitored Community Residential Treatment	2.5%	2.7%
H0019 - Behavioral Health - Long Term Residential	0.5%	0.9%
H2020 - Residential Treatment - Level II - Program Type (Therapeutic Behavioral Services)	0.7%	0.5%
YA230 - Psychiatric Residential Treatment Facility	2.2%	2.1%
YP780 - Group Living - High	3.0%	3.2%

Opioid Services	Initial	EC
H0020 - Opioid Treatment	0.0%	0.1%

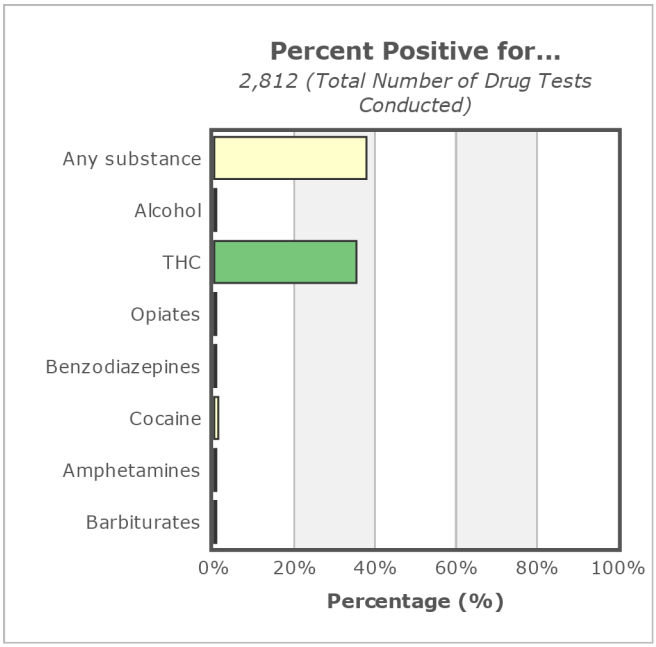
Therapeutic Foster Care Services	Initial	EC
S5145 - Residential Treatment - Level II - Family Type (Foster Care Therapeutic Child)	1.0%	1.2%

Other Services	Initial	EC
Other	5.9%	6.3%

Substance Use

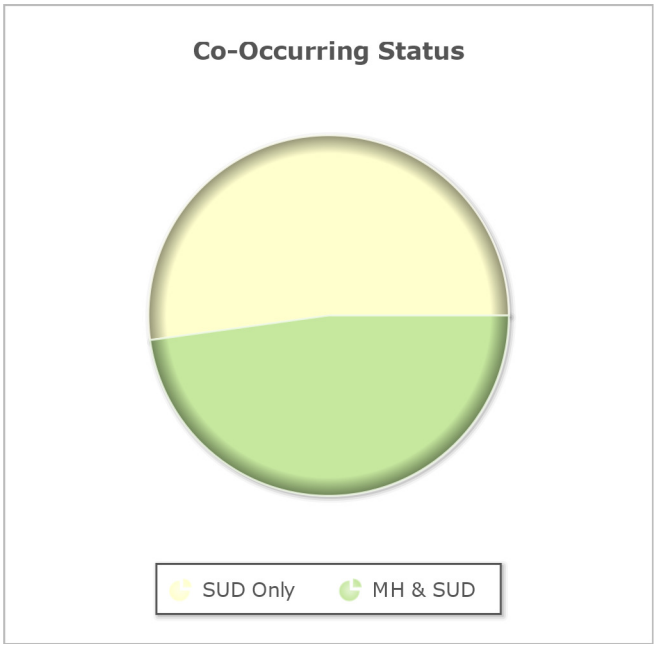


Drug Test Results N = 820	Past 3 Months (EC)
Number of Consumer(s) Tested	520
Percent of Consumer(s) Tested	63.4%
Average # of Tests for Each Consumer Tested	5.4



Needles Used To Inject Drugs, Non-Medically N = 493	
Needle Use Past 3 Months	0.6%

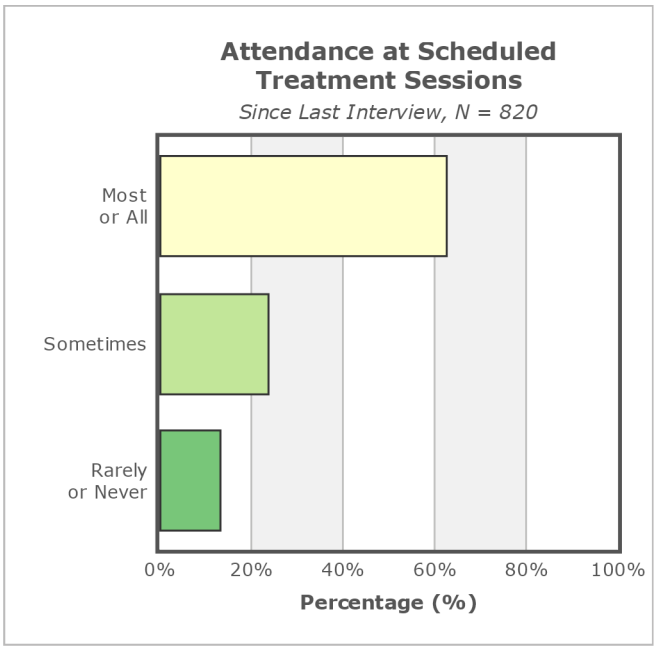
Treatment Demographics

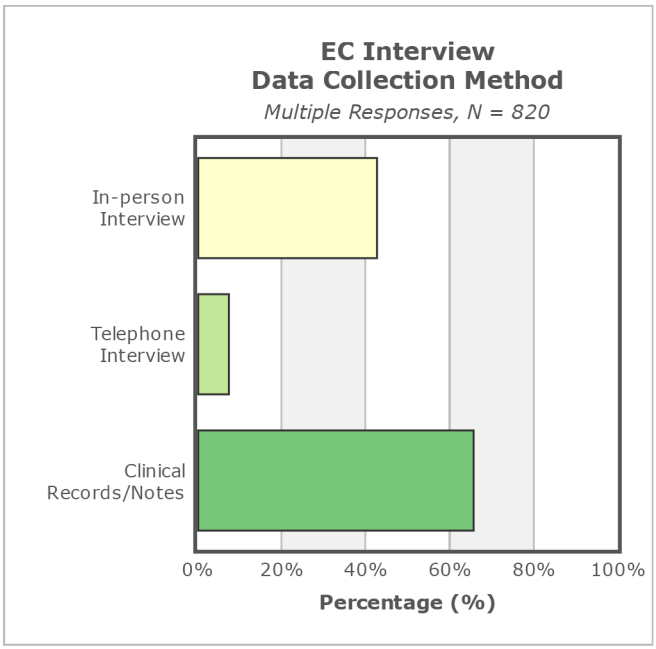


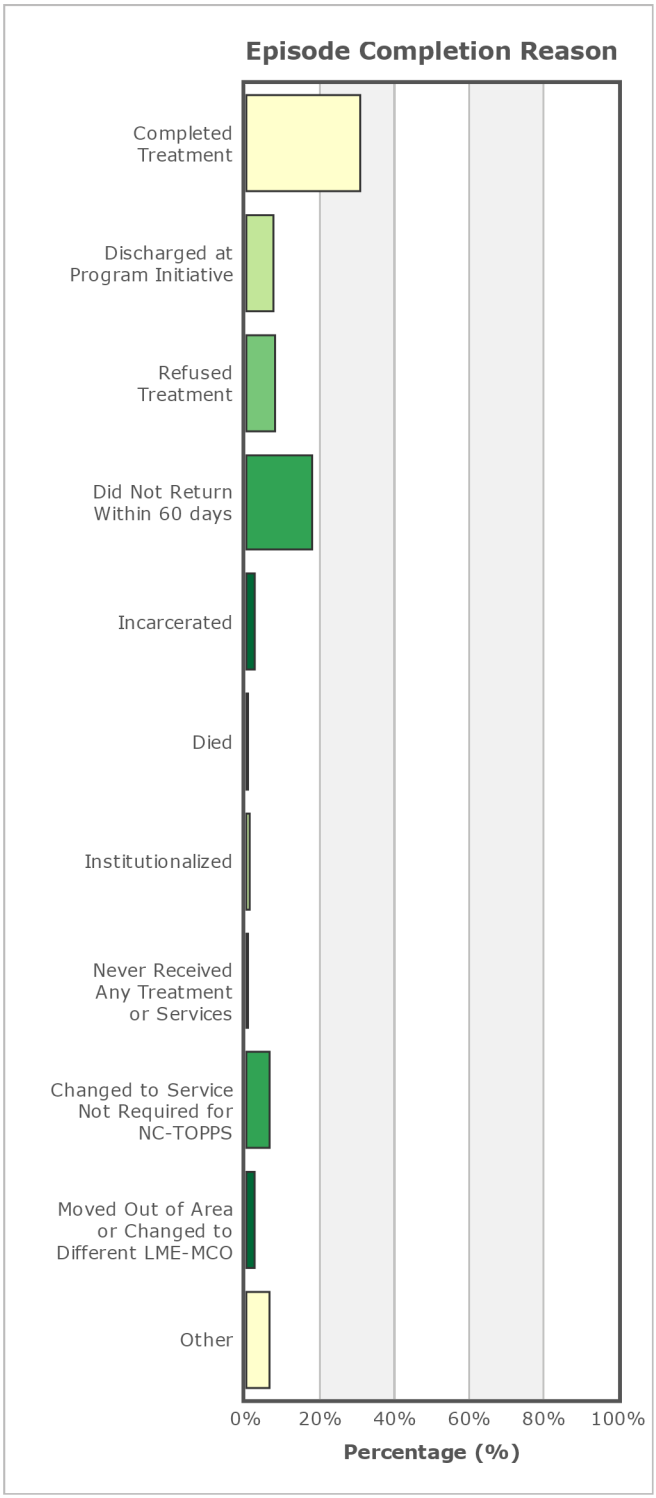
DSM-IV/DSM 5 Diagnoses Diagnostic Category N = 820	
Drug Dependence (DSM-IV)	0.0%
Alcohol Dependence (DSM-IV)	0.0%
Drug Abuse (DSM-IV)	0.0%
Alcohol Abuse (DSM-IV)	0.0%
Drug-Related Disorders (DSM 5)	82.6%
Alcohol-Related Disorders (DSM 5)	12.1%
Oppositional Defiant Disorder	24.5%
Conduct Disorder	17.0%
Attention Deficit Disorder	18.7%
Bipolar Disorders	3.9%
Depression	9.3%
Disruptive Behavior	4.5%
PTSD	8.8%

* Only most commonly diagnosed conditions shown.

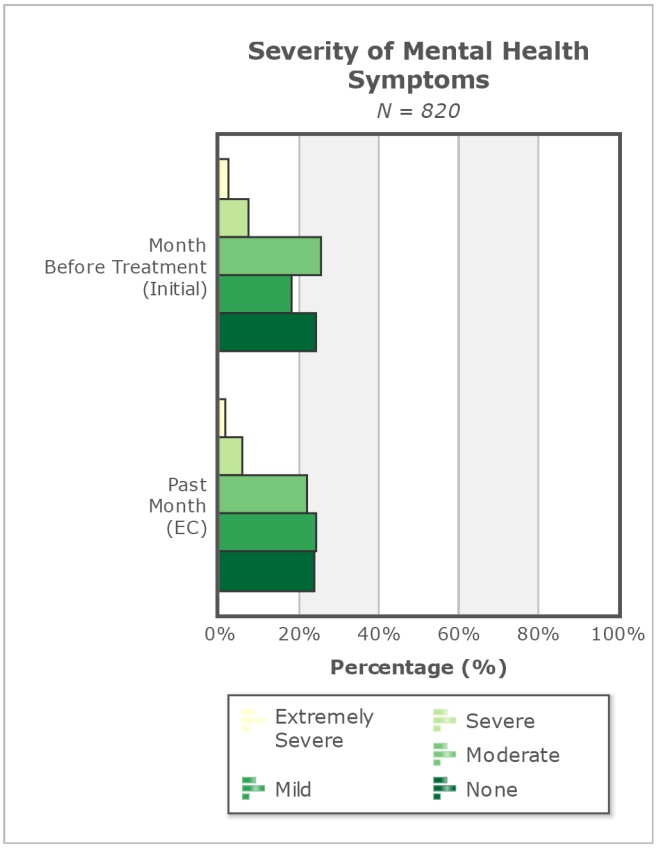
Family Involvement with... N = 820	
Treatment Services	81.1%
Person-centered Planning	64.0%
None	14.0%

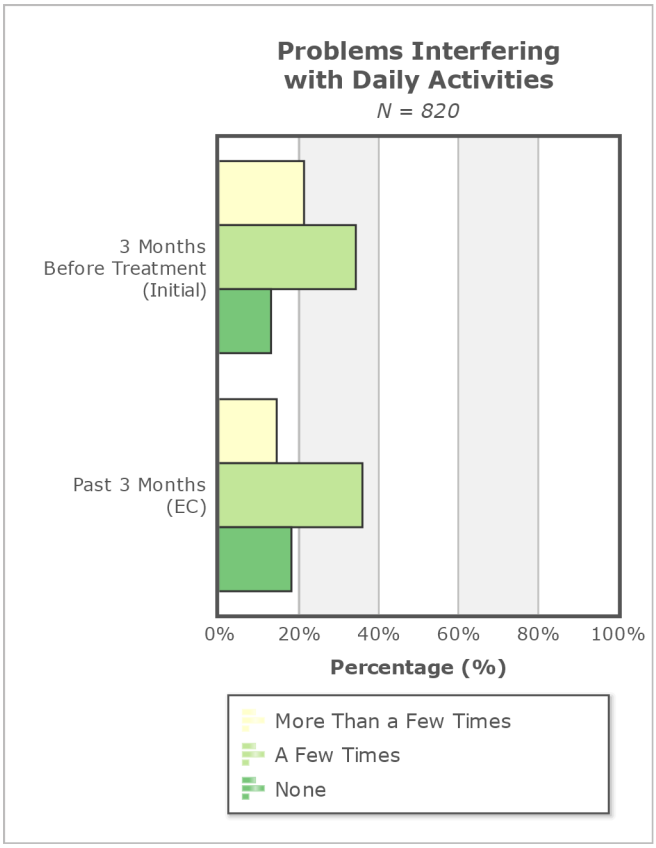




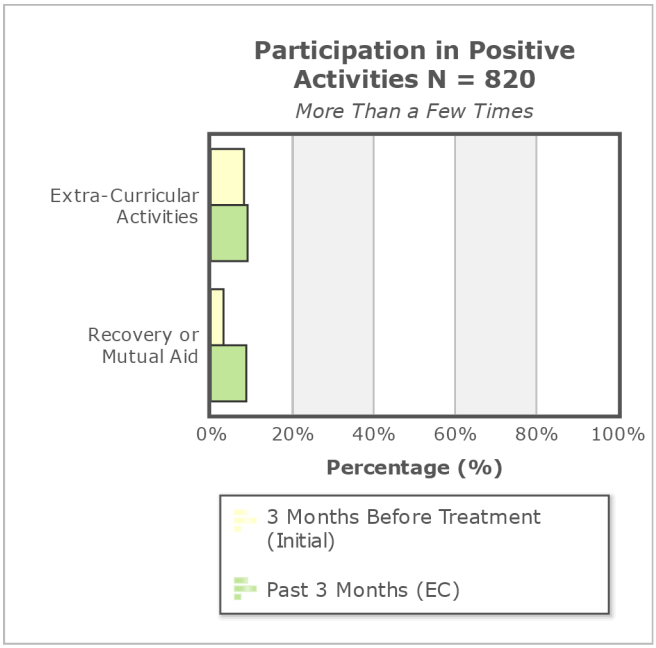

Episode Completion Reason
Completed Treatment
Discharged at Program Initiative
Refused Treatment
Did Not Return Within 60 days
Incarcerated
Died
Institutionalized
Never Received Any Treatment or Services
Changed to Service Not Required for NC-TOPPS
Moved Out of Area or Changed to Different LME-MCO
Other
0%
20%
40%
60%
80%
100%
Percentage (%)

Behaviors





Consumer Ratings on Quality of Life % Rated 'Excellent' or 'Good' N = 493		
	Year Before Treatment (Initial)	**Past 3 Months (EC)**
Emotional Well-Being	64.3%	73.8%
Physical Health	86.0%	91.3%
Family Relationships	64.5%	71.8%
Living/Housing Situation	78.7%	82.4%



Support for Recovery N = 493		
	Initial	**EC**
Have Positive Adult Role Model(s)	95.5%	98.6%
	Expect Support (Initial)	**Received Support (EC)**
Family and/or Friends Somewhat or Very Supportive	98.0%	99.0%

Experienced Abuse N = 493		
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Physical Violence Experienced	19.1%	10.8%
Hit/Physically Hurt Another Person	27.0%	15.8%

Justice System Involvement
N = 820
401 *(48.9%)* consumer(s) were under supervision at the time of their EC interview.

	Month Before Treatment (Initial)	Past Month (EC)
Arrests N = 820	12.1%	8.9%
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Nights in Jail or Detention N = 493	17.8%	7.3%

Suicide Ideation and Hurting Self
N = 493

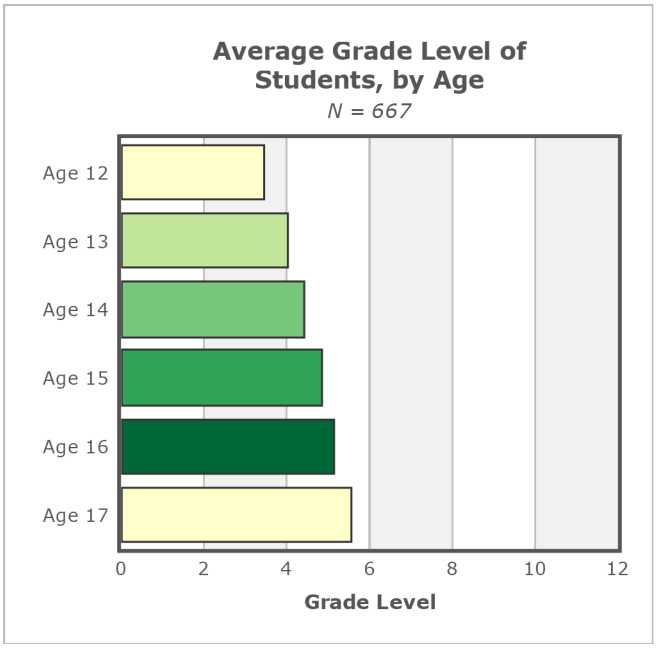
	Ever (Initial)	Since Last Interview (EC)
Suicidal Attempts	17.2%	2.0%
	3 Months Before Treatment (Initial)	**Since Last Interview (EC)**
Suicidal Thoughts	15.4%	6.5%
Tried to Hurt or Cause Self Pain	9.9%	3.0%

Psychotropic Medications at EC
288 *(35.1%)* consumer(s) have had a prescription for psychotropic medications in the past month. Of those, 207 *(71.9%)* take their medication as prescribed all or most of the time.

Education

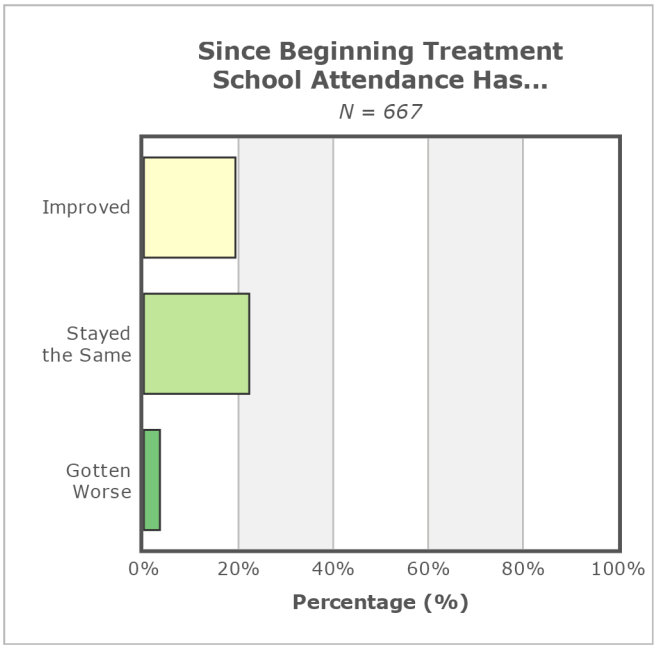
Enrollment in Academic Programs N = 820		
	Initial Interview	EC Interview
Enrolled in Any Academic Program	92.3%	86.1%
Not Enrolled in Any Academic Program	7.7%	13.9%

Of Those Enrolled in Academic Programs Note: Multiple Responses		
Enrolled in...	Initial Interview	EC Interview
N	**757**	**706**
Academic Schools (K-12)	79.8%	77.8%
Alternative Learning Program (ALP)	17.4%	17.4%
Technical or Vocational School	0.0%	0.6%
GED or Adult Literacy	0.5%	3.0%
College	0.1%	0.0%
Other Academic Program	2.8%	2.3%

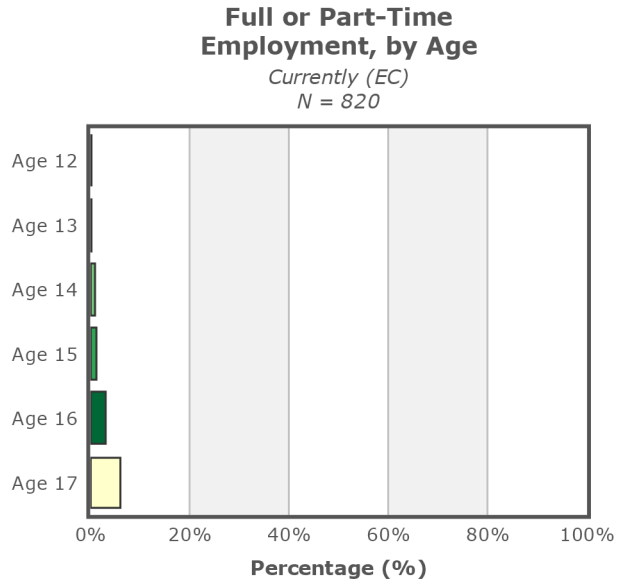


Students Who Received Mostly A's, B's, and C's at Most Recent Grading Period		
	Initial Interview	EC Interview
N	**731**	**667**
Received Mostly A's, B's, and C's	70.3%	76.2%

School Suspension and Expulsion		
	3 Months Before Treatment (Initial)	Currently (EC)
N	**731**	**667**
Suspension	41.5%	25.5%
Expulsion	6.3%	2.4%



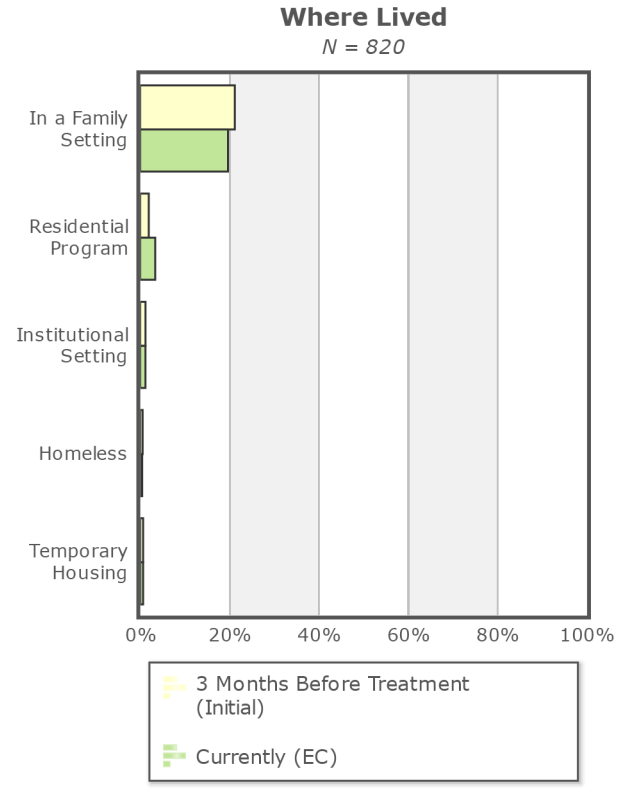
Employment/Housing



Job Classification	Initial N = 73	EC N = 73
Professional, Technical, or Managerial	0.0%	0.0%
Clerical or Sales	1.4%	0.0%
Service Occupation	53.4%	68.5%
Agricultural or Related Occupation	4.1%	2.7%
Processing Occupation	0.0%	1.4%
Machine Trades	0.0%	1.4%
Bench Work	0.0%	0.0%
Structural Work	9.6%	12.3%
Miscellaneous Occupation	31.5%	13.7%

Employee Benefits	Initial N = 73	EC N = 73
Insurance	0.0%	0.0%
Paid Time Off	1.4%	0.0%
Meal/Retail Discounts	9.6%	19.2%
Other	1.4%	2.7%
None	87.7%	78.1%

Rate of Pay	Initial N = 73	EC N = 73
Above Minimum Wage	46.6%	45.2%
Minimum Wage	45.2%	50.7%
Below Minimum Wage	8.2%	4.1%



Times Moved Residences Past 3 Months (EC) N = 820	
No Moves	81.2%
Moved Once	14.3%
Moved Two or More Times	4.5%

Number Living in Special Circumstances		
Where Lived Most of Time	**3 Months Before Treatment (Initial)**	**Currently (EC)**
Homeless Sheltered	2	2
Homeless Unsheltered	4	1
Therapeutic Foster Home	3	4
Level III Group Home	21	29
Level IV Group Home	6	3
State Residential Treatment Center	9	1
SA Residential Treatment Center	5	46
Halfway House	0	0
Other	10	22
Total Living in Special Circumstances	**60**	**108**
--Of the Total, Number in Home Community	17	15

Homeless Nights, Currently (EC)
Among 493 consumer(s), 6 *(1.2%)* consumer(s) reported night(s) homeless.

Service Needs

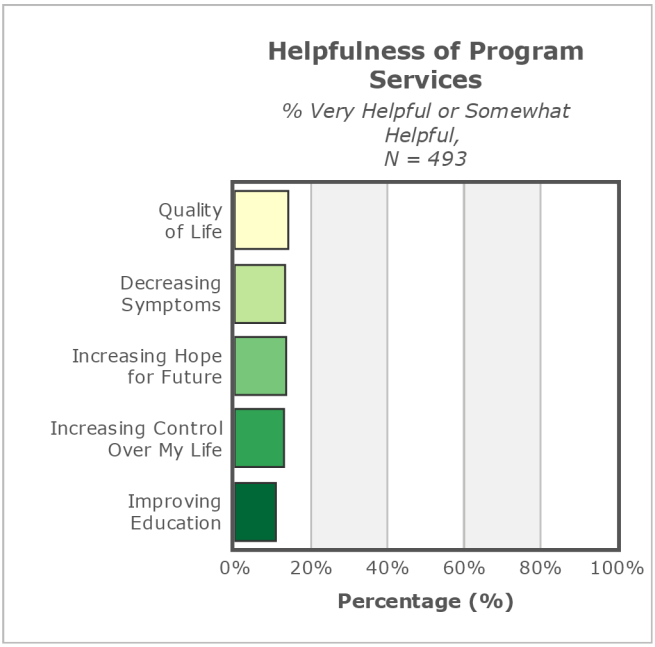
Services Deemed Important at Initial and Received at EC Multiple Responses, N = 820		
	Initial	**EC**
Education	57.6%	56.3%
Job	21.5%	11.5%
Housing	7.4%	6.5%
Transportation	9.5%	10.1%
Child Care	1.5%	0.5%
Medical	8.9%	12.3%
Dental	7.9%	3.7%
Screening/Treatment Referral for HIV/TB/HEP	N/A	4.4%
Legal	32.9%	37.9%
Volunteer Opportunities	5.6%	6.8%
None	27.1%	30.4%

Barriers to Treatment Multiple Responses, N = 820		
	Initial	**EC**
No Difficulties	78.5%	64.3%
Active MH Symptoms	2.2%	5.1%
Active SA Symptoms	3.8%	7.9%
Physical Health	0.1%	0.7%
Family Issues	1.6%	6.3%
Needs Not Met	0.4%	1.1%
Engagement	4.0%	13.7%
Cost	0.5%	0.6%
Stigma /Discrimination	0.1%	0.0%
Treatment /Auth. Access	1.2%	1.0%
Deaf/Hard of Hearing	0.0%	0.0%
Language/Comm.	0.6%	0.4%
Legal Reasons	2.0%	3.7%
Transportation	10.1%	11.7%
Scheduling Issues	3.2%	4.4%
Lack of Stable Housing	0.2%	1.8%
Personal Safety	0.0%	0.9%

Crisis/Hospital Care Past 3 Months N = 493		
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Crisis Contacts	10.1%	6.5%
ER Visits	16.0%	9.5%
Medical/Surgical Hospital Nights	4.3%	1.8%
Psychiatric Inpatient Hospital Nights	11.4%	3.7%

Routine Health Care
Among 493 consumer(s), 174 *(35.3%)* have seen their provider for a routine check-up since the last interview.

Routine Dental Care
Among 493 consumer(s), 103 *(20.9%)* have seen their dentist for a routine check-up since the last interview.



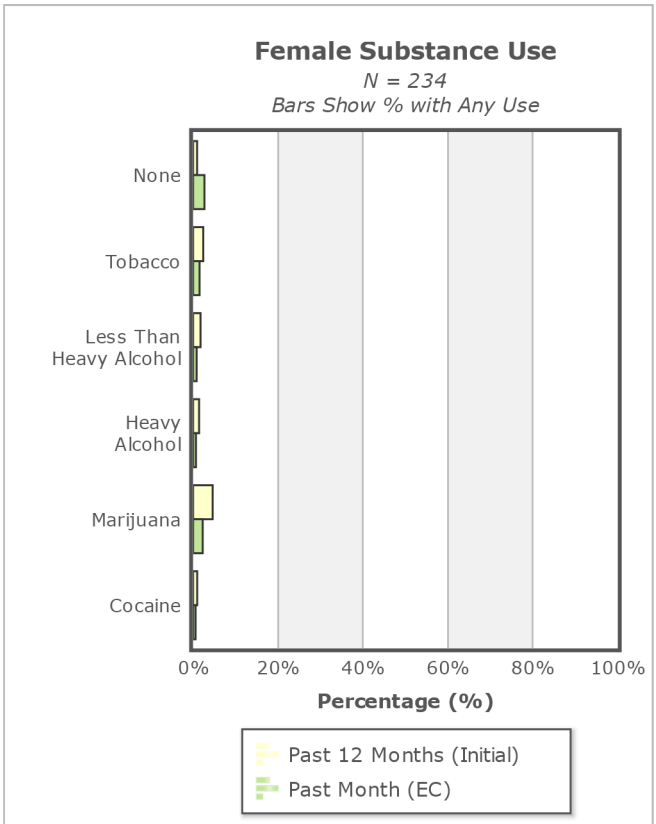
Maternal/Perinatal

Female Substance Use Consumers
Several questions on the NC-TOPPS interview are asked only to female consumers. The tables and charts on this page show the results for those questions. In addition, several other charts are shown for females only. The number of female consumer(s) is 315 *(29.8%)*.

0.0% of 234 female consumer(s) were admitted to a Maternal/Pregnant Program.

Pregnancy ***Female N = 151***	**Number**
Gave Birth in Past Year	1
Currently Pregnant	1
Uncertain about Pregnancy Status	2
In First Trimester*	0
In Second Trimester*	1
In Third Trimester*	0
Referred to Prenatal Care*	1
Receiving Prenatal Care*	1

* of those who are pregnant.



Females with Children Under 18
Of the 315 female consumer(s), 6 *(1.9%)* have children under the age of 18.

DSS Involvement Since Last Interview Among Females with Children Under 18 N = 6	
Investigated by DSS for Child Abuse/Neglect	0.0%

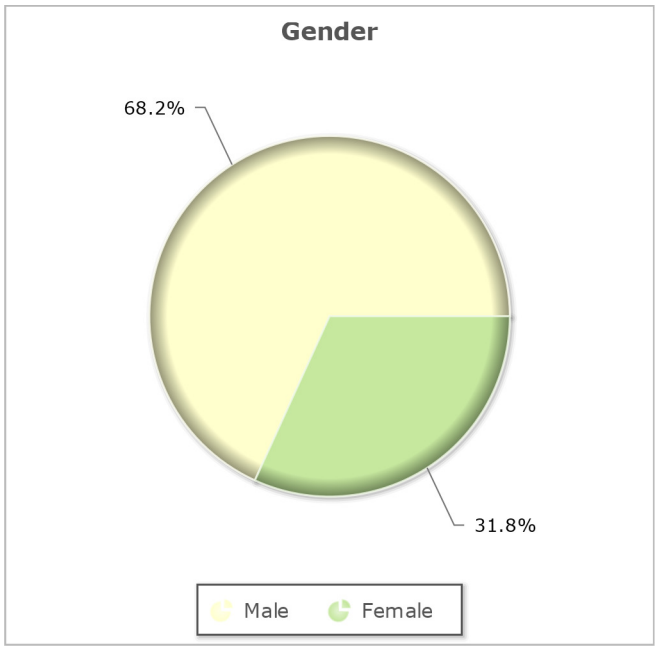
Females Experienced Abuse Past 3 Months N = 151	
Physical Violence	12.6%
Hit/Physically Hurt Another Person	15.9%

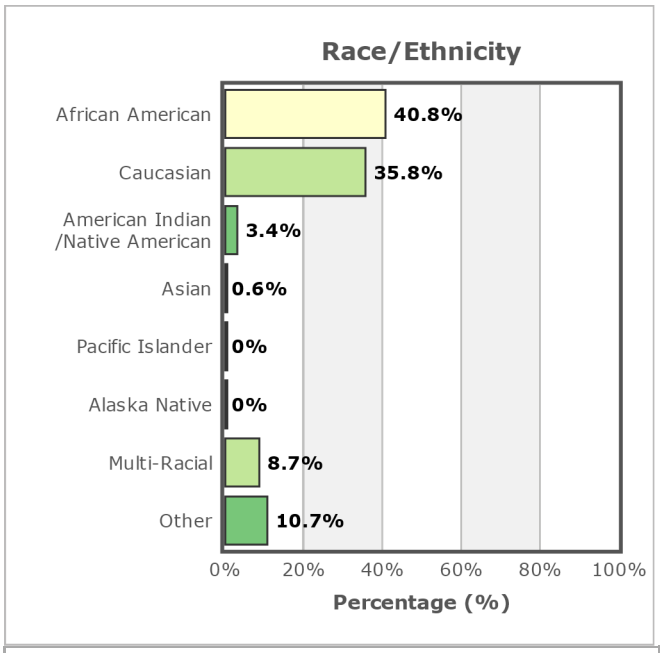
Suicide Ideation and Hurting Self, Since Last Interview Among Females N = 151	
Suicidal Attempts	3.3%
Suicidal Thoughts	11.9%
Tried to Hurt or Cause Self Pain	6.6%

NC-TOPPS Simple Query Report

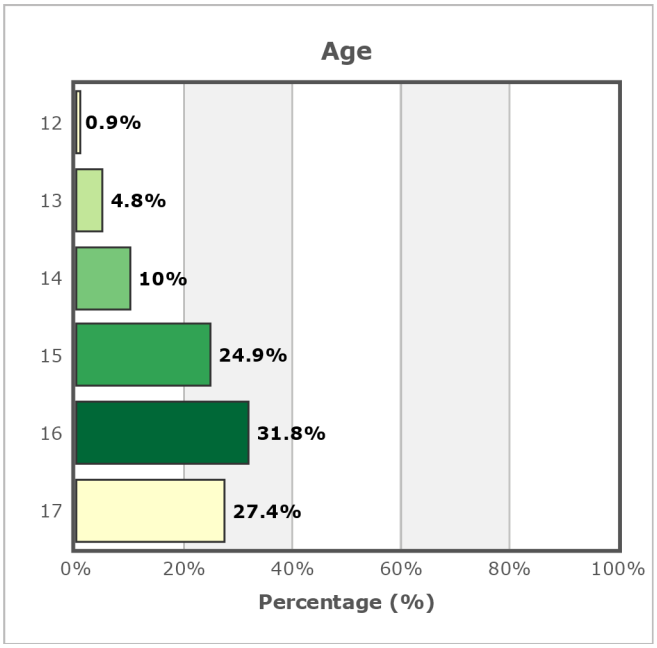
Alliance Health
Cardinal Innovations
Eastpointe
Partners Behavioral Health Management
Sandhills
Trillium Health Resources
Vaya Health
Adolescent Substance Use Disorder Consumers
Episode Completion Interviews started *Sunday, July 1, 2018* through *Sunday, June 30, 2019*
Number of Episode Completion Interviews: 978

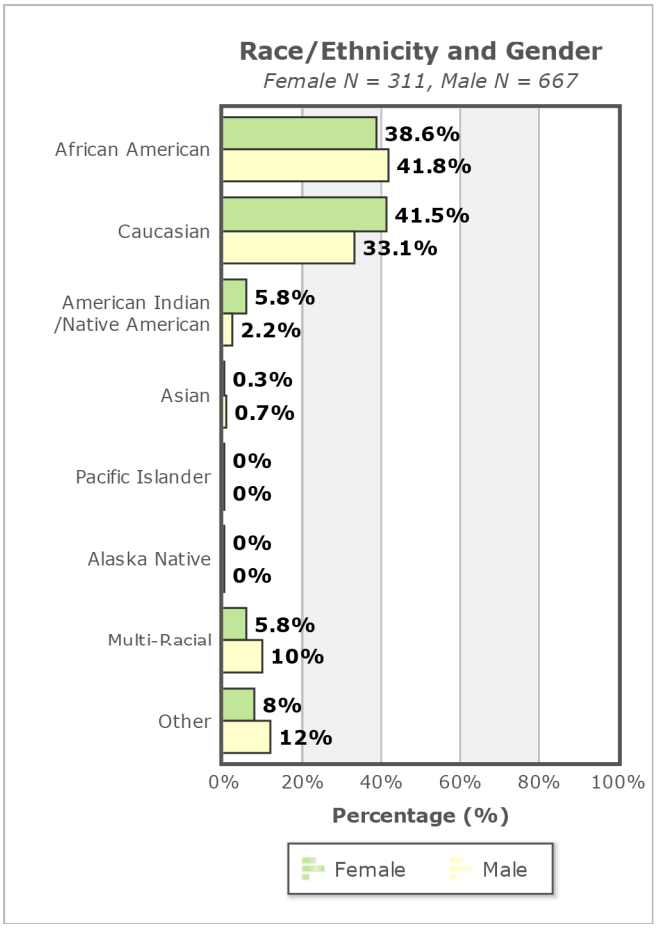
Demographics

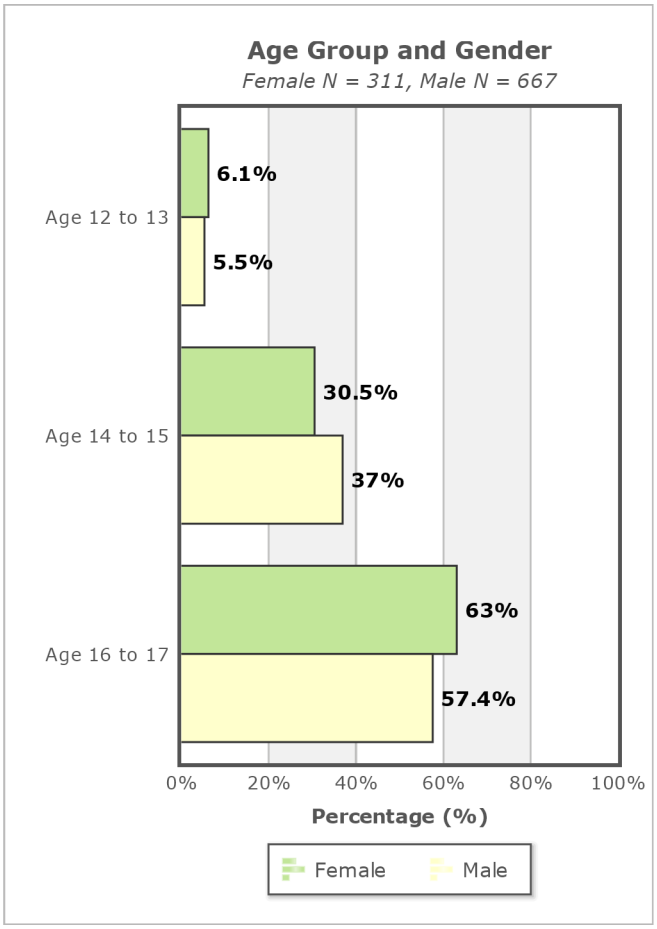




154 *(15.7%)* consumer(s) indicate that they are of Hispanic, Latino, or Spanish origin.


Age
12
0.9%
13
4.8%
14
10%
15
24.9%
16
31.8%
17
27.4%
0%
20%
40%
60%
80%
100%
Percentage (%)


Race/Ethnicity and Gender
Female N = 311, Male N = 667
African American
38.6%
41.8%
Caucasian
41.5%
33.1%
American Indian /Native American
5.8%
2.2%
Asian
0.3%
0.7%
Pacific Islander
0%
0%
Alaska Native
0%
0%
Multi-Racial
5.8%
10%
Other
8%
12%
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male


Age Group and Gender
Female N = 311, Male N = 667
Age 12 to 13
6.1%
5.5%
Age 14 to 15
30.5%
37%
Age 16 to 17
63%
57.4%
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male

Services

Periodic Services	Initial	EC
90832-90838 - Psychotherapy	20.8%	22.2%
90846 - Family Therapy without Patient	3.9%	4.0%
90847 - Family Therapy with Patient	12.1%	13.0%
90849 - Group Therapy (multiple family group)	5.5%	5.6%
90853 - Group Therapy (non-multiple family group)	15.5%	16.3%
H0004 - Behavioral Health Counseling - Individual Therapy	7.9%	8.8%
H0004 HQ - Behavioral Health Counseling - Group Therapy	7.8%	8.1%
H0004 HR - Behavioral Health Counseling - Family Therapy with Consumer	3.4%	4.0%
H0004 HS - Behavioral Health Counseling - Family Therapy without Consumer	0.5%	0.5%
YP831 - Behavioral Health Counseling (non-licensed provider)	0.1%	0.1%
YP832 - Behavioral Health Counseling - Group Therapy (non-licensed provider)	0.4%	0.4%
YP833 - Behavioral Health Counseling - Family Therapy with Consumer (non-licensed provider)	0.5%	0.6%
YP834 - Behavioral Health Counseling - Family Therapy without Consumer (non-licensed provider)	0.1%	0.2%
H0005 - Alcohol and/or Drug Group Counseling	13.7%	13.6%
YP835 - Alcohol and/or Drug Group Counseling (non-licensed provider)	1.7%	2.0%

Community Based Services	Initial	EC
H0015 - Substance Abuse Intensive Outpatient Program (SAIOP)	20.9%	20.6%
H2022 - Intensive In-Home Services (IIH)	15.3%	14.9%
H2033 - Multisystemic Therapy Services (MST)	12.7%	13.3%
H2035 - Substance Abuse Comprehensive Outpatient Treatment (SACOT)	1.5%	1.6%
YP630 - Individual Placement and Support (IPS) Supported Employment	0.0%	0.0%
H2023 U4 - Supported Employment	0.0%	0.0%
H2026 U4 - Ongoing Supported Employment	0.0%	0.0%

Facility Based Day Services	Initial	EC
H0035 - Mental Health - Partial Hospitalization	0.1%	0.1%
H2012 HA - Child and Adolescent Day Treatment	6.7%	7.2%

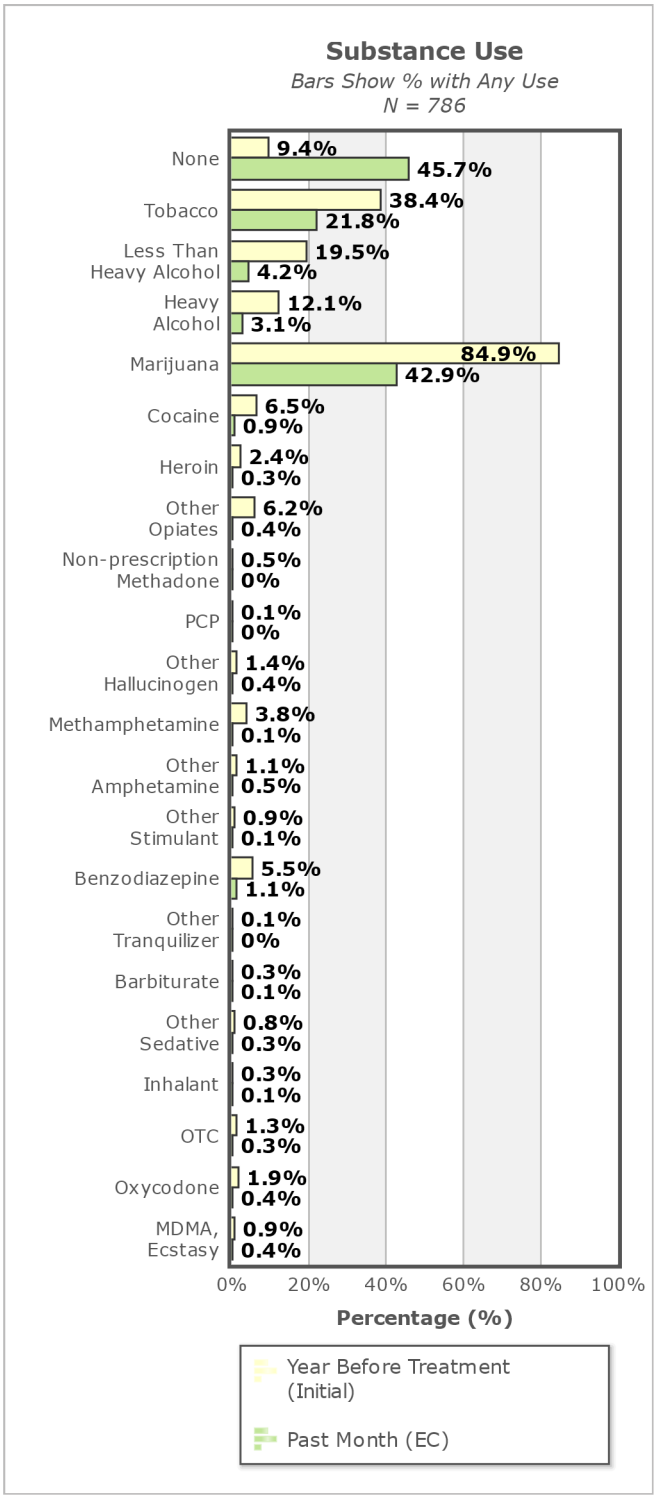
Residental Services	Initial	EC
H0013 - SA Medically Monitored Community Residential Treatment	1.9%	2.2%
H0019 - Behavioral Health - Long Term Residential	0.9%	1.0%
H2020 - Residential Treatment - Level II - Program Type (Therapeutic Behavioral Services)	0.8%	0.7%
YA230 - Psychiatric Residential Treatment Facility	3.0%	2.8%
YP780 - Group Living - High	1.9%	2.5%

Opioid Services	Initial	EC
H0020 - Opioid Treatment	0.0%	0.0%

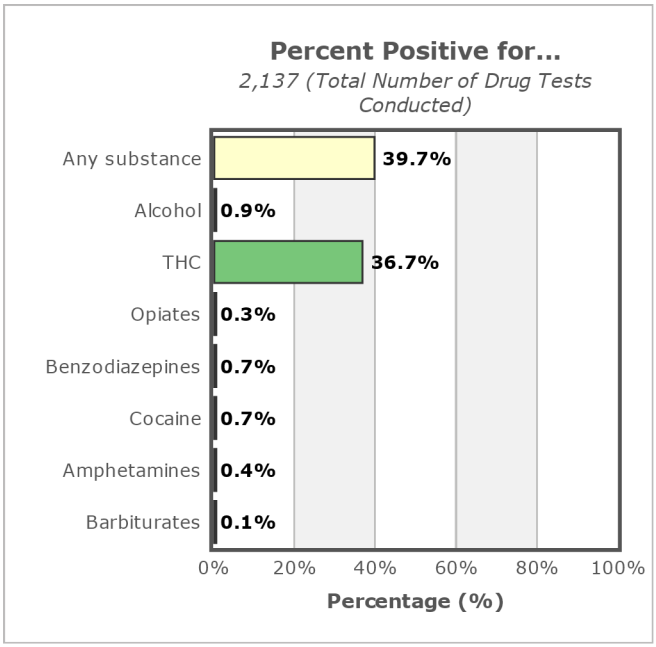
Therapeutic Foster Care Services	Initial	EC
S5145 - Residential Treatment - Level II - Family Type (Foster Care Therapeutic Child)	0.7%	0.8%

Other Services	Initial	EC
Other	5.7%	6.2%

Substance Use

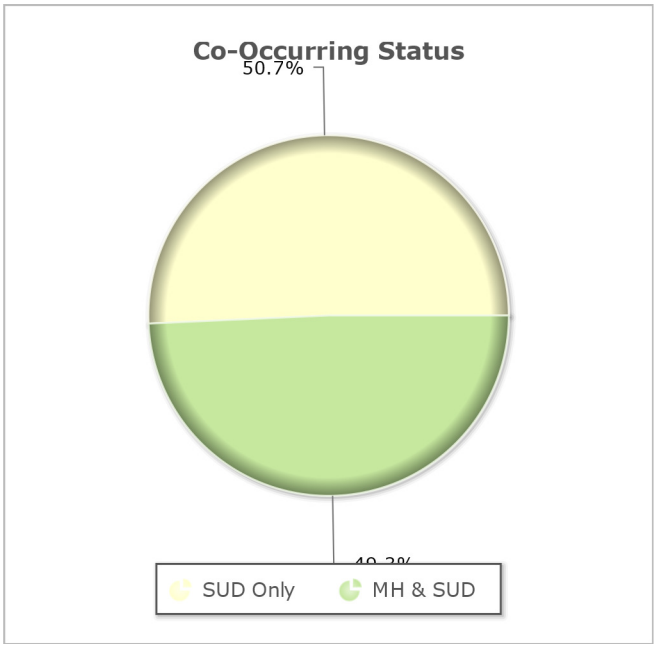


Drug Test Results N = 786	Past 3 Months (EC)
Number of Consumer(s) Tested	491
Percent of Consumer(s) Tested	62.5%
Average # of Tests for Each Consumer Tested	4.4



Needles Used To Inject Drugs, Non-Medically N = 481	
Needle Use Past 3 Months	0.6%

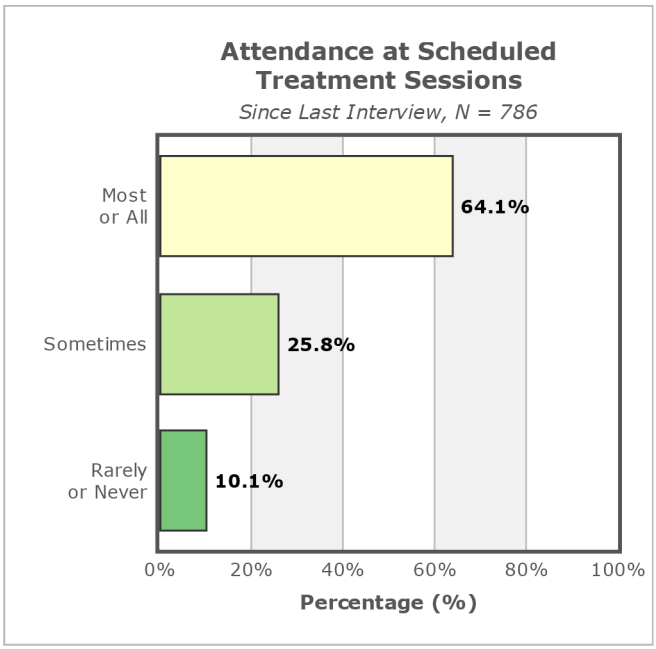
Treatment Demographics

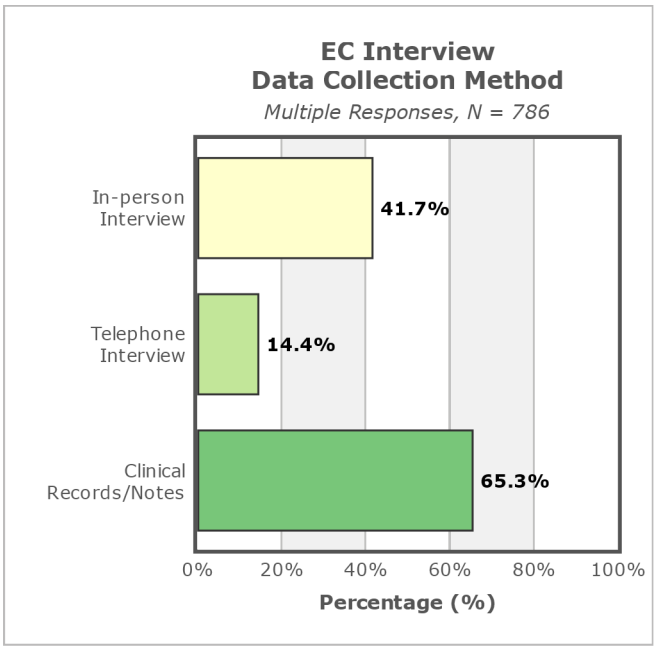


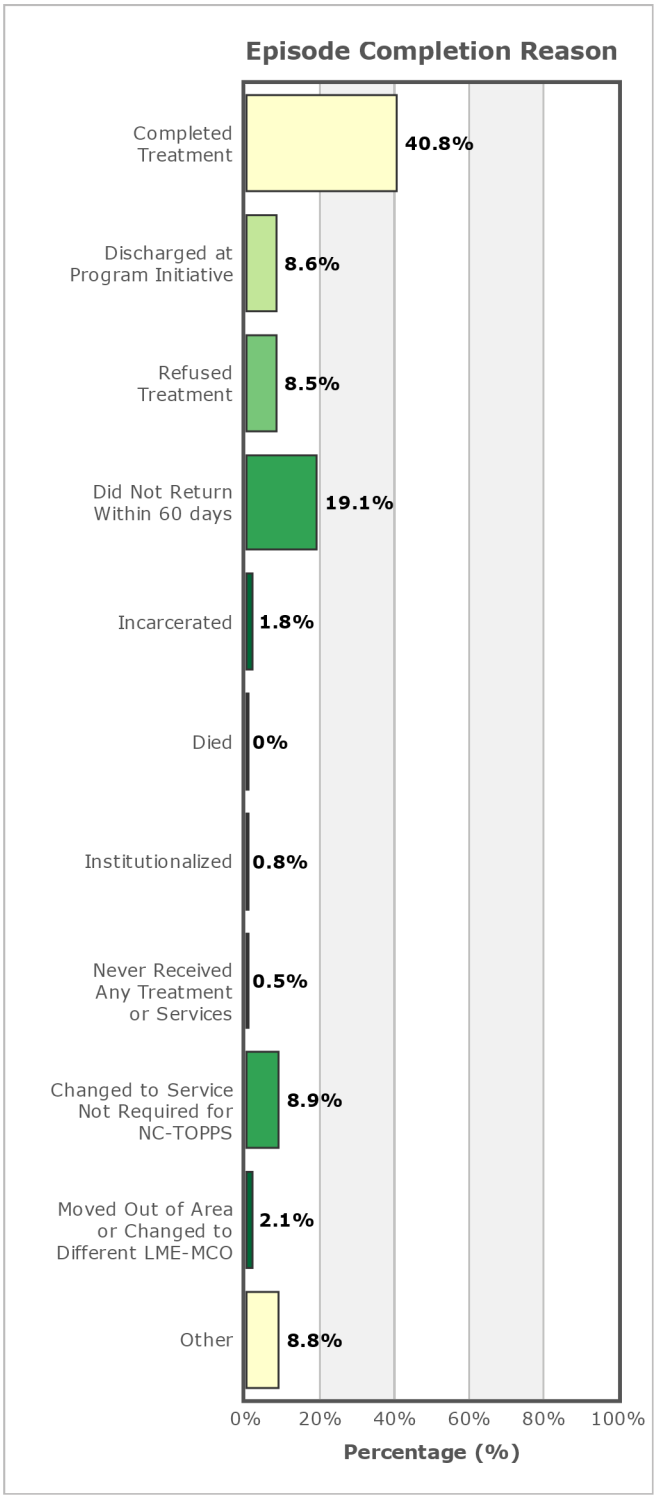
DSM-IV/DSM 5 Diagnoses Diagnostic Category N = 786	
Drug Dependence (DSM-IV)	0.0%
Alcohol Dependence (DSM-IV)	0.0%
Drug Abuse (DSM-IV)	0.0%
Alcohol Abuse (DSM-IV)	0.0%
Drug-Related Disorders (DSM 5)	79.3%
Alcohol-Related Disorders (DSM 5)	10.2%
Oppositional Defiant Disorder	23.0%
Conduct Disorder	14.4%
Attention Deficit Disorder	22.1%
Bipolar Disorders	3.9%
Depression	9.8%
Disruptive Behavior	5.0%
PTSD	7.5%

* Only most commonly diagnosed conditions shown.

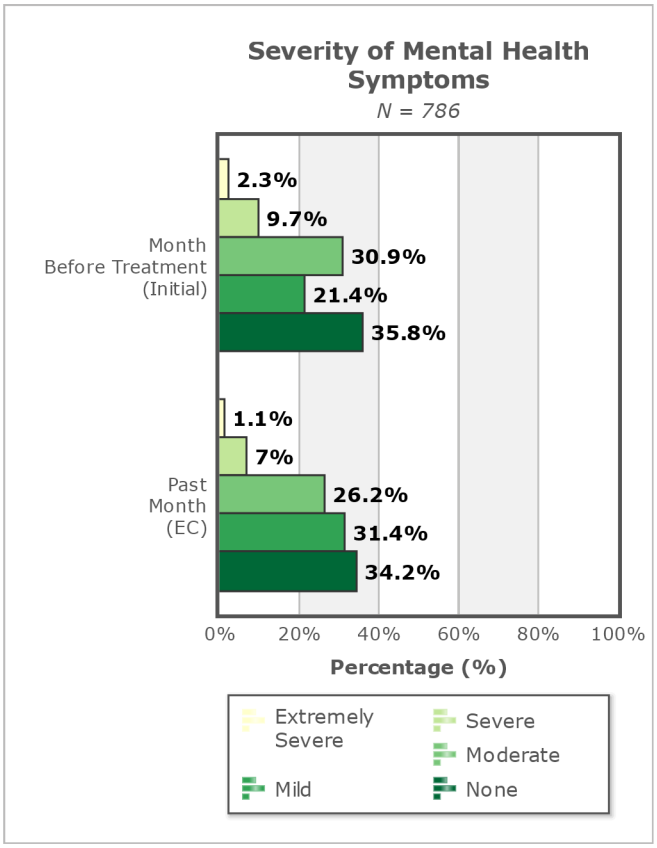
Family Involvement with... N = 786	
Treatment Services	82.6%
Person-centered Planning	60.7%
None	11.6%

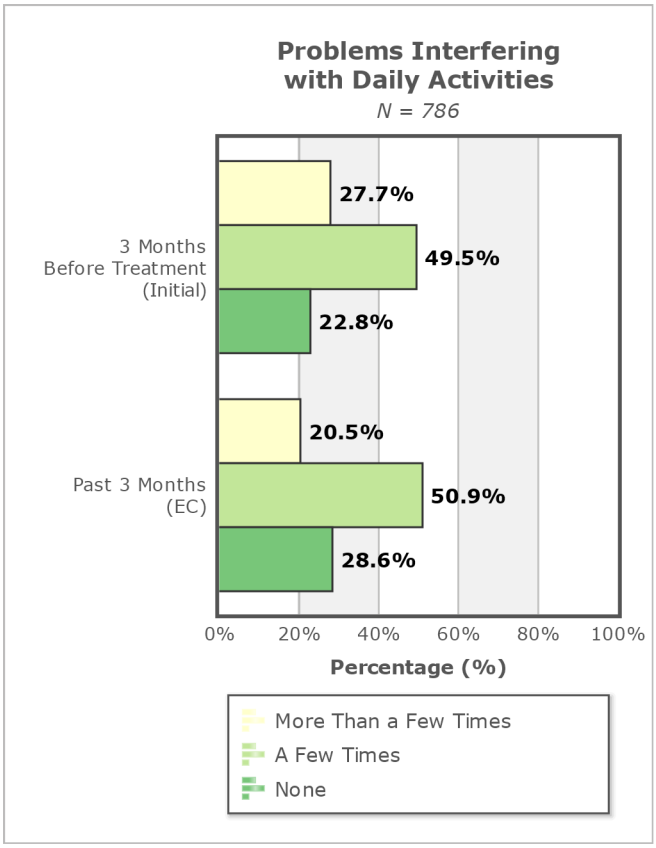




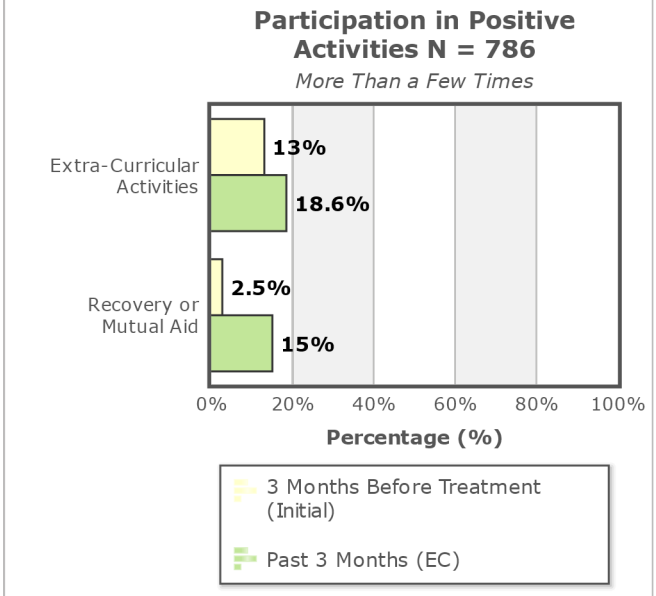

Episode Completion Reason
Completed Treatment
40.8%
Discharged at Program Initiative
8.6%
Refused Treatment
8.5%
Did Not Return Within 60 days
19.1%
Incarcerated
1.8%
Died
0%
Institutionalized
0.8%
Never Received Any Treatment or Services
0.5%
Changed to Service Not Required for NC-TOPPS
8.9%
Moved Out of Area or Changed to Different LME-MCO
2.1%
Other
8.8%
0%
20%
40%
60%
80%
100%
Percentage (%)

Behaviors





Consumer Ratings on Quality of Life % Rated 'Excellent' or 'Good' N = 481		
	Year Before Treatment (Initial)	**Past 3 Months (EC)**
Emotional Well-Being	61.7%	72.1%
Physical Health	85.0%	88.4%
Family Relationships	60.5%	75.3%
Living/Housing Situation	77.5%	83.4%



Support for Recovery N = 481		
	Initial	**EC**
Have Positive Adult Role Model(s)	95.8%	97.9%
	Expect Support (Initial)	**Received Support (EC)**
Family and/or Friends Somewhat or Very Supportive	98.5%	98.5%

Experienced Abuse N = 481		
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Physical Violence Experienced	19.8%	8.3%
Hit/Physically Hurt Another Person	28.7%	11.6%

Justice System Involvement
N = 786
378 *(48.1%)* consumer(s) were under supervision at the time of their EC interview.

	Month Before Treatment (Initial)	Past Month (EC)
Arrests N = 786	8.7%	6.0%
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Nights in Jail or Detention N = 481	19.8%	7.9%

Suicide Ideation and Hurting Self
N = 481

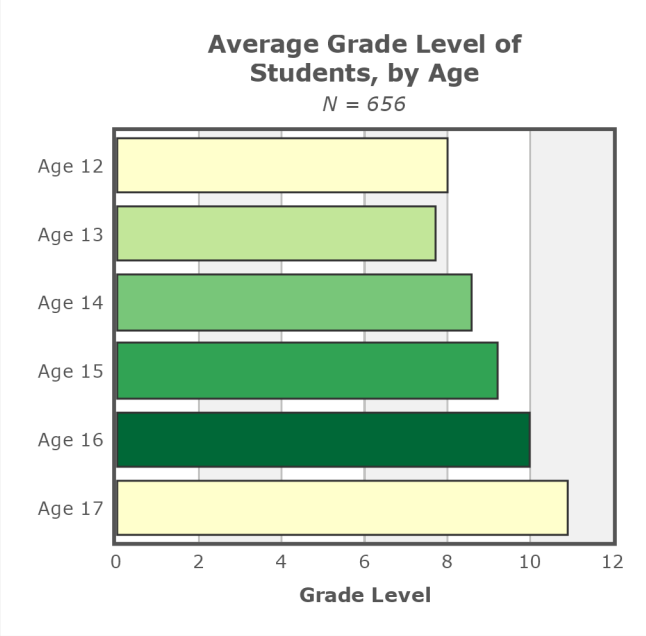
	Ever (Initial)	Since Last Interview (EC)
Suicidal Attempts	15.0%	2.7%
	3 Months Before Treatment (Initial)	**Since Last Interview (EC)**
Suicidal Thoughts	14.1%	6.7%
Tried to Hurt or Cause Self Pain	9.1%	2.7%

Psychotropic Medications at EC
312 *(39.7%)* consumer(s) have had a prescription for psychotropic medications in the past month. Of those, 226 *(72.4%)* take their medication as prescribed all or most of the time.

Education

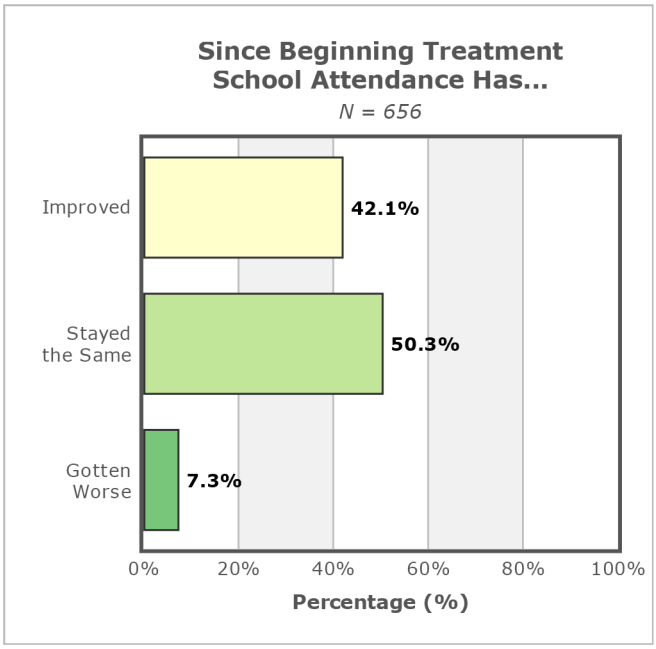
Enrollment in Academic Programs N = 786	Initial Interview	EC Interview
Enrolled in Any Academic Program	91.1%	86.1%
Not Enrolled in Any Academic Program	8.9%	13.9%

Of Those Enrolled in Academic Programs Note: Multiple Responses		
Enrolled in...	**Initial Interview**	**EC Interview**
N	**716**	**677**
Academic Schools (K-12)	83.4%	79.8%
Alternative Learning Program (ALP)	12.7%	15.2%
Technical or Vocational School	0.0%	0.0%
GED or Adult Literacy	1.3%	2.1%
College	0.1%	0.6%
Other Academic Program	1.3%	0.6%

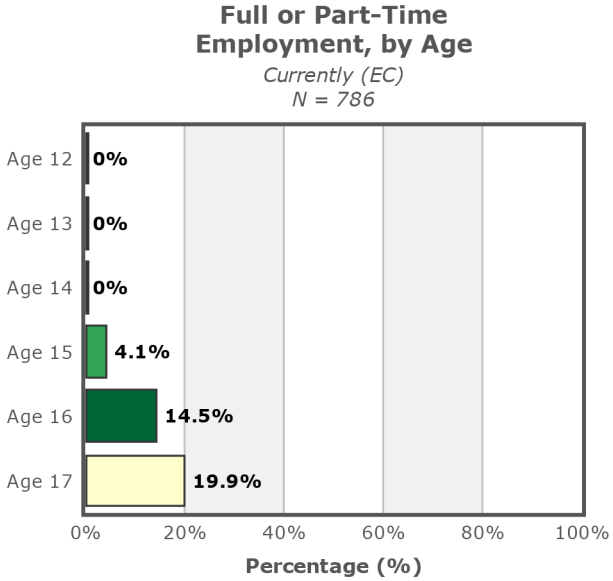


Students Who Received Mostly A's, B's, and C's at Most Recent Grading Period		
	Initial Interview	**EC Interview**
N	**697**	**656**
Received Mostly A's, B's, and C's	70.6%	76.1%

School Suspension and Expulsion		
	3 Months Before Treatment (Initial)	**Currently (EC)**
N	**697**	**656**
Suspension	41.6%	20.7%
Expulsion	5.5%	1.8%



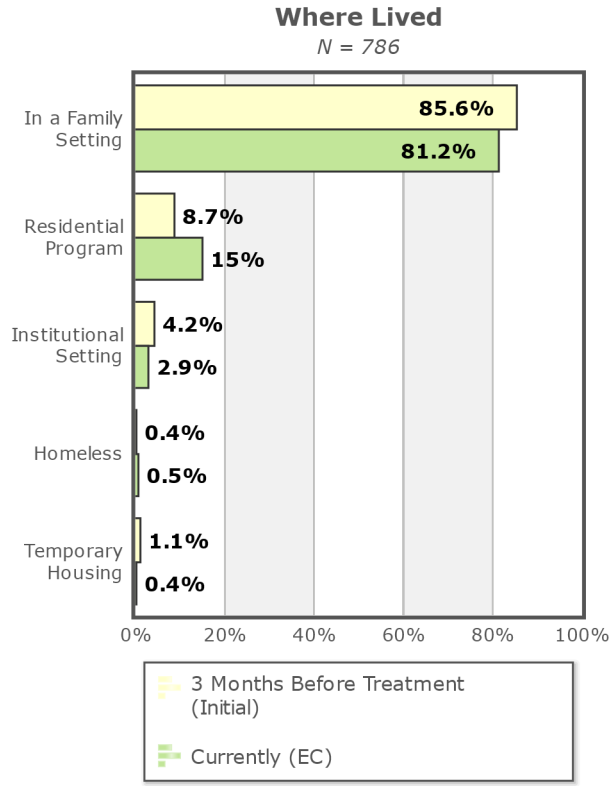
Employment/Housing



Job Classification	Initial N = 67	EC N = 85
Professional, Technical, or Managerial	0.0%	1.2%
Clerical or Sales	6.0%	5.9%
Service Occupation	49.3%	65.9%
Agricultural or Related Occupation	4.5%	1.2%
Processing Occupation	1.5%	3.5%
Machine Trades	1.5%	0.0%
Bench Work	1.5%	0.0%
Structural Work	14.9%	12.9%
Miscellaneous Occupation	20.9%	9.4%

Employee Benefits	Initial N = 67	EC N = 85
Insurance	0.0%	1.2%
Paid Time Off	0.0%	1.2%
Meal/Retail Discounts	25.4%	17.6%
Other	3.0%	0.0%
None	73.1%	81.2%

Rate of Pay	Initial N = 67	EC N = 85
Above Minimum Wage	55.2%	50.6%
Minimum Wage	35.8%	45.9%
Below Minimum Wage	9.0%	3.5%



Times Moved Residences Past 3 Months (EC) N = 786	
No Moves	83.0%
Moved Once	14.1%
Moved Two or More Times	2.9%

Number Living in Special Circumstances		
Where Lived Most of Time	**3 Months Before Treatment (Initial)**	**Currently (EC)**
Homeless Sheltered	2	2
Homeless Unsheltered	1	2
Therapeutic Foster Home	11	3
Level III Group Home	18	30
Level IV Group Home	6	0
State Residential Treatment Center	3	1
SA Residential Treatment Center	6	48
Halfway House	0	0
Other	9	11
Total Living in Special Circumstances	**56**	**97**
--Of the Total, Number in Home Community	11	15

Homeless Nights, Currently (EC)
Among 481 consumer(s), 6 *(1.2%)* consumer(s) reported night(s) homeless.

Service Needs

Services Deemed Important at Initial and Received at EC
Multiple Responses, N = 786

	Initial	EC
Education	58.4%	55.3%
Job	22.4%	12.8%
Housing	9.7%	8.3%
Transportation	14.8%	11.7%
Child Care	1.1%	0.5%
Medical	12.5%	14.6%
Dental	12.1%	8.1%
Screening/Treatment Referral for HIV/TB/HEP	N/A	5.1%
Legal	35.9%	38.7%
Volunteer Opportunities	6.6%	5.9%
None	27.0%	30.9%

Barriers to Treatment
Multiple Responses, N = 786

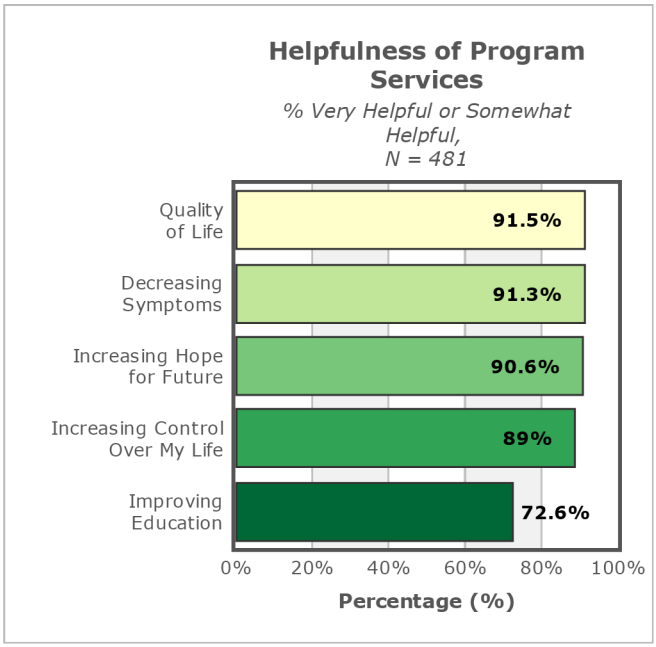
	Initial	EC
No Difficulties	76.7%	66.0%
Active MH Symptoms	3.1%	5.7%
Active SA Symptoms	4.2%	5.0%
Physical Health	0.3%	0.5%
Family Issues	1.4%	6.7%
Needs Not Met	0.5%	1.3%
Engagement	3.8%	13.7%
Cost	0.5%	0.1%
Stigma /Discrimination	0.0%	0.0%
Treatment /Auth. Access	1.5%	1.0%
Deaf/Hard of Hearing	0.0%	0.0%
Language/Comm.	0.3%	0.4%
Legal Reasons	2.4%	1.7%
Transportation	11.2%	12.7%
Scheduling Issues	2.8%	3.8%
Lack of Stable Housing	0.5%	1.0%
Personal Safety	0.1%	0.6%

Crisis/Hospital Care
Past 3 Months
N = 481

	3 Months Before Treatment (Initial)	Past 3 Months (EC)
Crisis Contacts	11.9%	5.6%
ER Visits	16.4%	11.4%
Medical/Surgical Hospital Nights	4.4%	2.9%
Psychiatric Inpatient Hospital Nights	12.1%	6.2%

Routine Health Care
Among 481 consumer(s), 189 *(39.3%)* have seen their provider for a routine check-up since the last interview.

Routine Dental Care
Among 481 consumer(s), 118 *(24.5%)* have seen their dentist for a routine check-up since the last interview.



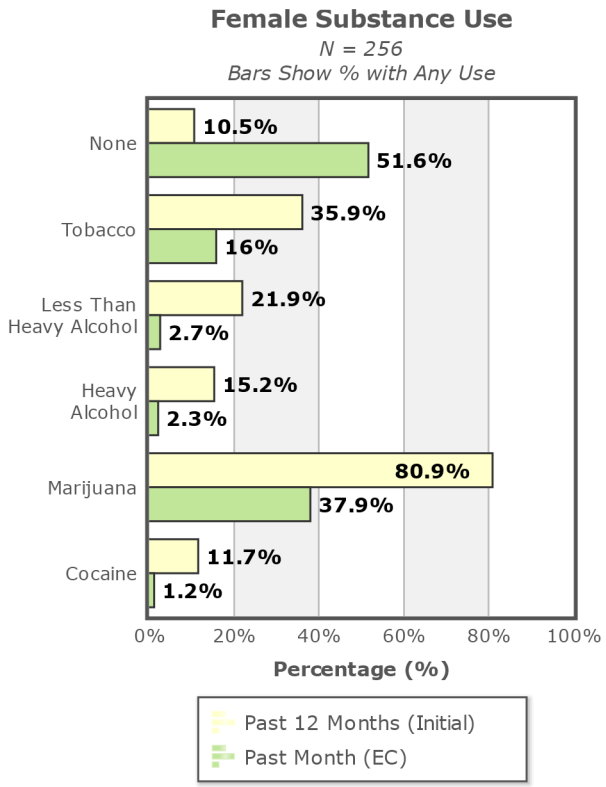
Maternal/Perinatal

Female Substance Use Consumers
Several questions on the NC-TOPPS interview are asked only to female consumers. The tables and charts on this page show the results for those questions. In addition, several other charts are shown for females only. The number of female consumer(s) is 311 *(31.8%)*.

0.0% of 256 female consumer(s) were admitted to a Maternal/Pregnant Program.

Pregnancy ***Female N = 162***	**Number**
Gave Birth in Past Year	2
Currently Pregnant	3
Uncertain about Pregnancy Status	2
In First Trimester*	2
In Second Trimester*	0
In Third Trimester*	1
Referred to Prenatal Care*	3
Receiving Prenatal Care*	2

* of those who are pregnant.



Females with Children Under 18
Of the 311 female consumer(s), 8 *(2.6%)* have children under the age of 18.

DSS Involvement Since Last Interview Among Females with Children Under 18 N = 8	
Investigated by DSS for Child Abuse/Neglect	37.5%

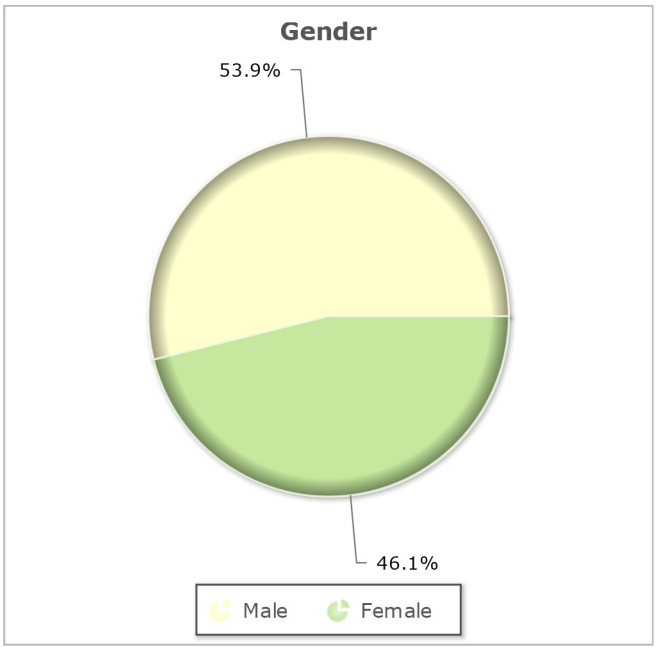
Females Experienced Abuse Past 3 Months N = 162	
Physical Violence	9.3%
Hit/Physically Hurt Another Person	12.3%

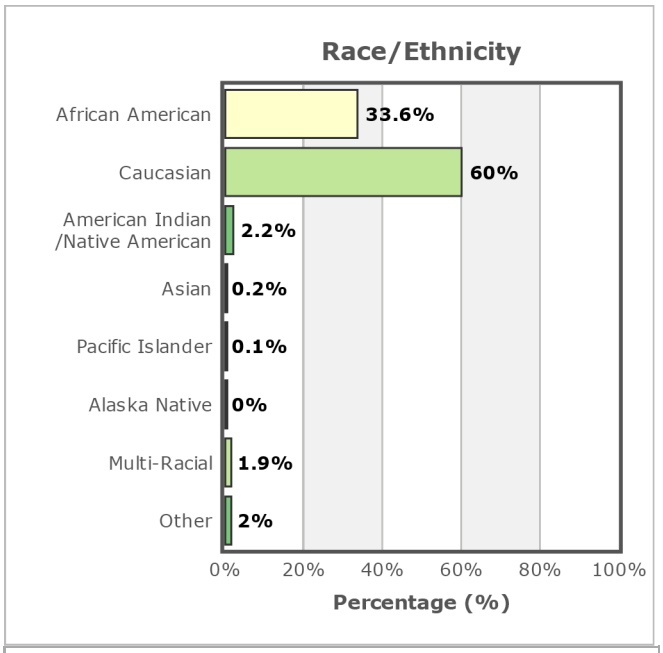
Suicide Ideation and Hurting Self, Since Last Interview Among Females N = 162	
Suicidal Attempts	1.2%
Suicidal Thoughts	10.5%
Tried to Hurt or Cause Self Pain	6.8%

NC-TOPPS Simple Query Report

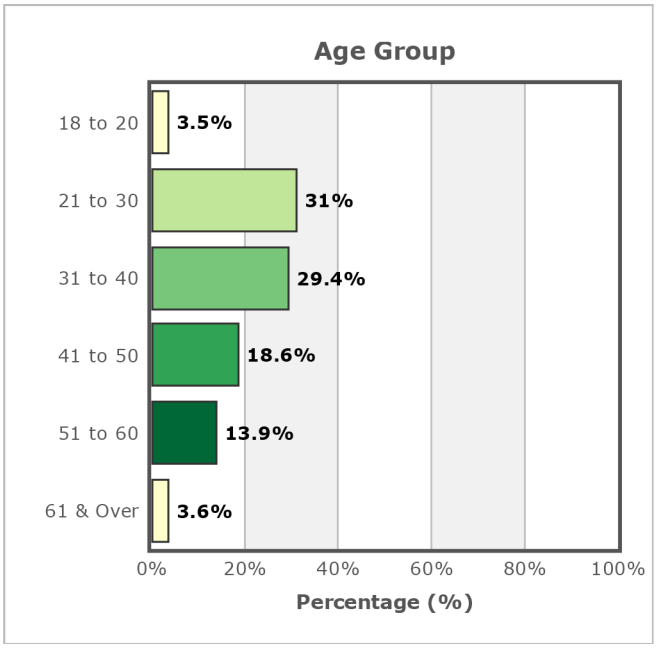
Alliance Health
Cardinal Innovations
Eastpointe
Partners Behavioral Health Management
Sandhills
Trillium Health Resources
Vaya Health
Adult Substance Use Disorder Consumers
Episode Completion Interviews started *Saturday, July 1, 2017* through *Saturday, June 30, 2018*
Number of Episode Completion Interviews: 27,898

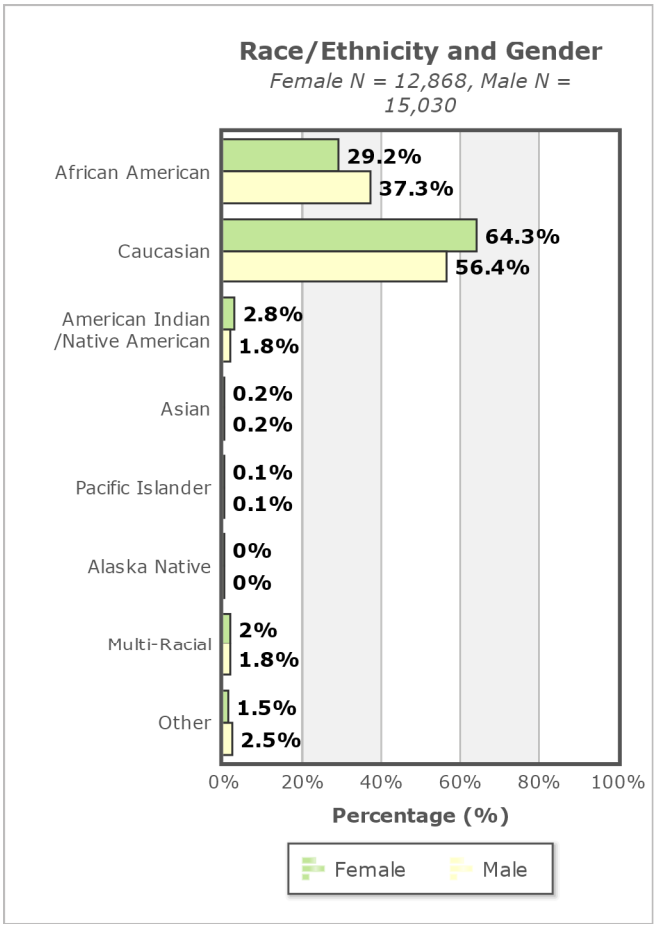
Demographics

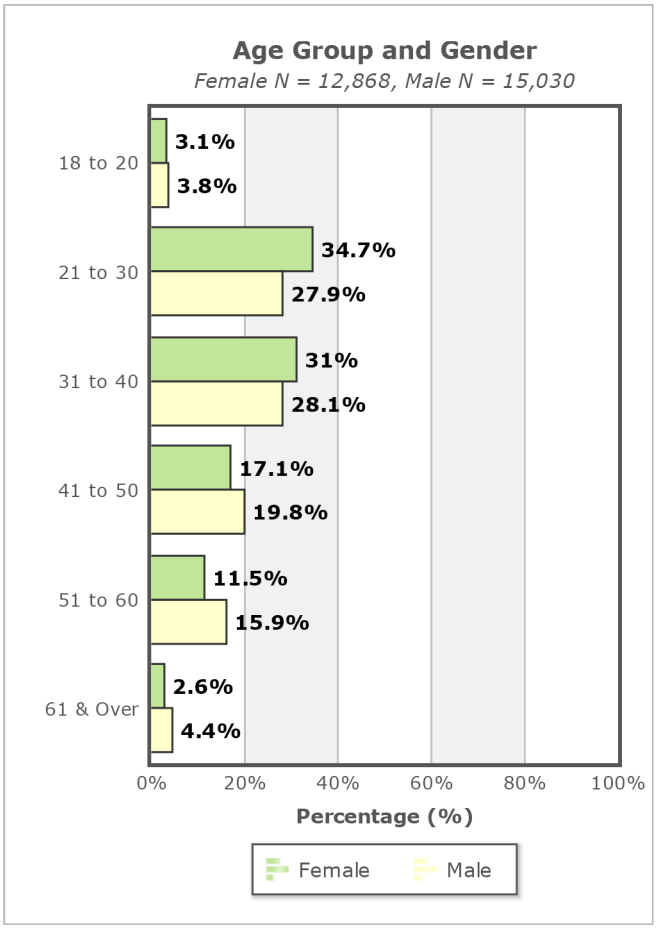




767 *(2.7%)* consumer(s) indicate that they are of Hispanic, Latino, or Spanish origin.


Age Group
18 to 20
3.5%
21 to 30
31%
31 to 40
29.4%
41 to 50
18.6%
51 to 60
13.9%
61 & Over
3.6%
0%
20%
40%
60%
80%
100%
Percentage (%)


Race/Ethnicity and Gender
Female N = 12,868, Male N = 15,030
African American
29.2%
37.3%
Caucasian
64.3%
56.4%
American Indian /Native American
2.8%
1.8%
Asian
0.2%
0.2%
Pacific Islander
0.1%
0.1%
Alaska Native
0%
0%
Multi-Racial
2%
1.8%
Other
1.5%
2.5%
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male


Age Group and Gender
Female N = 12,868, Male N = 15,030
18 to 20
3.1%
3.8%
21 to 30
34.7%
27.9%
31 to 40
31%
28.1%
41 to 50
17.1%
19.8%
51 to 60
11.5%
15.9%
61 & Over
2.6%
4.4%
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male

Services

Periodic Services	Initial	EC
90832-90838 - Psychotherapy	23.0%	25.5%
90846 - Family Therapy without Patient	2.9%	2.0%
90847 - Family Therapy with Patient	3.4%	2.5%
90849 - Group Therapy (multiple family group)	3.6%	2.7%
90853 - Group Therapy (non-multiple family group)	14.4%	16.7%
H0004 - Behavioral Health Counseling - Individual Therapy	9.7%	9.9%
H0004 HQ - Behavioral Health Counseling - Group Therapy	7.3%	6.9%
H0004 HR - Behavioral Health Counseling - Family Therapy with Consumer	3.2%	2.2%
H0004 HS - Behavioral Health Counseling - Family Therapy without Consumer	2.8%	1.9%
YP831 - Behavioral Health Counseling (non-licensed provider)	3.1%	2.9%
YP832 - Behavioral Health Counseling - Group Therapy (non-licensed provider)	3.1%	2.7%
YP833 - Behavioral Health Counseling - Family Therapy with Consumer (non-licensed provider)	2.9%	1.9%
YP834 - Behavioral Health Counseling - Family Therapy without Consumer (non-licensed provider)	2.9%	2.0%
H0005 - Alcohol and/or Drug Group Counseling	16.9%	16.8%
YP835 - Alcohol and/or Drug Group Counseling (non-licensed provider)	4.5%	4.4%

Community Based Services	Initial	EC
H0015 - Substance Abuse Intensive Outpatient Program (SAIOP)	32.7%	33.1%
H0040 - Assertive Community Treatment Team (ACTT)	0.9%	1.1%
H2015, H2015 HT - Community Support Team (CST)	2.7%	2.8%
H2035 - Substance Abuse Comprehensive Outpatient Treatment (SACOT)	12.6%	12.7%
YP630 - Individual Placement and Support (IPS) Supported Employment	0.4% N = 27,461*	0.4%
H2023 U4 - Supported Employment	0.3% N = 27,461*	0.4%
H2026 U4 - Ongoing Supported Employment	0.0% N = 27,461*	0.0%

* - Interview(s) were completed before the question was added to NC-TOPPS.

Facility Based Day Services	Initial	EC
H0035 - Mental Health - Partial Hospitalization	0.1%	0.1%
H2012 HA - Child and Adolescent Day Treatment	0.0%	0.0%

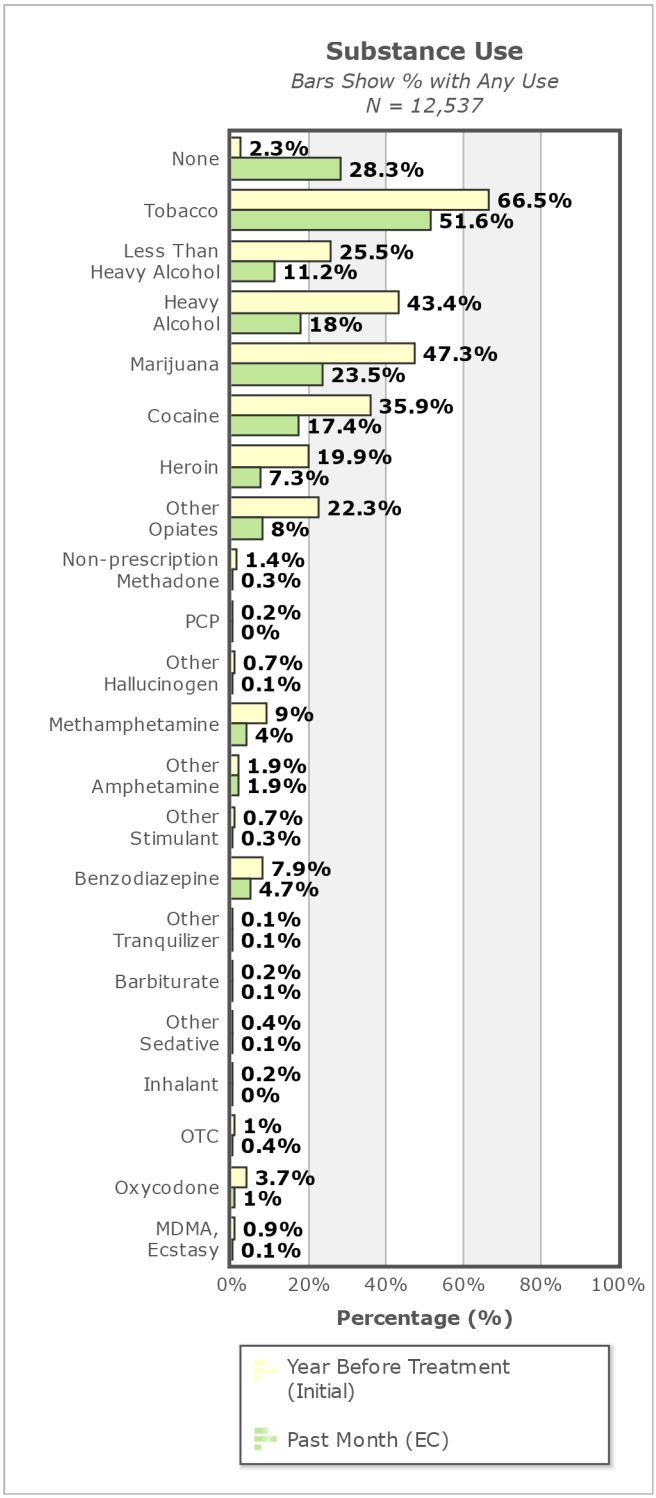
Residental Services	Initial	EC
H0012 HB - SA Non-Medical Community Residential Treatment - Adult	0.5%	0.7%
H0013 - SA Medically Monitored Community Residential Treatment	0.4%	0.4%
H0019 - Behavioral Health - Long Term Residential	0.0%	0.0%
H2020 - Residential Treatment - Level II - Program Type (Therapeutic Behavioral Services)	0.0%	0.0%
YA230 - Psychiatric Residential Treatment Facility	0.0%	0.0%
YP780 - Group Living - High	8.8%	8.9%

Opioid Services	Initial	EC
H0020 - Opioid Treatment	11.0%	11.8%

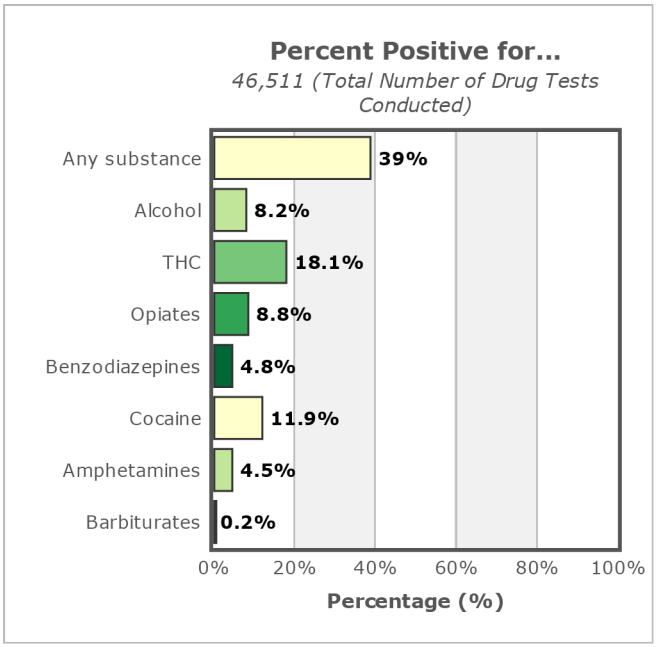
Therapeutic Foster Care Services	Initial	EC
S5145 - Residential Treatment - Level II - Family Type (Foster Care Therapeutic Child)	0.0%	0.0%

Other Services	Initial	EC
Other	4.9%	6.2%

Substance Use



Drug Test Results N = 12,537	Past 3 Months (EC)
Number of Consumer(s) Tested	8120
Percent of Consumer(s) Tested	64.8%
Average # of Tests for Each Consumer Tested	5.7

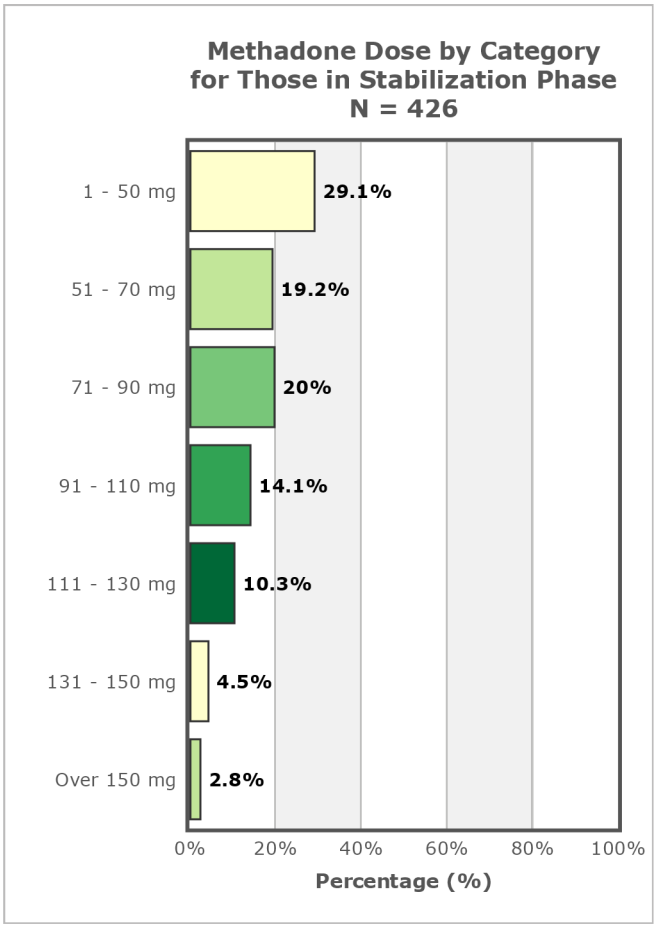


Needles Used To Inject Drugs, Non-Medically N = 4,816	
Needle Use Past 3 Months	8.6%

Consumers in Special Programs	Number N = 12,537
Enrolled in Maternal/Pregnant Program	315
CASAWORKS consumer	141
Work First Consumer	159
Methadone Consumer	908

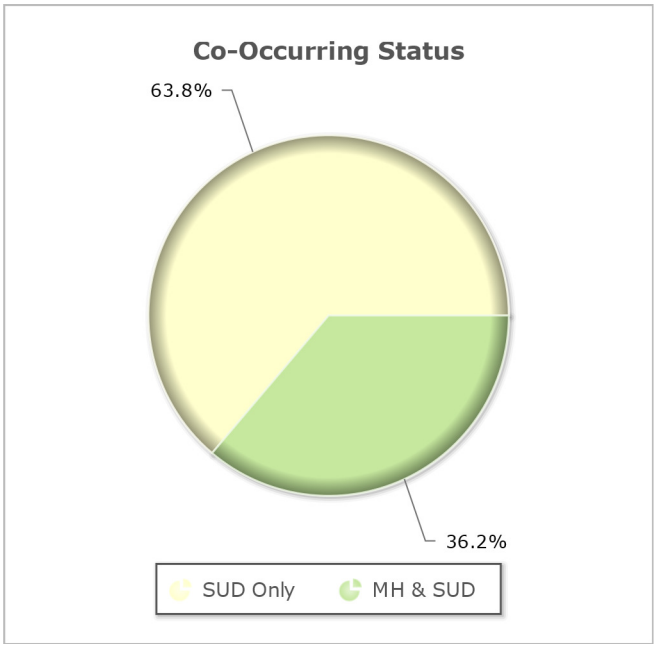
Methadone Dose Information	
# Currently Receiving a Methadone Dose	884
# in Induction Phase	84
# in Stabilization Phase	426
# in Taper Phase	374

Average Methadone Dose for Those in Stabilization Phase N = 426	
Average dose	78.8
NOTE: Zero dose indicates no consumers are in stabilization phase.	



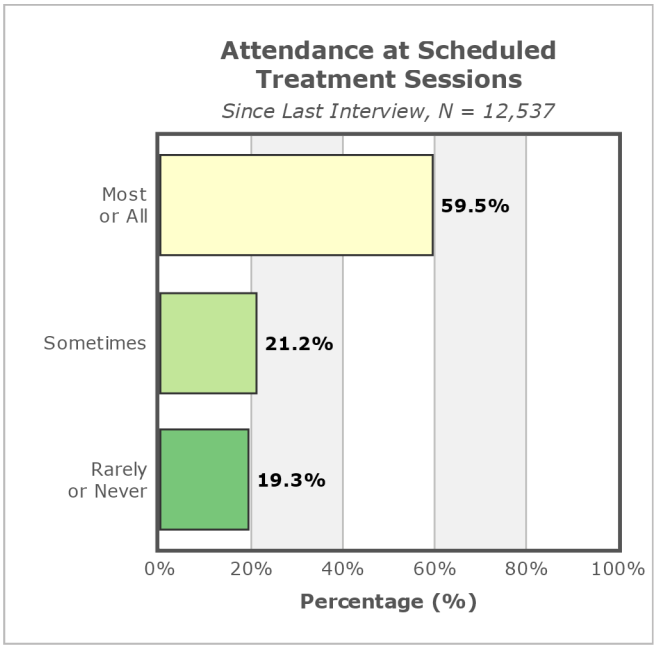
Consumers Receiving Other Medications	
Naltrexon	3
Buprenorphine	12
Antabuse	3
None of these	0

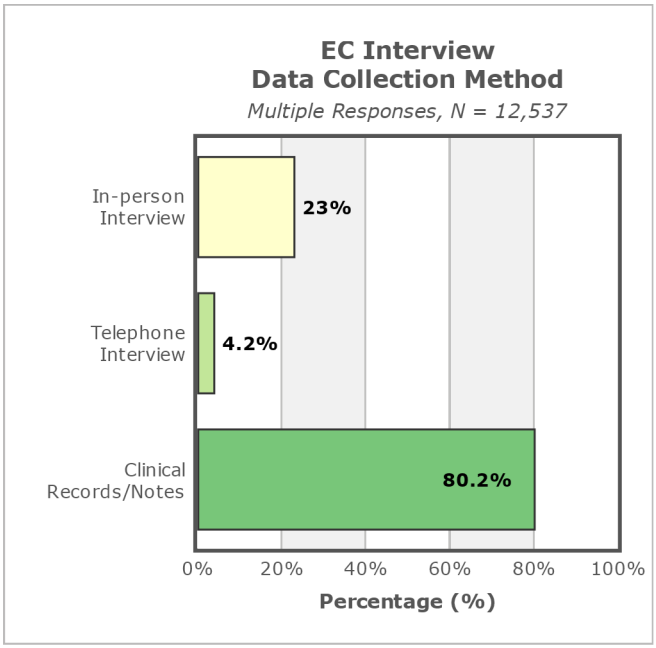
Treatment Demographics



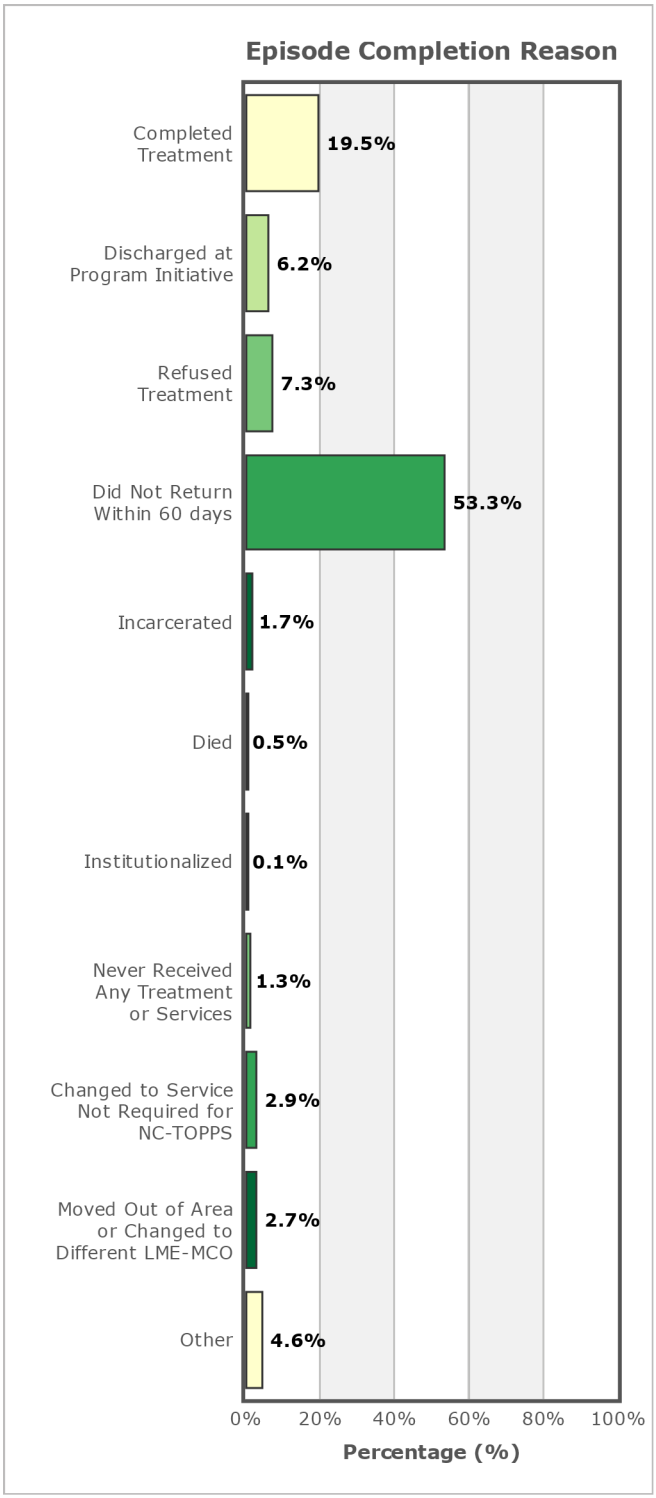
DSM-IV/DSM 5 Diagnoses Diagnostic Category N = 12,537	
Drug Dependence (DSM-IV)	0.0%
Alcohol Dependence (DSM-IV)	0.0%
Drug Abuse (DSM-IV)	0.0%
Alcohol Abuse (DSM-IV)	0.0%
Drug-Related Disorders (DSM 5)	80.6%
Alcohol-Related Disorders (DSM 5)	44.5%
Anxiety Disorder	10.4%
Major Depression	17.6%
Bipolar Disorders	9.4%
Schizophrenia	5.7%
Personality Disorders	2.0%
PTSD	10.7%

* Only most commonly diagnosed conditions shown.

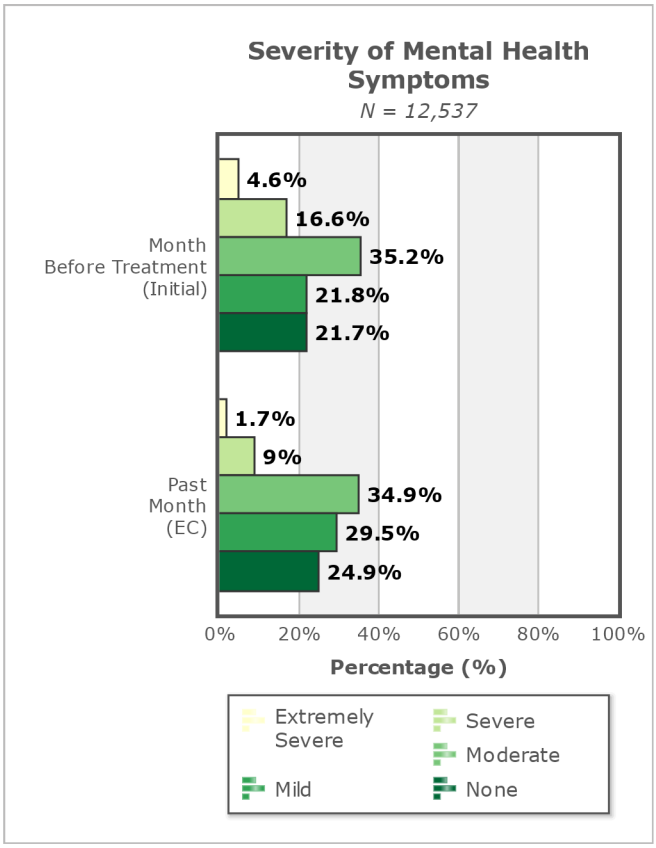


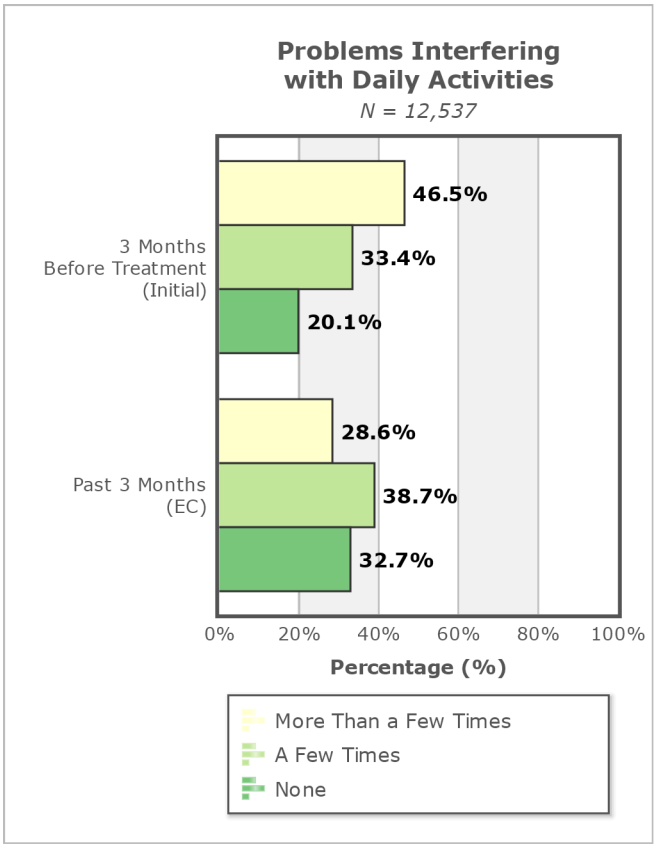


Consumers in Special Programs	Number N = 12,537
TASC program consumer	859



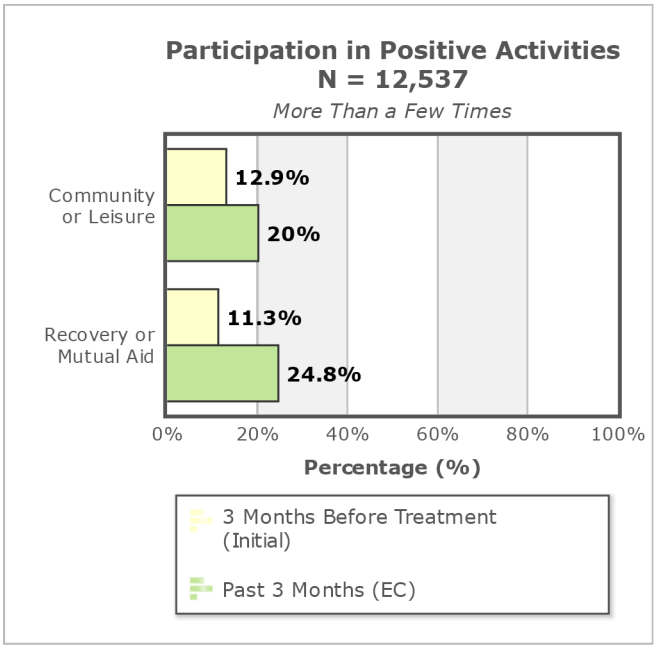
Behaviors





Consumer Ratings on Quality of Life % Rated 'Excellent' or 'Good' N = 4,816		
	Year Before Treatment (Initial)	**Past 3 Months (EC)**
Emotional Well-Being	30.6%	56.8%
Physical Health	46.9%	62.3%
Family Relationships	39.3%	58.0%
Living/Housing Situation	44.5% N = 4,746 *	60.6%

* - Interview(s) were completed after the question was added to NC-TOPPS.



Family and/or Friends Somewhat or Very Supportive N = 4,816		
	Expect Support (Initial)	**Received Support (EC)**
Family Support	88.5%	91.9%

Experienced Abuse N = 4,816		
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Physical Violence	10.9%	4.9%
Hit/Physically Hurt Someone	8.3%	3.8%

Justice System Involvement
N = 12,537
3,094 *(24.7%)* consumer(s) were under supervision at the time of their EC interview.

	Month Before Treatment (Initial)	**Past Month (EC)**
Arrests N = 12,537	5.7%	4.5%
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Nights in Jail or Detention N = 4,816	12.6%	6.3%

Suicide Ideation and Hurting Self
N = 4,816

	Ever (Initial)	**Since Last Interview (EC)**
Suicidal Attempts	23.0%	1.4%
	3 Months Before Treatment (Initial)	**Since Last Interview (EC)**
Suicidal Thoughts	21.8%	4.8%
Tried to Hurt or Cause Self Pain	5.3%	1.3%

Psychotropic Medications at EC
5,578 *(44.5%)* consumer(s) have had a prescription for psychotropic medications in the past month. Of those, 4,255 *(76.3%)* take their medication as prescribed all or most of the time.

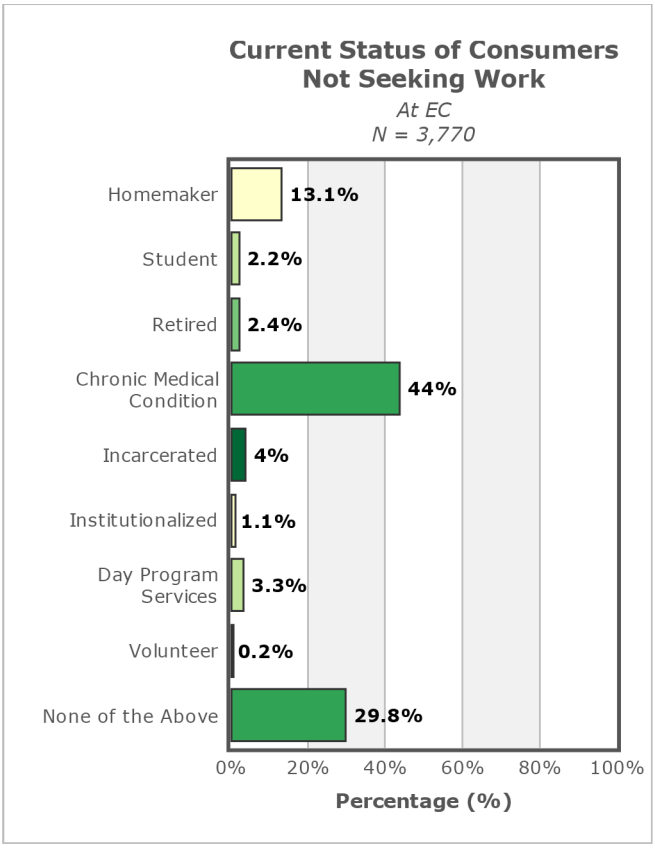
Employment/Housing

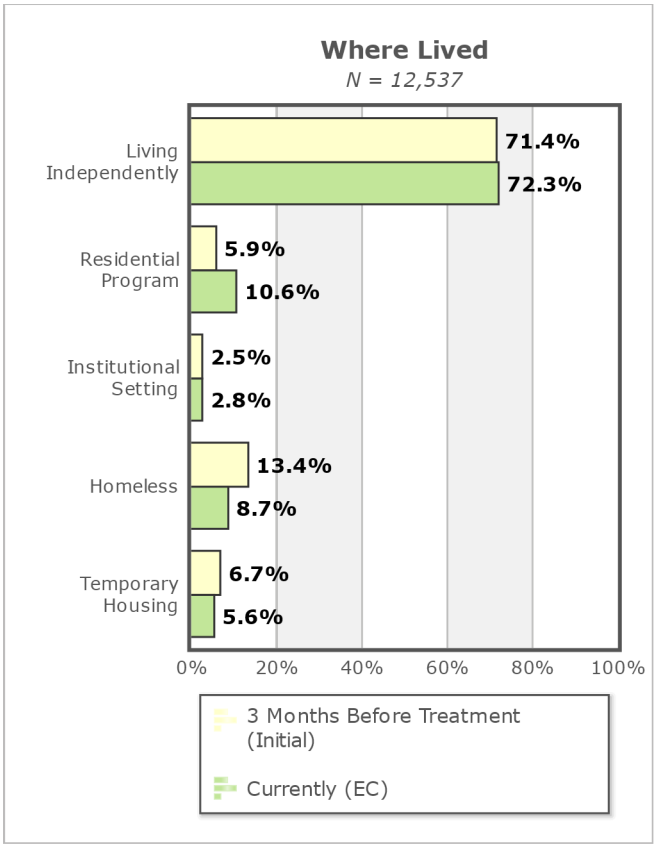
Employment N = 12,537	3 Months Before Treatment (Initial)	Currently (EC)
% In Labor Force	72.2%	69.9%
Of those in the labor force (N)...	**9,055**	**8,767**
Employed Full-time	17.5%	20.9%
Employed Part-time	13.6%	16.3%
Unemployed (seeking work)	68.8%	62.8%

Job Classification	Initial N = 2,781	EC N = 3,263
Professional, Technical, or Managerial	9.1%	8.3%
Clerical or Sales	6.1%	5.4%
Service Occupation	35.3%	41.3%
Agricultural or Related Occupation	2.8%	3.1%
Processing Occupation	2.9%	3.5%
Machine Trades	4.1%	2.3%
Bench Work	2.8%	3.5%
Structural Work	15.0%	14.6%
Miscellaneous Occupation	21.7%	17.9%

Employee Benefits	Initial N = 2,781	EC N = 3,263
Insurance	6.3%	8.6%
Paid Time Off	6.2%	7.2%
Meal/Retail Discounts	6.0%	6.9%
Other	4.4%	6.7%
None	81.7%	77.6%

Rate of Pay	Initial N = 2,781	EC N = 3,263
Above Minimum Wage	72.3%	75.3%
Minimum Wage	21.5%	21.1%
Below Minimum Wage	6.2%	3.5%



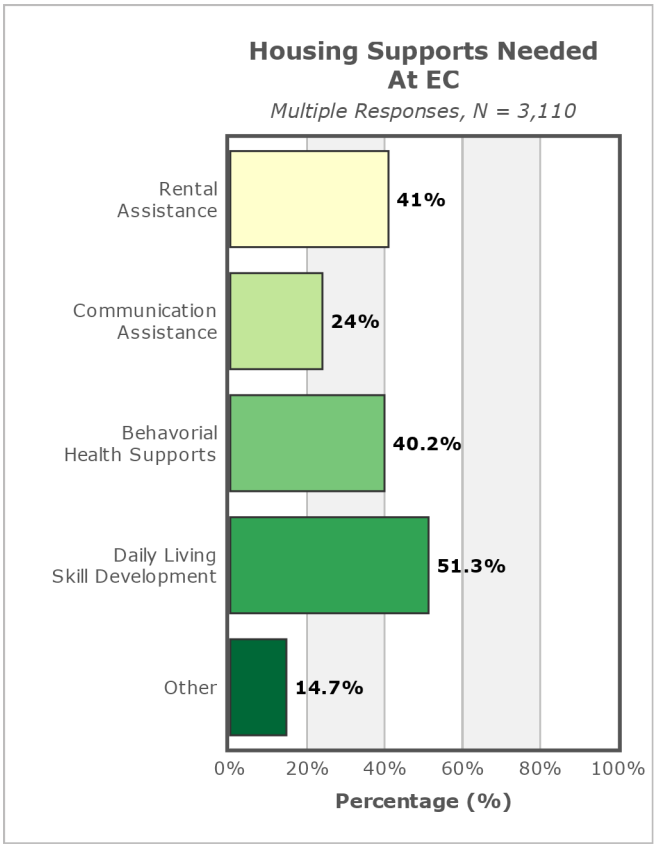


Times Moved Residences Past 3 Months (EC) N = 12,537	
No Moves	70.1%
Moved Once	19.3%
Moved Two or More Times	10.6%

Homeless Consumers	3 Months Before Treatment (Initial)	Currently (EC)
In Shelters	877	682
Not In Shelters	808	404
Total Homeless (N)	1685	1086

Service Needs

Services Deemed Important at Initial and Received at EC Multiple Responses, N = 12,537		
	Initial	**EC**
Education	28.5%	10.0%
Job	41.0%	18.5%
Housing	38.5%	24.8%
Transportation	34.2%	22.3%
Child Care	8.6%	3.6%
Medical	31.7%	24.9%
Dental	24.2% N = 12,285 *	5.4%
Screening/Treatment Referral for HIV/TB/HEP	N/A	12.0%
Legal	19.9%	14.9%
Volunteer Opportunities	9.1% N = 12,285 *	4.8%
None	27.1%	40.0%
* - Interview(s) were completed before the question was added to NC-TOPPS.		



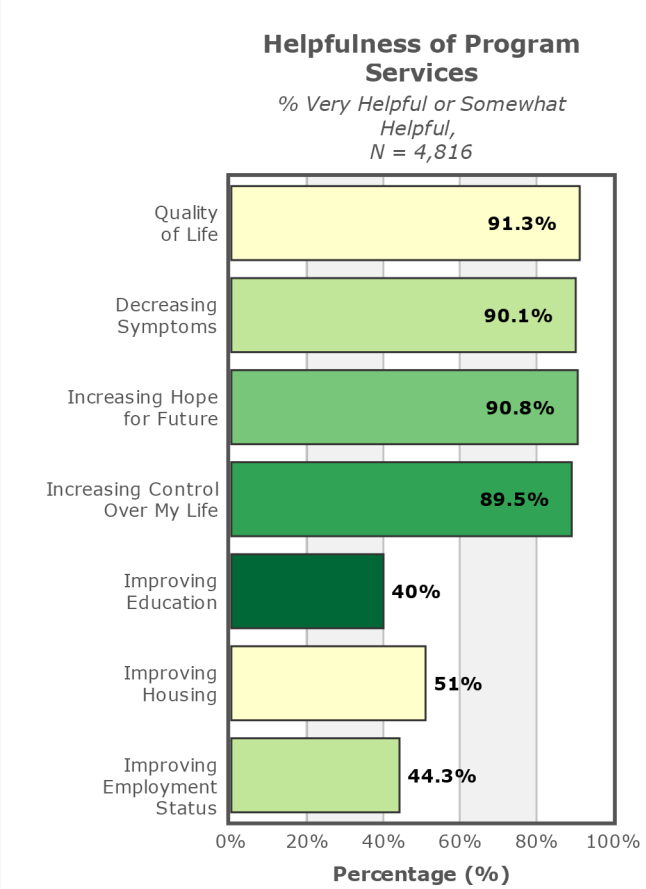
Barriers to Treatment Multiple Responses, N = 12,537		
	Initial	**EC**
No Difficulties	68.3%	65.5%
Active MH Symptoms	8.9%	9.1%
Active SA Symptoms	16.5%	17.5%
Physical Health	2.0%	2.5%
Family Issues	1.4%	2.3%
Needs Not Met	0.8%	0.6%
Engagement	2.9%	7.8%
Cost	4.1%	1.6%
Stigma /Discrimination	0.4%	0.1%
Treatment /Auth. Access	1.7%	0.4%
Deaf/Hard of Hearing	0.1%	0.1%
Language/Comm.	0.1%	0.0%
Legal Reasons	1.8%	2.6%
Transportation	9.5%	8.7%
Scheduling Issues	3.2%	5.1%
Lack of Stable Housing	3.4% N = 12,285 *	2.7%
Personal Safety	0.5% N = 12,285 *	0.4%
* - Interview(s) were completed before the question was added to NC-TOPPS.		

Crisis/Hospital Care Past 3 Months N = 4,816		
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Crisis Contacts	17.6%	10.4%
ER Visits	32.5%	21.0%
Medical/Surgical Hospital Nights	11.8%	7.2%
Psychiatric Inpatient Hospital Nights	14.3% N = 4,746 *	7.3%
* - Interview(s) were completed after the question was added to NC-TOPPS.		

Routine Health Care
Among 4,816 consumer(s), 2,448 *(50.8%)* have seen their provider for a routine check-up since the last interview.

Routine Dental Care

Among 4,816 consumer(s), 798 *(16.6%)* have seen their dentist for a routine check-up since the last interview.

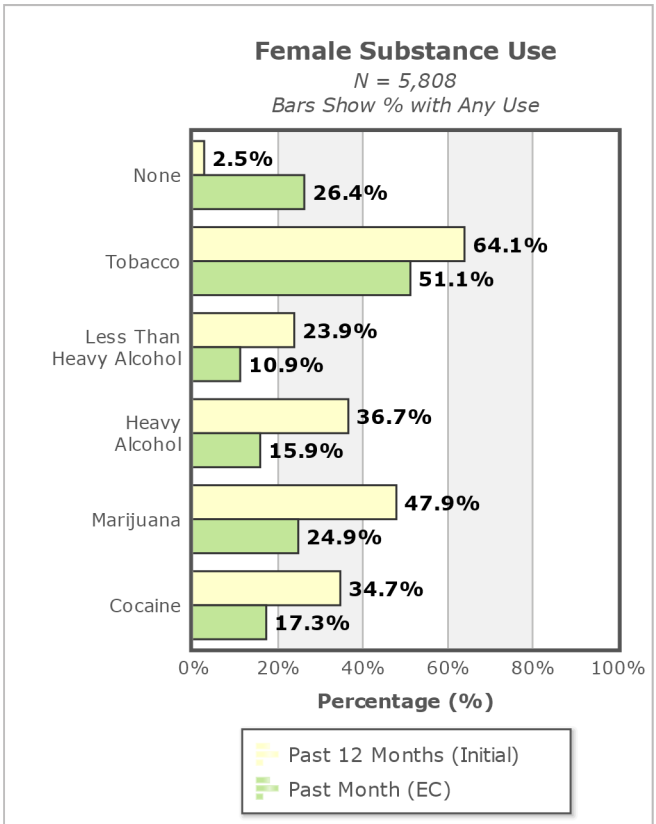


Maternal/Perinatal

Female Substance Use Consumers
Several questions on the NC-TOPPS interview are asked only to female consumers. The tables and charts on this page show the results for those questions. In addition, several other charts are shown for females only. The number of female consumer(s) is 12,868 *(46.1%)*.

Pregnancy ***Female N = 2,390***	**Number**
Gave Birth in Past Year	227
Currently Pregnant	100
Uncertain about Pregnancy Status	24
In First Trimester*	13
In Second Trimester*	40
In Third Trimester*	47
Referred to Prenatal Care*	92
Receiving Prenatal Care*	90

* of those who are pregnant.



Females with Children Under 18
Of the 5,808 female consumer(s), 3,176 *(54.7%)* have children under the age of 18.

DSS Involvement Since Last Interview Among Females with Children Under 18 N = 3,176	
Investigated by DSS for Child Abuse/Neglect	8.9%

Sexual Risk Activity Among Females
Participation in any one or more of these activities: (a) had sex with someone who was not your spouse or primary partner, (b) knowingly had sex with someone who injected drugs, or (c) traded, gave, or received sex for drugs.

N = 2,390	
In Past 3 Months	7.1%

Females Forced or Pressured to Do Sexual Acts N = 2,390	
In Past 3 Months	2.1%

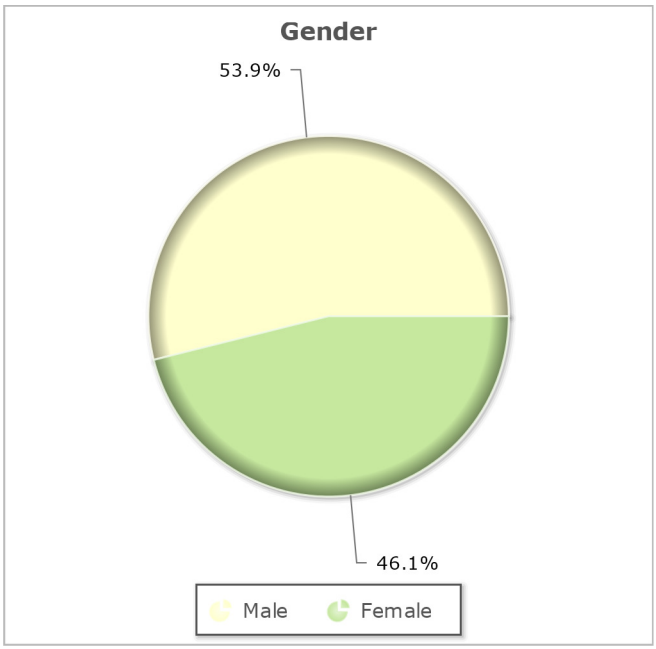
Females Experienced Abuse Past 3 Months N = 2,390	
Physical Violence	5.6%
Hit/Physically Hurt Another Person	4.4%

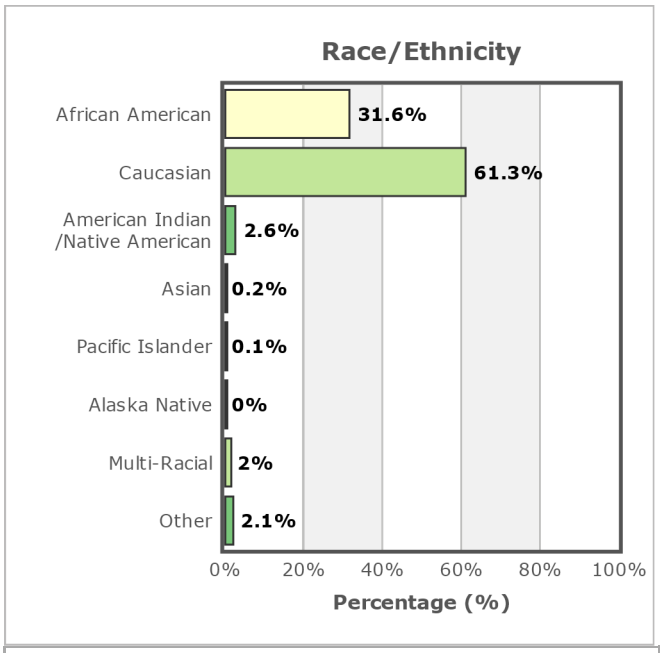
Suicide Ideation and Hurting Self, Since Last Interview Among Females N = 2,390	
Suicidal Attempts	1.2%
Suicidal Thoughts	4.9%
Tried to Hurt or Cause Self Pain	1.3%

NC-TOPPS Simple Query Report

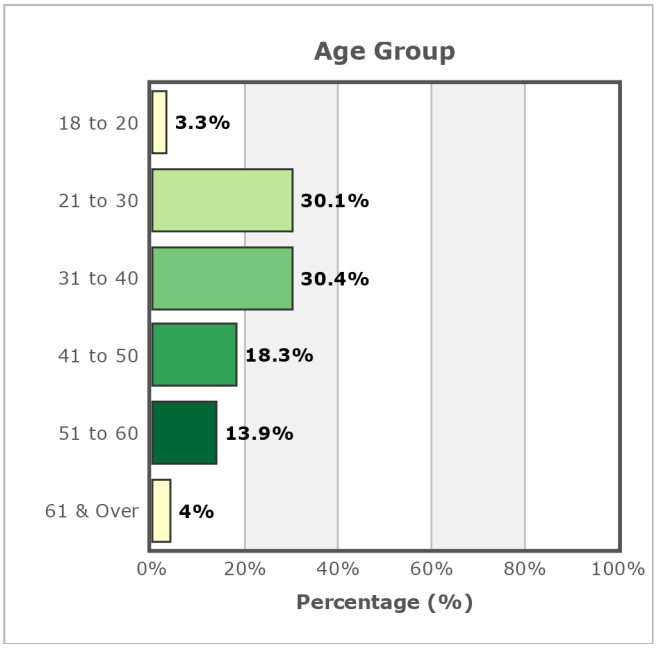
Alliance Health
Cardinal Innovations
Eastpointe
Partners Behavioral Health Management
Sandhills
Trillium Health Resources
Vaya Health
Adult Substance Use Disorder Consumers
Episode Completion Interviews started *Sunday, July 1, 2018* through *Sunday, June 30, 2019*
Number of Episode Completion Interviews: 27,622

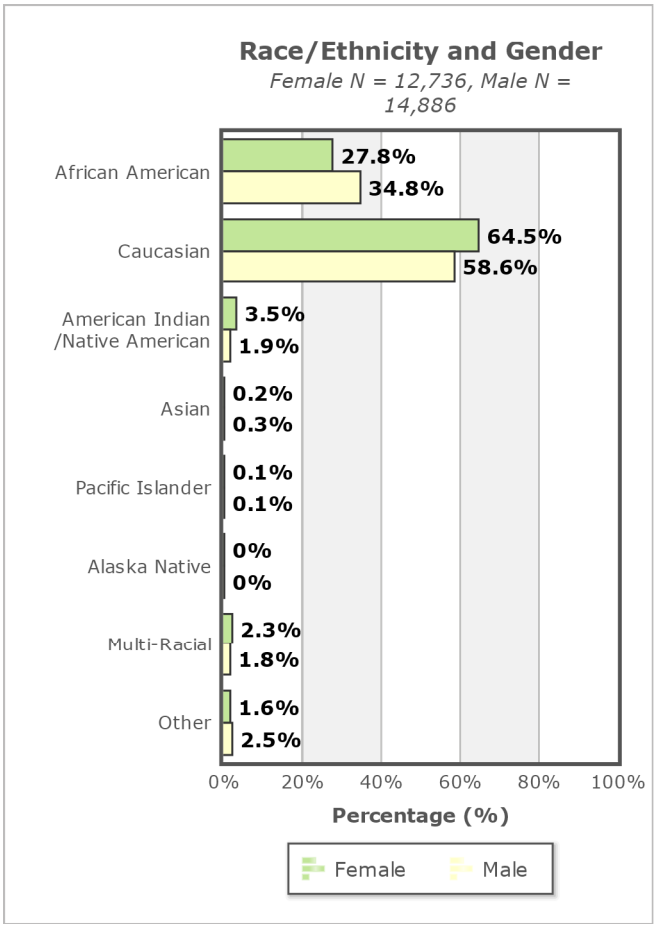
Demographics

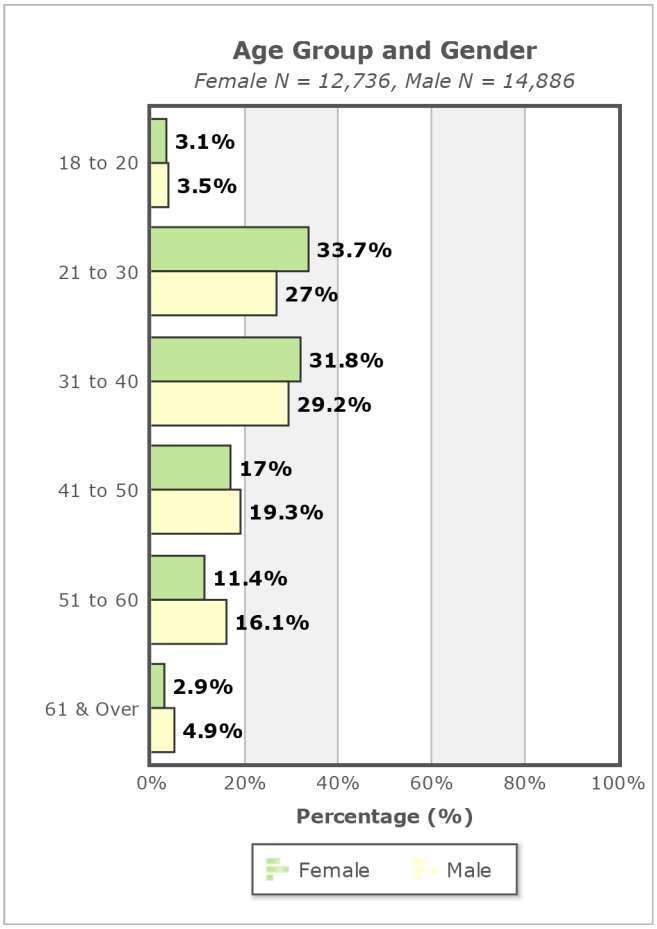




764 *(2.8%)* consumer(s) indicate that they are of Hispanic, Latino, or Spanish origin.


Age Group
18 to 20
3.3%
21 to 30
30.1%
31 to 40
30.4%
41 to 50
18.3%
51 to 60
13.9%
61 & Over
4%
0%
20%
40%
60%
80%
100%
Percentage (%)


Race/Ethnicity and Gender
Female N = 12,736, Male N = 14,886
African American
27.8%
34.8%
Caucasian
64.5%
58.6%
American Indian /Native American
3.5%
1.9%
Asian
0.2%
0.3%
Pacific Islander
0.1%
0.1%
Alaska Native
0%
0%
Multi-Racial
2.3%
1.8%
Other
1.6%
2.5%
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male


Age Group and Gender
Female N = 12,736, Male N = 14,886
18 to 20
3.1%
3.5%
21 to 30
33.7%
27%
31 to 40
31.8%
29.2%
41 to 50
17%
19.3%
51 to 60
11.4%
16.1%
61 & Over
2.9%
4.9%
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male

Services

Periodic Services	Initial	EC
90832-90838 - Psychotherapy	24.6%	27.3%
90846 - Family Therapy without Patient	3.4%	3.1%
90847 - Family Therapy with Patient	4.1%	3.8%
90849 - Group Therapy (multiple family group)	4.0%	3.8%
90853 - Group Therapy (non-multiple family group)	16.0%	18.5%
H0004 - Behavioral Health Counseling - Individual Therapy	9.2%	9.5%
H0004 HQ - Behavioral Health Counseling - Group Therapy	7.6%	7.5%
H0004 HR - Behavioral Health Counseling - Family Therapy with Consumer	3.6%	3.3%
H0004 HS - Behavioral Health Counseling - Family Therapy without Consumer	3.3%	3.0%
YP831 - Behavioral Health Counseling (non-licensed provider)	3.4%	3.4%
YP832 - Behavioral Health Counseling - Group Therapy (non-licensed provider)	3.5%	3.4%
YP833 - Behavioral Health Counseling - Family Therapy with Consumer (non-licensed provider)	3.3%	3.0%
YP834 - Behavioral Health Counseling - Family Therapy without Consumer (non-licensed provider)	3.3%	3.0%
H0005 - Alcohol and/or Drug Group Counseling	17.1%	17.8%
YP835 - Alcohol and/or Drug Group Counseling (non-licensed provider)	5.1%	5.6%

Community Based Services	Initial	EC
H0015 - Substance Abuse Intensive Outpatient Program (SAIOP)	31.5%	31.4%
H0040 - Assertive Community Treatment Team (ACTT)	0.9%	1.0%
H2015, H2015 HT - Community Support Team (CST)	2.5%	2.7%
H2035 - Substance Abuse Comprehensive Outpatient Treatment (SACOT)	13.5%	13.5%
YP630 - Individual Placement and Support (IPS) Supported Employment	0.4% N = 27,299*	0.6%
H2023 U4 - Supported Employment	0.3% N = 27,299*	0.3%
H2026 U4 - Ongoing Supported Employment	0.0% N = 27,299*	0.0%

* - Interview(s) were completed before the question was added to NC-TOPPS.

Facility Based Day Services	Initial	EC
H0035 - Mental Health - Partial Hospitalization	0.1%	0.2%
H2012 HA - Child and Adolescent Day Treatment	0.0%	0.0%

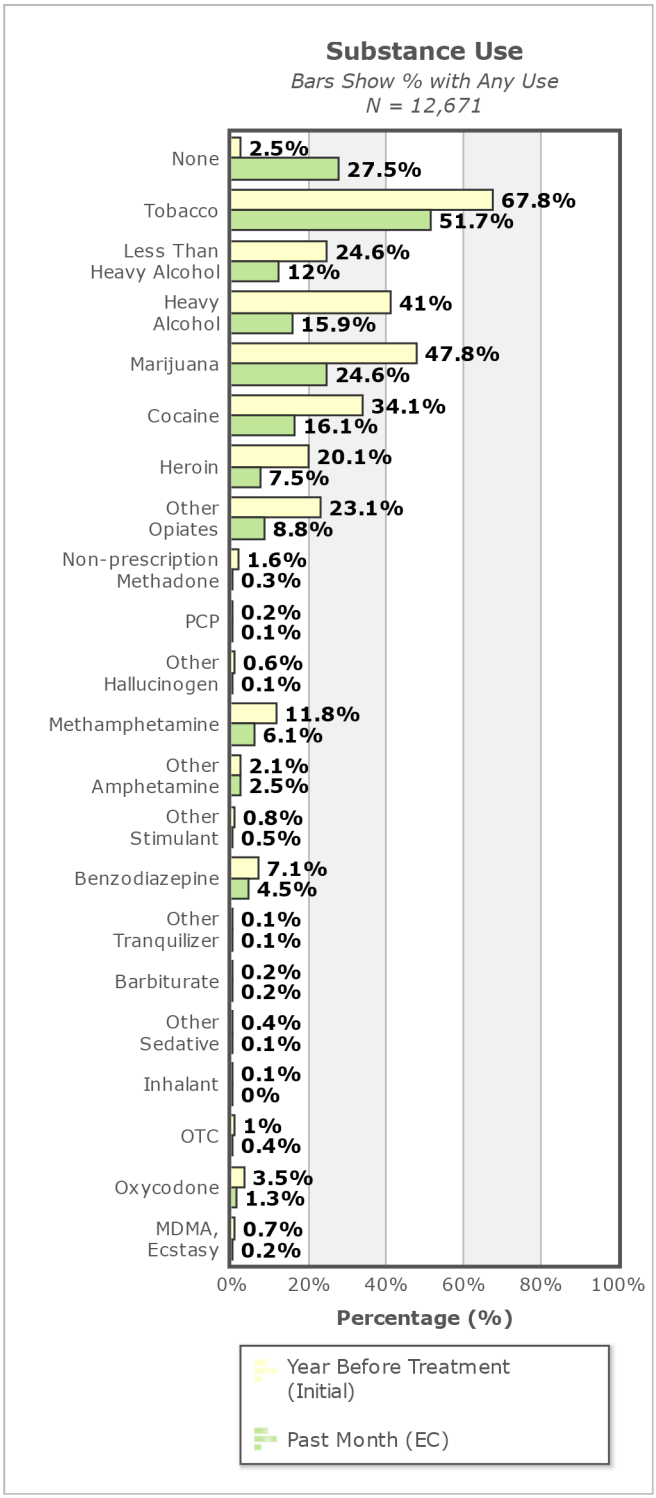
Residental Services	Initial	EC
H0012 HB - SA Non-Medical Community Residential Treatment - Adult	0.6%	0.6%
H0013 - SA Medically Monitored Community Residential Treatment	0.3%	0.3%
H0019 - Behavioral Health - Long Term Residential	0.0%	0.0%
H2020 - Residential Treatment - Level II - Program Type (Therapeutic Behavioral Services)	0.0%	0.0%
YA230 - Psychiatric Residential Treatment Facility	0.0%	0.0%
YP780 - Group Living - High	8.1%	8.4%

Opioid Services	Initial	EC
H0020 - Opioid Treatment	12.2%	13.3%

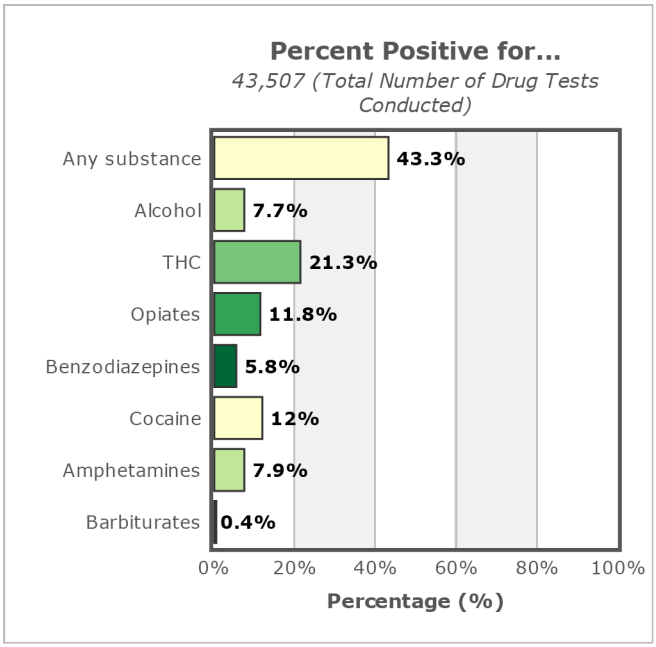
Therapeutic Foster Care Services	Initial	EC
S5145 - Residential Treatment - Level II - Family Type (Foster Care Therapeutic Child)	0.1%	0.1%

Other Services	Initial	EC
Other	5.1%	6.4%

Substance Use



Drug Test Results N = 12,671	Past 3 Months (EC)
Number of Consumer(s) Tested	8309
Percent of Consumer(s) Tested	65.6%
Average # of Tests for Each Consumer Tested	5.2

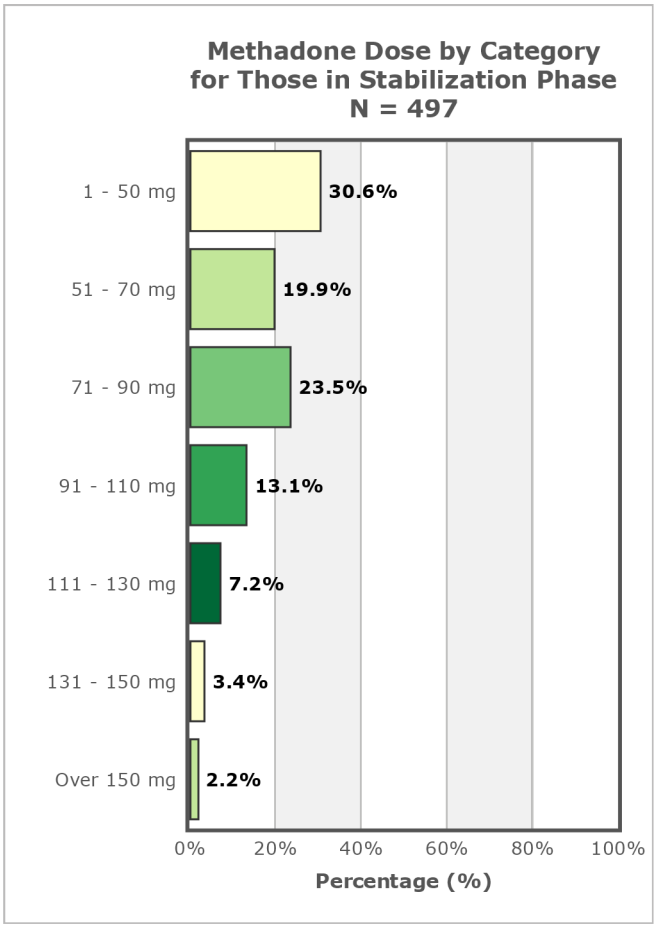


Needles Used To Inject Drugs, Non-Medically N = 4,307	
Needle Use Past 3 Months	8.1%

Consumers in Special Programs	Number N = 12,671
Enrolled in Maternal/Pregnant Program	244
CASAWORKS consumer	131
Work First Consumer	148
Methadone Consumer	1,095

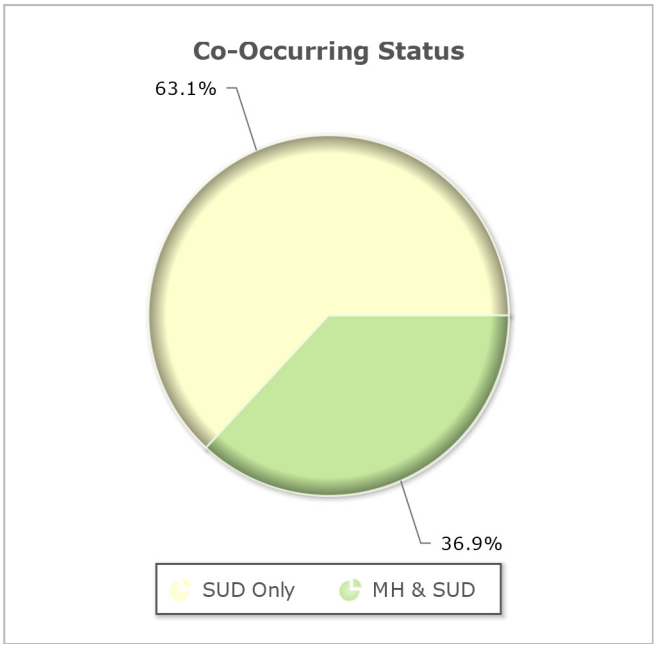
Methadone Dose Information	
# Currently Receiving a Methadone Dose	1070
# in Induction Phase	106
# in Stabilization Phase	497
# in Taper Phase	467

Average Methadone Dose for Those in Stabilization Phase N = 497	
Average dose	73.2
NOTE: Zero dose indicates no consumers are in stabilization phase.	



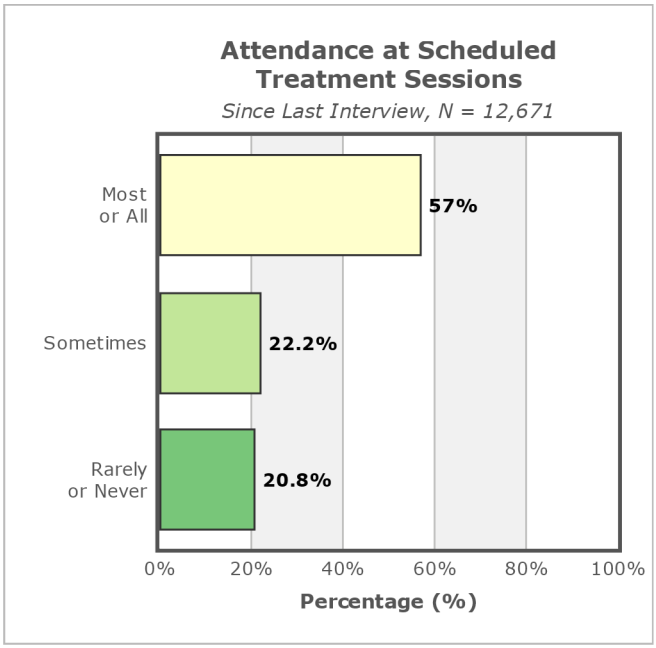
Consumers Receiving Other Medications	
Naltrexon	3
Buprenorphine	8
Antabuse	1
None of these	0

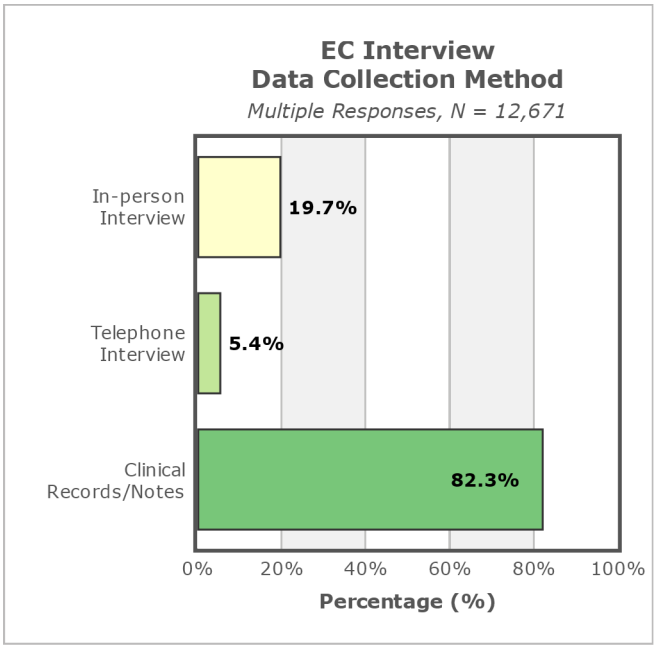
Treatment Demographics



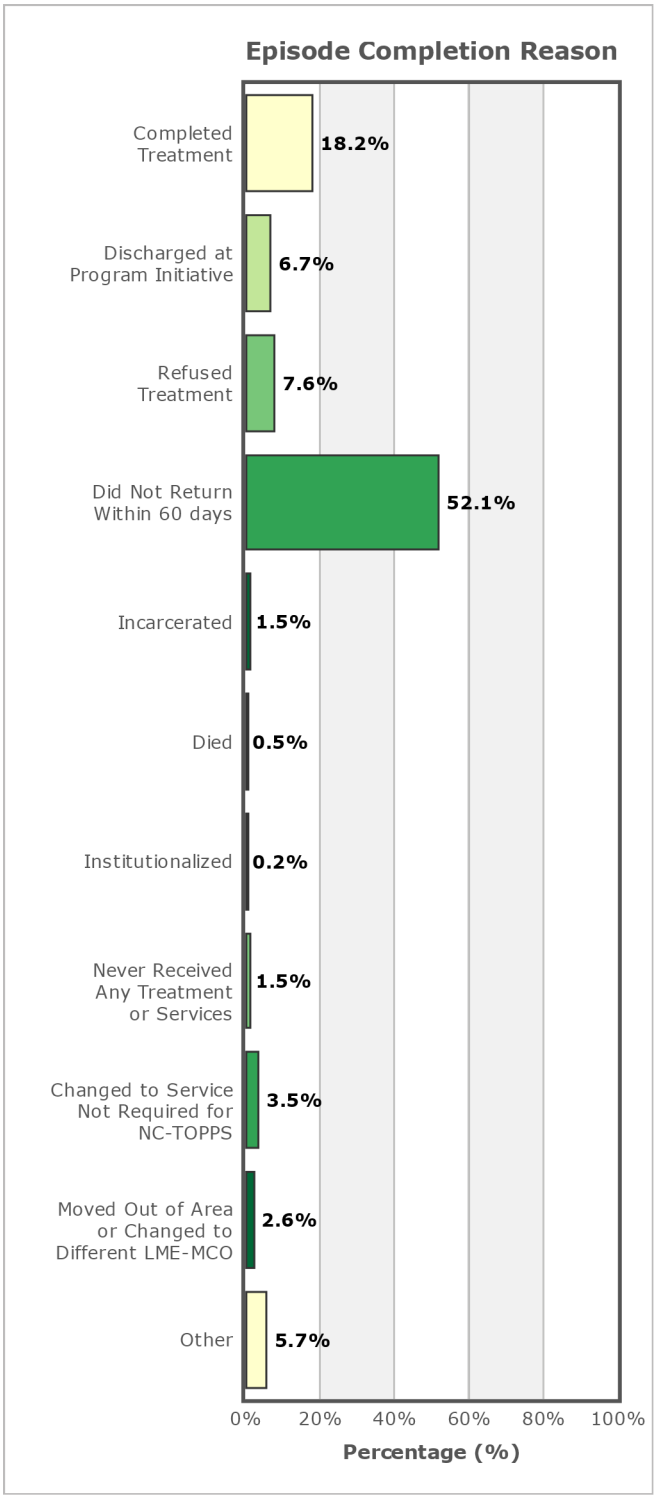
DSM-IV/DSM 5 Diagnoses Diagnostic Category N = 12,671	
Drug Dependence (DSM-IV)	0.0%
Alcohol Dependence (DSM-IV)	0.0%
Drug Abuse (DSM-IV)	0.0%
Alcohol Abuse (DSM-IV)	0.0%
Drug-Related Disorders (DSM 5)	82.1%
Alcohol-Related Disorders (DSM 5)	41.4%
Anxiety Disorder	11.5%
Major Depression	17.5%
Bipolar Disorders	8.8%
Schizophrenia	4.9%
Personality Disorders	1.7%
PTSD	10.1%

* Only most commonly diagnosed conditions shown.

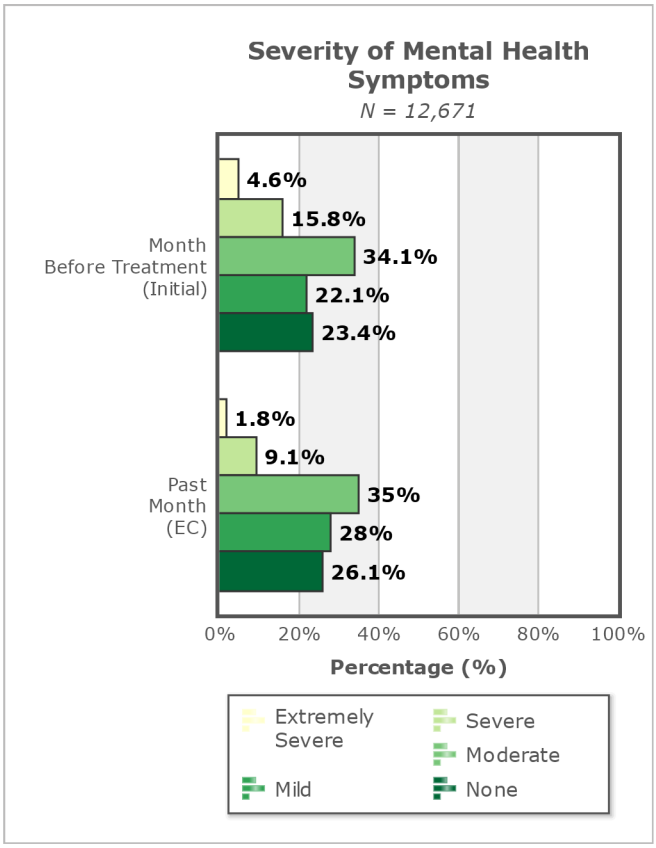


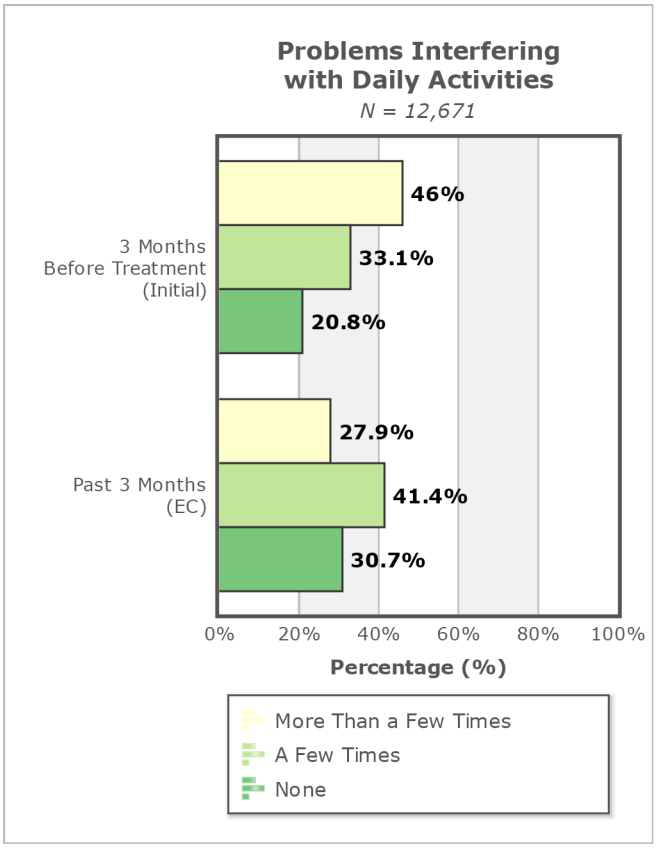


Consumers in Special Programs	Number N = 12,671
TASC program consumer	896



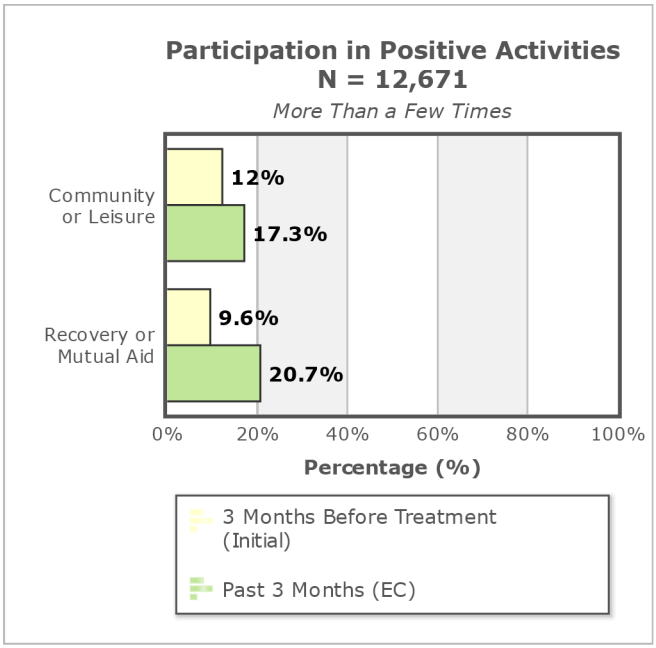
Behaviors





Consumer Ratings on Quality of Life % Rated 'Excellent' or 'Good' N = 4,307		
	Year Before Treatment (Initial)	Past 3 Months (EC)
Emotional Well-Being	33.7%	56.0%
Physical Health	46.0%	59.4%
Family Relationships	40.3%	56.4%
Living/Housing Situation	46.3% N = 4,261 *	59.4%

* - Interview(s) were completed after the question was added to NC-TOPPS.



Family and/or Friends Somewhat or Very Supportive N = 4,307		
	Expect Support (Initial)	Received Support (EC)
Family Support	90.5%	91.7%

Experienced Abuse N = 4,307		
	3 Months Before Treatment (Initial)	Past 3 Months (EC)
Physical Violence	9.4%	4.6%
Hit/Physically Hurt Someone	7.1%	3.8%

Justice System Involvement
N = 12,671
3,048 *(24.1%)* consumer(s) were under supervision at the time of their EC interview.

	Month Before Treatment (Initial)	Past Month (EC)
Arrests N = 12,671	4.9%	4.1%
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Nights in Jail or Detention N = 4,307	12.7%	6.7%

Suicide Ideation and Hurting Self
N = 4,307

	Ever (Initial)	Since Last Interview (EC)
Suicidal Attempts	21.5%	1.5%
	3 Months Before Treatment (Initial)	**Since Last Interview (EC)**
Suicidal Thoughts	19.7%	5.4%
Tried to Hurt or Cause Self Pain	5.6%	1.2%

Psychotropic Medications at EC
5,476 *(43.2%)* consumer(s) have had a prescription for psychotropic medications in the past month. Of those, 4,183 *(76.4%)* take their medication as prescribed all or most of the time.

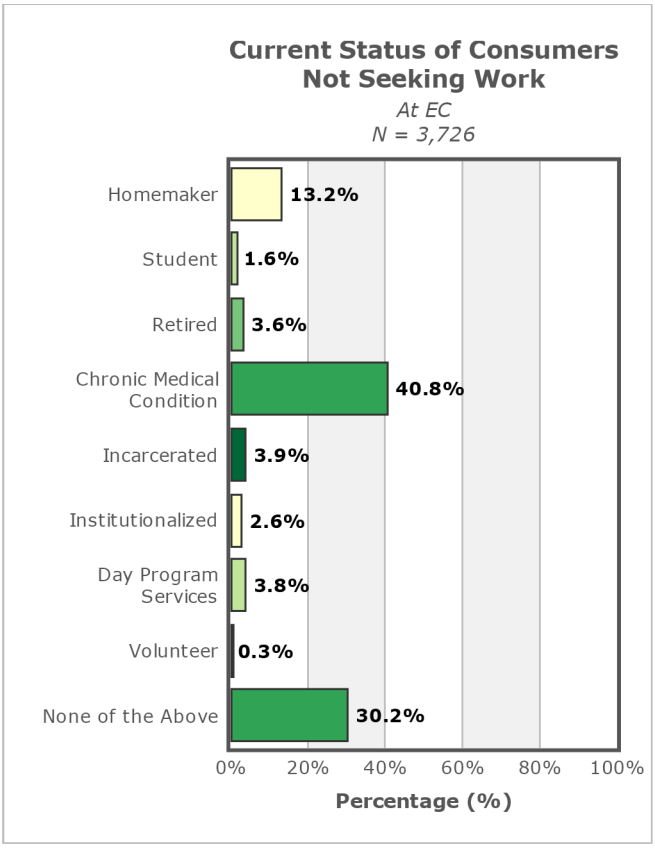
Employment/Housing

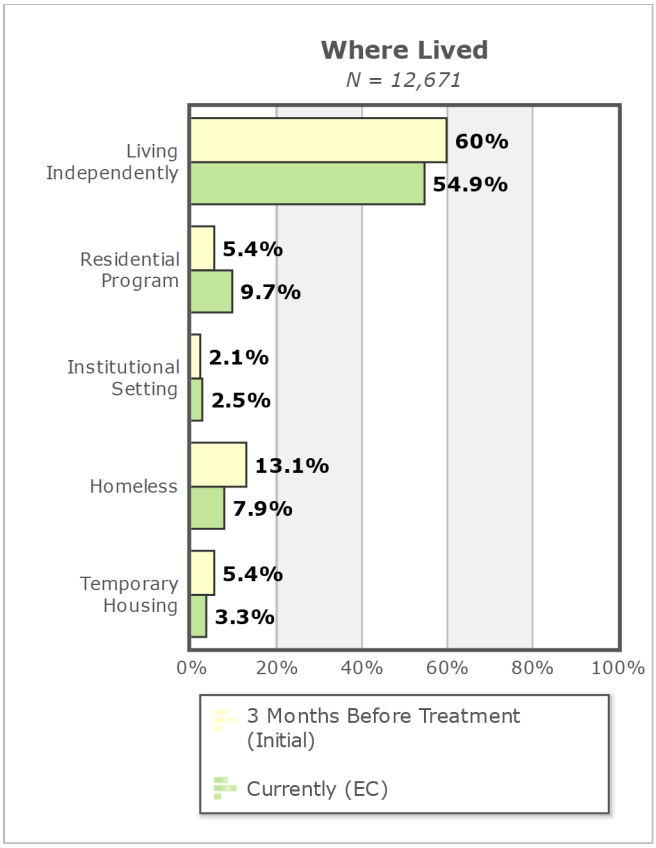
Employment N = 12,671	3 Months Before Treatment (Initial)	Currently (EC)
% In Labor Force	73.8%	70.6%
Of those in the labor force (N)...	**9,349**	**8,945**
Employed Full-time	18.0%	23.9%
Employed Part-time	13.9%	17.2%
Unemployed (seeking work)	68.1%	58.9%

Job Classification	Initial N = 2,936	EC N = 3,678
Professional, Technical, or Managerial	9.2%	7.1%
Clerical or Sales	6.6%	6.2%
Service Occupation	33.6%	40.3%
Agricultural or Related Occupation	2.2%	2.1%
Processing Occupation	3.8%	4.2%
Machine Trades	3.7%	2.4%
Bench Work	2.8%	3.1%
Structural Work	15.2%	14.6%
Miscellaneous Occupation	23.0%	19.9%

Employee Benefits	Initial N = 2,936	EC N = 3,678
Insurance	6.2%	9.0%
Paid Time Off	5.8%	7.7%
Meal/Retail Discounts	5.3%	5.5%
Other	4.5%	6.3%
None	82.8%	78.4%

Rate of Pay	Initial N = 2,936	EC N = 3,678
Above Minimum Wage	74.3%	78.3%
Minimum Wage	20.1%	18.1%
Below Minimum Wage	5.7%	3.5%





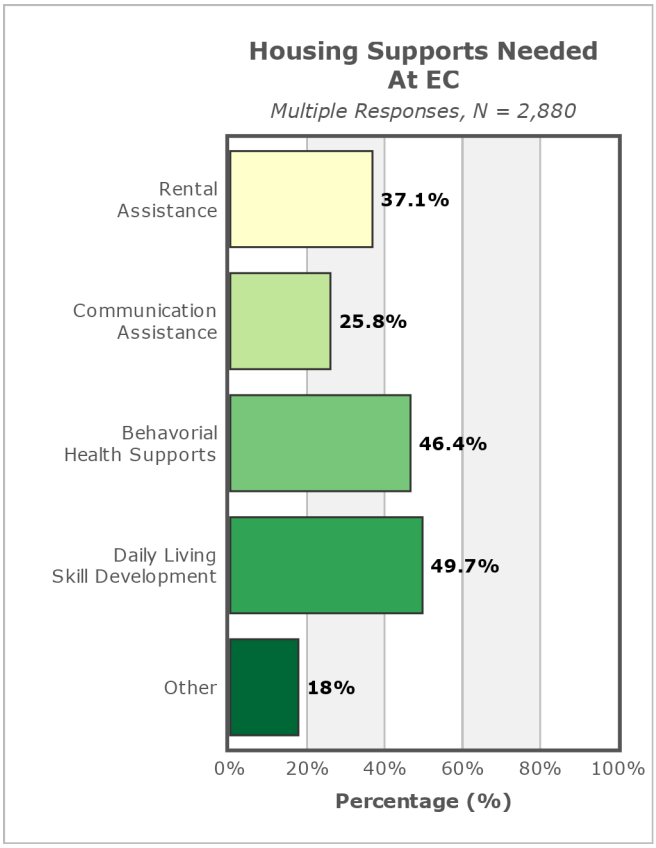
Times Moved Residences Past 3 Months (EC) N = 12,671	
No Moves	72.4%
Moved Once	18.5%
Moved Two or More Times	9.1%

Homeless Consumers	3 Months Before Treatment (Initial)	Currently (EC)
In Shelters	801	539
Not In Shelters	856	466
Total Homeless (N)	1657	1005

Service Needs

Services Deemed Important at Initial and Received at EC Multiple Responses, N = 12,671		
	Initial	**EC**
Education	26.5%	8.8%
Job	40.6%	15.3%
Housing	37.3%	22.7%
Transportation	35.4%	22.4%
Child Care	7.3%	2.8%
Medical	30.9%	20.5%
Dental	24.2% N = 12,448 *	4.7%
Screening/Treatment Referral for HIV/TB/HEP	N/A	9.4%
Legal	18.3%	12.2%
Volunteer Opportunities	8.6% N = 12,448 *	3.9%
None	27.2%	45.9%

* - Interview(s) were completed before the question was added to NC-TOPPS.



Barriers to Treatment Multiple Responses, N = 12,671		
	Initial	**EC**
No Difficulties	67.1%	64.0%
Active MH Symptoms	8.8%	8.6%
Active SA Symptoms	16.9%	17.8%
Physical Health	1.8%	2.5%
Family Issues	1.5%	2.0%
Needs Not Met	0.9%	0.5%
Engagement	2.2%	7.1%
Cost	4.6%	1.6%
Stigma /Discrimination	0.4%	0.1%
Treatment /Auth. Access	1.6%	0.4%
Deaf/Hard of Hearing	0.1%	0.0%
Language/Comm.	0.1%	0.1%
Legal Reasons	1.8%	2.4%
Transportation	10.2%	9.3%
Scheduling Issues	3.2%	5.2%
Lack of Stable Housing	3.9% N = 12,448 *	2.3%
Personal Safety	0.6% N = 12,448 *	0.3%

* - Interview(s) were completed before the question was added to NC-TOPPS.

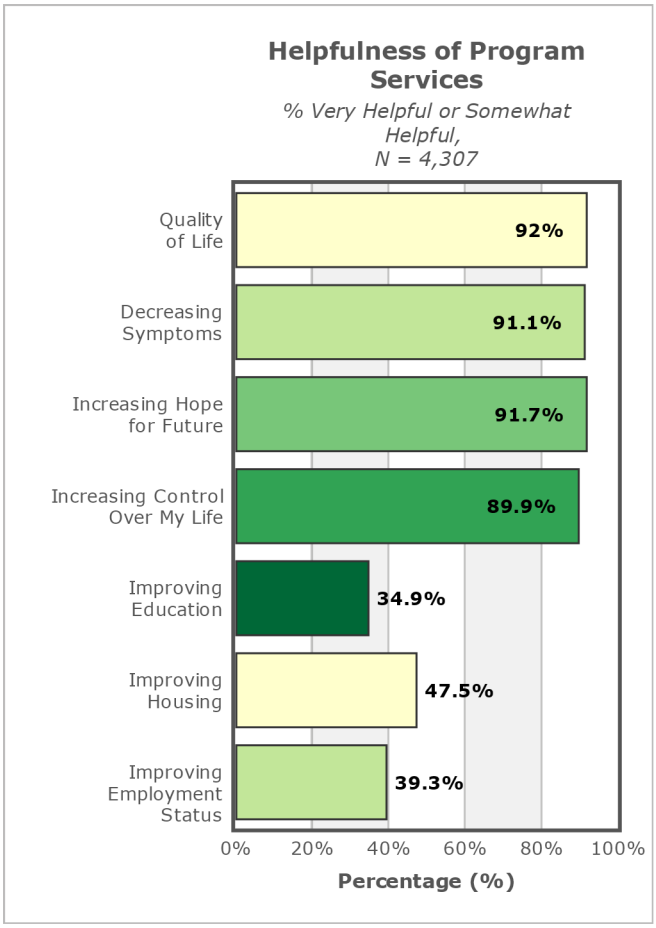
Crisis/Hospital Care Past 3 Months N = 4,307		
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Crisis Contacts	16.4%	9.9%
ER Visits	29.4%	19.4%
Medical/Surgical Hospital Nights	11.6%	7.5%
Psychiatric Inpatient Hospital Nights	12.4% N = 4,261 *	6.8%

* - Interview(s) were completed after the question was added to NC-TOPPS.

Routine Health Care
Among 4,307 consumer(s), 1,848 *(42.9%)* have seen their provider for a routine check-up since the last interview.

Routine Dental Care

Among 4,307 consumer(s), 660 *(15.3%)* have seen their dentist for a routine check-up since the last interview.

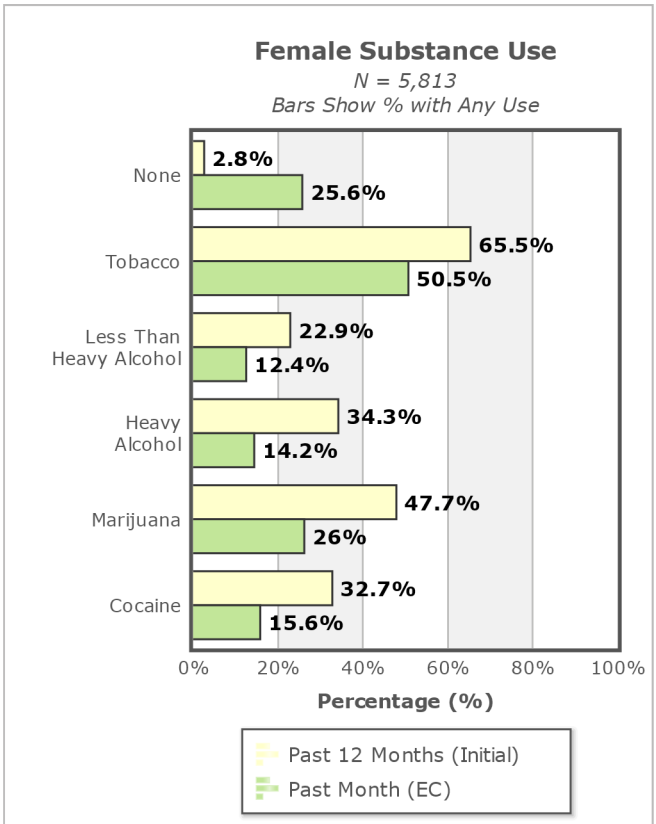


Maternal/Perinatal

Female Substance Use Consumers
Several questions on the NC-TOPPS interview are asked only to female consumers. The tables and charts on this page show the results for those questions. In addition, several other charts are shown for females only. The number of female consumer(s) is 12,736 *(46.1%)*.

Pregnancy ***Female N = 2,153***	**Number**
Gave Birth in Past Year	209
Currently Pregnant	98
Uncertain about Pregnancy Status	20
In First Trimester*	20
In Second Trimester*	38
In Third Trimester*	40
Referred to Prenatal Care*	86
Receiving Prenatal Care*	87

* of those who are pregnant.



Females with Children Under 18
Of the 5,813 female consumer(s), 3,081 *(53%)* have children under the age of 18.

DSS Involvement Since Last Interview Among Females with Children Under 18 N = 3,081	
Investigated by DSS for Child Abuse/Neglect	7.9%

Sexual Risk Activity Among Females
Participation in any one or more of these activities: (a) had sex with someone who was not your spouse or primary partner, (b) knowingly had sex with someone who injected drugs, or (c) traded, gave, or received sex for drugs.

N = 2,153	
In Past 3 Months	6.7%

Females Forced or Pressured to Do Sexual Acts N = 2,153	
In Past 3 Months	2.0%

Females Experienced Abuse Past 3 Months N = 2,153	
Physical Violence	5.5%
Hit/Physically Hurt Another Person	4.3%

Suicide Ideation and Hurting Self, Since Last Interview Among Females N = 2,153	
Suicidal Attempts	1.4%
Suicidal Thoughts	5.4%
Tried to Hurt or Cause Self Pain	1.1%

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the State's application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) of the North Carolina Department of Health and Human Services is the Single State Agency for the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the State Mental Health Agency for the Community Mental Health Services (CMHS) Block Grant. The Division consists of the Director's Office and five (5) sections, each of which contains one or more teams. The position of Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services has been vacant for over one year and is still in the recruiting process. The Deputy Director of DMH/DD/SAS and the Division of State Operated Health Facilities has been the Interim Director during this time.

The overall structure of DMH/DD/SAS is both functional in nature as well as disability-specific. Sections include Policy and Program Design, System Performance, Operations, Engagement and the Chief Medical Officer's section. **Please see the DMH/DD/SAS organizational chart in the Attachments section.**

The Assistant Director for Policy and Program Design is responsible for the largest number of sections and teams within the Division. Those teams consist of the Addictions and Management Operations team, the Prevention and Wellness team, the Transitioning Populations team and the Drug Control team, as well as the Mental Health team and the Intellectual/Developmental Disabilities team. The Mental Health, Addictions and Management Operations and Intellectual/Developmental Disabilities sections have staff with expertise in each of the populations of focus, who are further specialized along the developmental stages of early childhood (0-5), later childhood (6-12), youth (13-17) and adulthood.

The Addictions and Management Operations team is primarily responsible for SUD treatment and recovery services. It is comprised of the Section Chief, the Women's Services Coordinator, the State Opioid Treatment Authority Administrator (SOTA) and two field staff who provide technical assistance and monitoring of the 75 opioid treatment programs in North Carolina, a recovery-oriented systems of care specialist and an adolescent services specialist. Additional time-limited staff

function as Project Directors for several federal discretionary grants, including the Medication Assisted Treatment-Prescription Drug and Opioid Abuse (MAT-PDOA) grant, the Pregnant and Post-Partum Women Pilot (PPW-PLT) grant and the State Opioid Response (SOR) and State Opioid Response (SOR) Supplement grant.

Primary prevention services are currently housed in the Prevention and Wellness team. This team is comprised of the Section Chief and staff that are responsible for SUD primary prevention initiatives under the block grant, including programmatic and financial compliance, monitoring and reporting, training and technical assistance, interagency relationships, coordination and planning, needs assessment and the utilization of evidenced based programs, policies and practices. Other areas of focus include underage drinking, as well as Synar/FDA compliance and the prevention components of the State Opioid Response grant. Time-limited staff oversee the SPF-Rx grant focusing on prescription drug use/misuse and the Partnership for Success grant, which focuses on the prevention of underage drinking ages 9-20, marijuana and e-cigarettes.

The Drug Control Unit is responsible for the Controlled Substances Reporting System, North Carolina's prescription drug monitoring program (PDMP), and criminal and juvenile justice programming, such as TASC and the Behavioral Health Juvenile Justice Partnership (BHJJP).

The Assistant Director for System Performance oversees the Quality Management team, the Program Integrity team, the Financial Audit team, the Systems Information team, the LME/MCO Liaisons team, the DWI team and the System Advocacy team.

The Assistant Director of Operations oversees the Consumer Rights team, the Budget and Finance team, the Legislative and Regulatory Affairs team and Human Resources.

The Assistant Director of Consumer Policy oversees the Consumer Engagement and Empowerment team, and Military and Veterans Services. The Consumer Empowerment section provides consumer advocacy leadership and ensures that state-operated healthcare facilities and community-based systems are in compliance with rights' protections for individuals served through the system.

The Chief Medical Office oversees the PASSAR team as well as various medical and pharmacy personnel in both DMH/DD/SAS and DSOHF.

Substance use disorder treatment and prevention and mental health services were formerly provided directly by service providers (individuals) employed by area/county programs. With the 2001 Mental Health Reform legislation passed by the NC General Assembly, the focus of area programs shifted from direct service provision to the management of the local service delivery system. These Local Management Entities (LMEs) began contracting with providers for the delivery of services in their catchment areas. Between 2001 and 2010, the number of LMEs was incrementally reduced from 48 to 23. In April 2005, the state piloted the 1915 (b) Freedom of Choice Waiver/(c) Innovations Home and Community Based Services (HCBS) Managed Care Waiver with one LME. Under these waivers, Medicaid services are funded through capitated Pre-paid Inpatient Health Plans (PIHP) that allow the MCO to have more flexibility in service delivery. Due to the success of the pilot, in December 2009, DHHS submitted a waiver amendment to CMS designed to expand the 1915 (b)/(c) waiver statewide over a period of several years. Numerous mergers between LMEs have occurred since then, resulting to date in seven (7) LME/MCOs covering all 100 counties. DMH/DD/SAS

and the Division of Health Benefits (also called NC Medicaid) jointly administer the LME/MCOs. The Division is primarily responsible for the oversight of services delivered by Local Management Entities/Managed Care Organizations (LME/MCOs), as they are the Division's intermediaries at the local level. **Please see the map in the Attachments section for the counties covered by each LME/MCO.**

More recently, in October 2018, the federal Centers for Medicare and Medicaid Services (CMS) approved North Carolina's 1115 Demonstration Waiver application submitted in November 2017. The approval is effective January 1, 2019 through October 31, 2024. The amended waiver is the result of collaboration among DHHS, beneficiaries and their families, advocates, health care providers, health plans and associations, lawmakers and other stakeholders throughout North Carolina. Beginning in November 2019, the Department of Health and Human Services will enroll most Medicaid beneficiaries into integrated managed care products called Standard Plans that will cover physical health, behavioral health and pharmacy services. Later in 2021, individuals with significant behavioral health disorders, intellectual and developmental disabilities (I/DD) and traumatic brain injuries (TBI) will be enrolled into Behavioral Health and Intellectual and Developmental Disability (I/DD) Tailored Plans, which are specialized managed care products targeting the needs of these populations. This final policy guidance describes detailed eligibility criteria and processes to guide enrollment into Behavioral Health I/DD Tailored Plans, including transitions of these beneficiaries across health plans and delivery systems. In developing these criteria and processes, the Department relied on the following key principles:

- **Enroll Beneficiaries in the Managed Care Product that Best Meets Their Needs.** Standard Plans and Behavioral Health I/DD Tailored Plans will offer integrated physical health, behavioral health and pharmacy services but Behavioral Health I/DD Tailored Plans will offer a more robust set of behavioral health, I/DD and TBI benefits, and specialized care management. The Department will leverage available data to enroll beneficiaries in the product best suited to meet their needs.
- **Minimize Barriers to Access.** The Department will strive to minimize barriers for beneficiaries who need to transition between plans to access a benefit only available in a Behavioral Health I/DD Tailored Plan. This includes making sure there is a clear process for beneficiaries who are not identified as meeting Behavioral Health I/DD Tailored Plan eligibility through available data.
- **Comply with Legislation.** The Department will ensure that Behavioral Health I/DD Tailored Plan eligibility criteria and benefits meet the North Carolina General Assembly's vision for Behavioral Health I/DD Tailored Plans as articulated in legislation.
- **Be Responsible Stewards of Public Funds.** The Department will ensure that only beneficiaries who will benefit from more intensive behavioral health, I/DD, and TBI services and specialized care management enroll in a Behavioral Health I/DD Tailored Plan, and other beneficiaries who do not meet the level of need do not unnecessarily enroll in the higher cost Behavioral Health I/DD Tailored Plan.

The above information speaks to the department's commitment to transform the Medicaid system to one that addresses both medical and non-medical drivers of health. During the current long

session of the North Carolina General Assembly, Medicaid expansion has been a frequent topic. House Bill 655 would allow for people who earn too much to qualify for Medicaid and too little to receive subsidies on the health insurance online marketplace to get access to insurance through the Medicaid program. The Health Care for Working Families Act would charge people who fall into the "coverage gap," earning between 50 and 133 percent of the federal poverty level (from about $6,200 to $16,611 per year for an individual) to pay small premiums and copays in order to receive coverage. Although this bill has passed the House Health Committee, it has not been heard in the Senate, so the outcome, as well as final version of the bill, is uncertain.

Additionally, as part of its commitment to expand access to treatment for substance use disorders (SUDs), North Carolina's Department of Health and Human Services has been approved for an 1115 SUD Demonstration waiver to strengthen its SUD delivery system by:

- Expanding its SUD benefits to offer the complete American Society of Addiction Medicine (ASAM) continuum of SUD services;
- Obtaining a waiver of the Medicaid institution for mental diseases (IMD) exclusion for SUD services;
- Ensuring that providers and services meet evidence-based program and licensure standards;
- Building SUD provider capacity;
- Strengthening care coordination and care management for individuals with SUDs; and
- Improving North Carolina's prescription drug monitoring program (PDMP).

Please see the attached document titled ***North Carolina Substance Use Disorder Implementation Plan Protocol*** for more details.

The SSA supports a comprehensive system of care to enable individuals that it serves to live in communities of their choosing and avoid inpatient hospitalization and institutionalization to the greatest extent possible. The array of available services includes basic outpatient services (assessment, individual therapy, group therapy, family therapy), enhanced services (Substance Abuse Intensive Outpatient Program, Substance Abuse Comprehensive Outpatient Treatment, Community Support Team, Intensive In-Home, Adolescent Day Treatment), opioid/medication assisted treatment, halfway house and supported housing services, Work First services and Treatment Accountability for Safer Communities (TASC) for people involved in the criminal justice system. A robust array of gender-specific/gender responsive services are available for women, including women who are pregnant and/or have dependent children. In addition, mobile and walk-in crisis services, various levels of detoxification, residential and inpatient treatment services are available throughout the state. Over the last few years, the Division has focused on more fully developing and implementing its recovery-oriented system of care philosophy. Funding is provided for recovery community organizations that work with several funded and grass-roots recovery community centers and collegiate recovery programs.

Utilization of peer supports, recovery coaching and mentoring are becoming more embedded in services as integral components of treatment and recovery success, including in emergency departments, prisons and jails. DMHDDSAS and the Division of health Benefits have been working together to develop a statewide Peer Supports service definition. The state-funded service definition became effective August 1, 2019, and the Medicaid-funded peer support will soon be

added to the State Plan Amendment. Please see the section on Recovery Services for more detailed information.

A Cross Area Service Program (CASP) is a Division designated specialty service program that is funded by the Division through federal and/or state funds to address the distinctive needs of an identified age and disability consumer and family special population. A CASP is designated by the Division as a result of a critical federal grant initiative or a priority state service initiative.

Dedicated federal and/or state one-time and continuation funding is directed by the Division and allocated to an identified sponsoring LME/MCO in a three-way partnership with a Division designated or approved provider. Funds are intended to address comprehensive statewide service needs, most commonly across multiple Local Management Entity/Managed Care Organizations (LME/MCOs). This sponsoring LME/MCO partners with the Division and a designated provider in implementing a specific age and disability based initiative, in accordance with Division established requirements, guidelines, and parameters. CASP services are planned, contracted, authorized, reimbursed, and evaluated by the LME/MCO, in consultation with the Division. Most CASPs are intended to be able to serve consumers, providers and LME/MCOs from any region of the state. This better assures that availability for services is adequate, as some populations, such as adolescents or pregnant women, may access any program or level of care across the state if local programs are at capacity.

Examples of Cross Area Services Programs include opioid treatment programs (OTPs), juvenile detention centers, regional residential treatment programs for adolescents with substance use disorders, CASAWORKS programs, residential treatment programs for women who are pregnant and parenting and their children, initiatives for preventing underage drinking, etc.

Prevention and Wellness Services

LME/MCOs currently subcontract to local prevention providers in their catchment areas to deliver services across the state. There are 26 local prevention providers across 7 LME/MCO catchment areas. They implement the SPF in each of their assigned counties, identifying needs, resources, and capabilities. Local prevention agencies plan and address local needs and implement evidence based prevention strategies. They receive support from the NC Training and Technical Assistance Center, who participates in a Statewide Prevention Consortium that consists of training and TA agencies, discretionary grant leads, prevention evaluation center, and other statewide prevention resources. This oversight ensures effective implementation and high-quality prevention services, delivered in alignment with state business policies for the prevention system.

The state has contracted with Prospectus Group to utilize their ECCO system for capturing primary prevention implementation plans and reporting. The state communicates policies and procedures for the delivery of primary prevention services every six months during regional statewide meetings and are published with support from the North Carolina Training and Technical Assistance Center (NCTTA). NCTTA is independent of provider agencies and provides coordinated training and technical assistance to prevention block grant providers across the state.

Strengths of the state' s substance abuse prevention program include long and strong relationships with the NC Commission on Indian Affairs, NC Department of Public Instruction, NC Office of Juvenile

Justice and Delinquency Prevention, NC Teen Pregnancy Prevention Program, NC Department of Social Services, NC Office of Youth Advocacy, NC Highway Safety Program , Wake Forest University, East Carolina University, Research Triangle Institute, Pacific Institute for Research and Evaluation Southeast CAPT, CADCA and statewide substance abuse prevention partnerships, alliances, collaboratives and coalitions who have contributed time, resources, effort, and passion to ensure the delivery of quality and effective substance abuse prevention services to youth, their families and communities.

North Carolina has transitioned our prevention system to one that requires providers to utilize the Strategic Prevention Framework to assess local needs, build community capacity, plan strategically, and implement evidence-based strategies for the prevention of alcohol, tobacco, and other drugs, with a majority of funds (approximately 80%) expended for universal, population-based strategies. To that end we have recently provided administrative data for all 100 counties for the completion of a needs assessment in FY18 and will do so again in FY20, have administered a statewide youth prevention survey in FY18 with plans for another survey in FY21. We have also issued a contract for evaluation services to Wake Forest University since FY18.

The SUD contract prevention providers are dedicated to the delivery of appropriate and quality services. There are several partnerships, alliances, coalitions and collaboratives providing individual and population-based strategies to communities throughout NC. The LME/MCOs contract with local prevention providers to deliver primary prevention activities throughout the 100 counties across the state. The LME/MCO receives guidance from the state office prevention staff about federal substance abuse prevention guidelines and policies. Local contract prevention providers conduct community need assessments to determine services and activities. The LME/MCO and prevention provider enter into a contract agreement that outlines specific prevention activities including target population and use of evidence-based curriculum. The LME/MCO is responsible for monitoring, reporting, and participation in any evaluation of the local prevention providers. The LME/MCO is required to conduct a needs assessment and gap analysis of their service area. Each LME/MCO works with the contract substance abuse prevention provider to assist with identifying target populations and services based on the results. Local contract prevention providers infuse cultural diversity policies into all prevention activities.

For data collection, the state requires prevention providers to complete a needs assessment to determine populations in need of primary prevention services, as well as the specific intervening variables that should be targeted for each population. Providers are required to capture substance use prevention consumption, consequences, and intervening variables for every county in the state. They are further given guidance on identifying disparately impacted populations. The state has developed a data dashboard, providing a wide cross section of administrative data available at the county level, and conducted a youth prevention survey to support prevention providers in this effort. They have also provided training in assessment, including data collection methods and follow-up technical assistance, to provide a theoretical understanding of the process, hands on application, and then individually tailored assistance with the assessment process.

The NC Prevention System operates a Behavioral Health Equity Initiative to serve as a resource to further address behavioral health disparities. This Initiative provides training and guidance, through the NC Prevention Consortium to ensure adequate planning and identification of disparities across

the state. This is a project that serves as a framework that is used to provide guidance statewide. Identification of and planning for behavioral health disparities is built into the SPF process that every prevention agency implements.

Women's and Children's SUD Services

The mission of Women's and Children's Substance Use Services is to provide comprehensive gender-specific, family-centered substance use disorder treatment and recovery services and supports to pregnant and parenting women with substance use disorders and their children. The major Initiatives address the treatment, health, and safety needs of a high risk group of women and children, reducing the impact of maternal and parental substance use on the health and wellbeing of women and their children and families through provision of gender specific, trauma informed, and evidence based or evidence informed treatment and health care services. Evidence based, evidence informed, and best practices for this population have been found in national clinical trials to reduce symptoms of neonatal abstinence syndrome for prenatally exposed infants, improve the health and wellbeing of children and their mothers, and reduce risk of criminal justice or child welfare involvement for families, thus having a positive impact on family wellbeing and reducing societal costs. Families involved in the programs have a wide range of needs to be addressed as part of recovery, health and stability for their families. Many of the needs that are met outside the scope of the initiatives' direct services, are accomplished through linkages and active coordination with other services and programs. The following are examples of the current Initiatives:

1. **Alcohol/Drug Council of NC (ADCNC): Perinatal Substance Use Project:** The NC Division of MH/DD/SAS and the NC Division Public Health jointly fund a Substance Use Specialist position housed at ADCNC. The Substance Use Specialist can be reached at 1-800-688-4232 or through the 1-800-FOR-BABY hotline, Monday through Friday, from 8 am to 5 pm. Services are available to the public and professionals to provide support in accessing gender-specific substance abuse treatment services statewide. Technical assistance, training and education regarding screening and referral for pregnant women with a substance use disorder are also available. A capacity management (bed availability) listing of residential substance use disorder treatment services for pregnant and parenting women and their children is maintained to assist the public and professionals to identify appropriate and available services statewide.

2. **North Carolina Perinatal and Maternal Substance Use & NC CASAWORKS for Families Residential Initiative:** The Perinatal and Maternal Substance Use Initiative is composed of 19 specialized programs for pregnant and parenting women with a primary substance use disorder and their children. These programs provide comprehensive gender-responsive substance use disorder treatment services that include, but are not limited to, the following: screening, assessment, case management, out-patient substance use disorder and mental health services, parenting skills, residential services, referrals for primary and preventative health care, and referrals for appropriate interventions for the children. The children also benefit from the services provided by the local health departments (pediatric care), early intervention programs and care coordination for children (CC4C).

The NC CASAWORKS for Families Residential Initiative supports seven (7) comprehensive residential substance use disorder programs for women a primary substance use disorder and their children. The CASAWORKS for Families model was developed by the Center for the Study of Addiction and Substance Abuse (CASA) at Columbia University in response to the impact of welfare reform on families who are substance use involved. The model proposes that the best way to help families receiving TANF become economically self-sufficient is to provide an integrated and concurrent gender specific substance use disorder and co-occurring treatment and job readiness, training, and employment program.

The residential services that are a part of the NC Perinatal and Maternal Substance Use Initiative and the CASAWORKS for Families Residential Initiative are considered Cross Area Service Programs and are available to any pregnant or parenting women and her children who meet medical necessity for the services based on ASAM criteria. The outpatient only programs are offered to pregnant and parenting women who meet the ASAM criteria for this level of care in the specific LME/MCO catchment area.

3. **Work First/CPS Substance Use Initiative:** The Work First/CPS Substance Use Initiative is a joint initiative of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the North Carolina's Division of Social Services (DSS). The two Divisions have an interagency memorandum of agreement in place delineating the roles and responsibilities of each entity. This Initiative provides appropriate assessment, treatment referral, and case coordination for eligible Work First (TANF), Class H or I Controlled Substance Felons eligible for Food and Nutrition Services (FNS) and certain categories of recipients of Child Protection Services (CPS). The goal of the Work First/CPS Substance Use Initiative is to provide early identification and connection to treatment, of Work First recipients and eligible Food and Nutrition Services recipients who have substance use problems severe enough to affect their ability to become self-sufficient. The program also assists parents who have substance use problems and who are involved with CPS engage in appropriate treatment. Each of the county department of social services has access to a Qualified Professional in Substance Abuse (QPSA), contracted by the Local Management Entity -Managed Care Organization (LME/MCO). Generally, QPSAs are located in local county departments of social services and are easily accessible to families and social services staff. Each LME/MCO establishes a local MOA between county DSS and LME/MCO and/or QPSA provider, which is reviewed annually. The LME/MCO is responsible for submitting quarterly reports to DMH/DD/SAS. These reports reflect the numbers of individuals who have had assessments completed, delineated by referral source or cause (Work First, CPS, H or I felon). The number of individuals that a QPSA is coordinating services for, per quarter, is also reflected on this report. Quarterly statewide Initiative meetings with the QPSAs and LME/MCOs occur to review the aggregate quarterly data and discuss the barriers and successes that each county is experiencing in serving these populations. Monitoring of the Initiative occurs annually at the state level of both the LME/MCO's management of the Initiative and of the individual cases. The LME/MCO's are responsible for local monitoring of

the community providers that have been contracted for the QPSA positions. Ongoing technical assistance is provided to the LME/MCOs, DSSs, and QPSAs by DMH/DD/SAS.

4. **NC Plan of Safe Care Interagency Collaborative:** 2016 CARA federal legislation, and within it, CAPTA, has impacted North Carolina policies as they relate to infants who have been born exposed to substances during pregnancy. The goal of the federal legislation and subsequent state policies are to support the health and wellbeing of the infant, mother and family. North Carolina policies went into effect August 1, 2017. The intentions of North Carolina policies are:
    - To include infants, children and families in the Plans of Safe Care.
    - To support the health of the infant and mother, not to penalize the mother and family.
    - To increase access to treatment and support for all women with a substance use disorder and their children. To provide access to appropriate screening and surveillance, assessment and intervention services for infants determined to be affected by substance abuse, withdrawal or Fetal Alcohol Spectrum Disorders (FASD).

    The following agencies have been meeting since January 2017, as the NC Plan of Safe Care Interagency Collaborative (NC POSCIC), to develop the required policies, procedures and implementation:

    - Division of Mental Health, Developmental Disabilities and Substance Abuse Services
    - Division of Public Health
    - Division of Social Services
    - Division of Medical Assistance
    - Community Care of North Carolina
    - North Carolina Hospital Association
    - North Carolina Obstetrics and Gynecological Society
    - North Carolina Commission on Indian Affairs

    The Infant Plan of Safe Care itself, is simply a referral of an identified infant to Care Coordination for Children (CC4C) from Child Welfare, that includes services and linkages that the infant and family may benefit from. All infants identified as meeting criteria as 'affected by substance abuse' have a notification go to their local county Child Welfare, who screen and then universally refer to CC4C for ongoing support services. Approximately 70% of the notifications statewide result in child welfare assessments.

5. **Reproductive Life Planning and Substance Use Disorder Treatment Project:** The North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) has partnered with the North Carolina Division of Public Health (NCDPH) Family Planning and Reproductive Health Unit to provide training to the staff of perinatal and maternal substance use and opioid treatment programs in our statewide initiatives. Participants include staff from the Federal Title X funded Local Health Departments (LHDs) corresponding to the identified treatment programs.

The cross disciplinary training on reproductive life planning and substance use disorders promotes the local partnerships of the identified substance use disorder treatment programs and their Local Health Departments. These partnerships will impact effective support of individuals with substance use disorders, and in recovery, in their reproductive life plans. It is specifically intended to be non-coercive and non-judgmental in the provision of the information and connection to services. Training objectives Include:

- Increase knowledge about the key components of reproductive life planning.
- Increase or review knowledge about addiction and the importance of language when work with individuals with substance use disorder.
- Increase or review knowledge about reproductive biology and sexually transmitted diseases.
- Increase awareness about the importance of counseling all individuals of reproductive age with substance use disorder about reproductive life planning.
- Improve reproductive life planning counseling skills.
- Facilitate local partnerships.

The SUD treatment programs track the occurrences of individual and group reproductive life planning specific sessions and referrals, reporting on the aggregate data quarterly. Also included in the quarterly report data are the numbers of individuals who required transportation assistance to necessary appointments related to reproductive life planning.

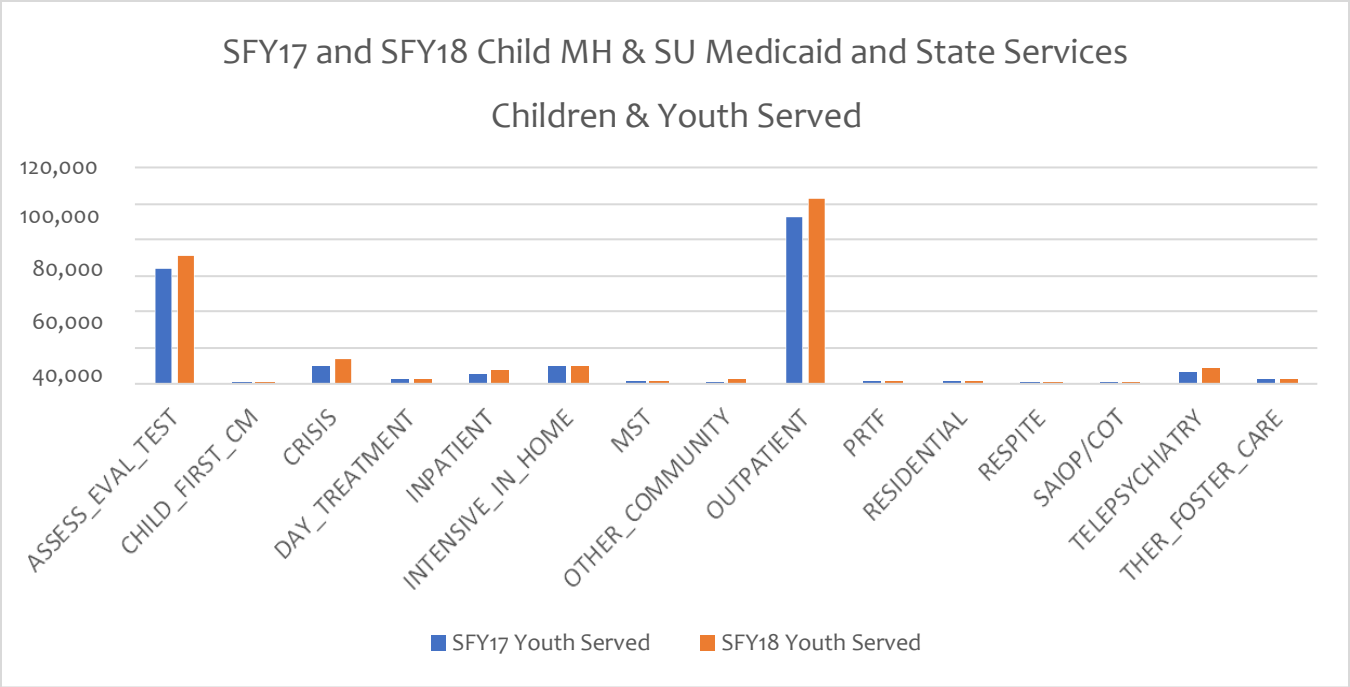
Monthly meetings to support the implementation of the RLP-SUD practices include the state partners and the community level SUD treatment programs and the LHD professionals. These meetings include deidentified case presentations and specific topics that are covered through didactic and discussion. Technical assistance is available to the SUD treatment programs and the Title X LHD on an ongoing basis from the state partners.

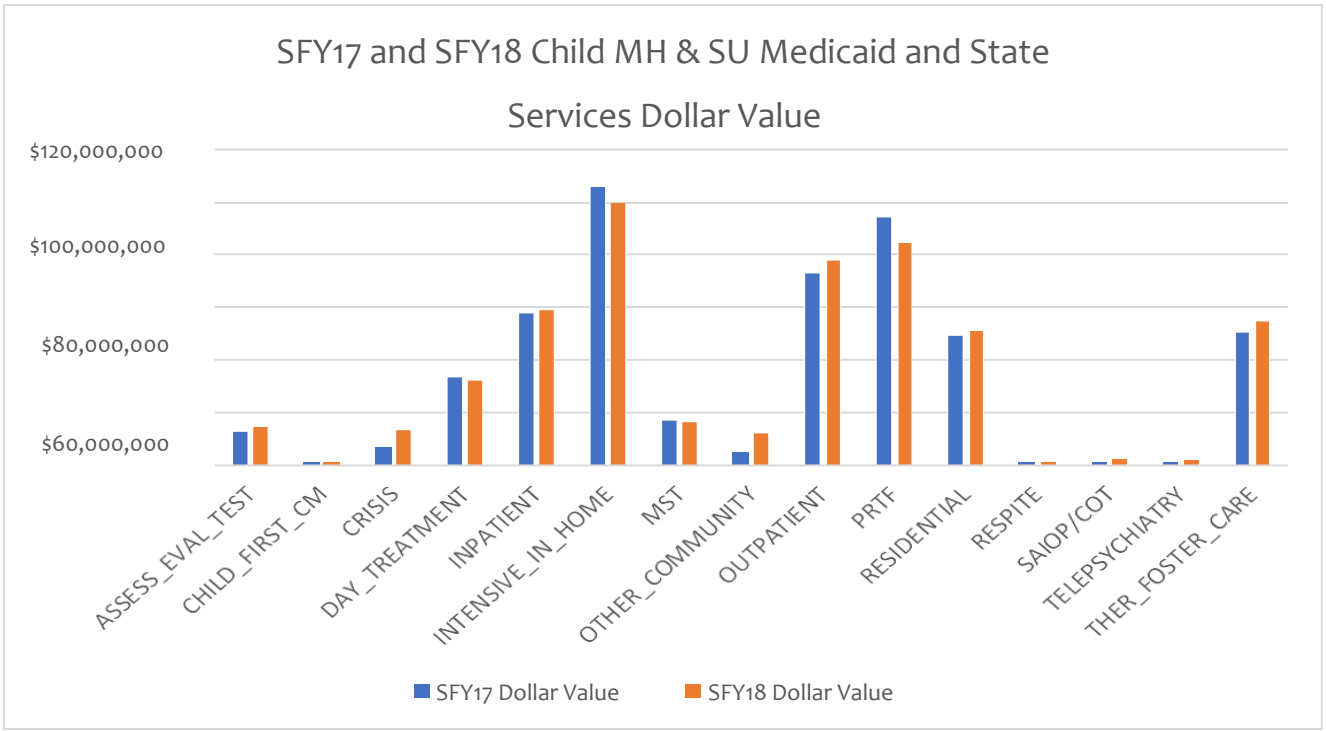
Adolescent Substance Use Disorder Services

Services available for youth, who are often diagnosed with other behavioral or mental health disorders, in addition to substance use, include:

- Outpatient Therapy
- Outpatient Therapy Plus (some LME/MCOs)
- Day Treatment
- SA Intensive Outpatient
- Intensive In-Home Services
- Multisystemic Therapy

The charts below provide a comparison for child services for state fiscal years 2017 and 2018 for both Medicaid and state-funded (including block grant) services by type of service and dollar value.





In addition to the above, the Adolescent Substance Use Disorder Regional Residential Program Initiative was created to ensure the availability of SUD residential services for adolescents in every region of the State of North Carolina. The mission is to provide medium-term residential services and

public education to prepare individuals under 18 years old with Substance Use Disorders, and other co-occurring problems, for ongoing community- based recovery services.

All programs under this initiative admit youth from anywhere in the state, serving all 100 counties, giving them the distinction of Cross Area Service Programs (CASPs). All programs use proven evidence- based SUD models at their facilities. These programs provide 24-hour residential services through supervised living or similar licensure and intensive outpatient or day treatment services. The majority of sites provide public education through local teachers assigned to the program by the local education authority or Department of Public Instruction.

These programs provide evidence-based SUD treatment services that include counseling to assist youth and their families in becoming actively involved in their own recovery. This is achieved through comprehensive assessment, treatment planning, group therapy, individual therapy and continued care planning. A Child and Family Team is constructed for every youth and family. The team has the responsibility of developing and updating the youth's Person Centered Plan (PCP) for recovery. This also includes discharge planning and care coordination for when youth return to their homes and community to ensure continuing treatment through their local community outpatient treatment programs, and other community resources.

The youth receive psychological services that include the provision of diagnostic testing and specialized psychotherapy for youth when appropriate. Psychiatric evaluation and medication-management are also available to youth. Family services are offered to family members and other significant people in the youth's life, and include weekly individual, and multi-group sessions.

Therapeutic Recreation Services are provided daily, and programs use their own recreation facilities on site along with community facilities such as the YMCA. Each program develops internal incentives to teach and encourage the youth while in the program. Each adolescent Substance Use Disorder Regional Residential Program is unique; therefore, there are some variations in the services offered by the individual programs across the state.

Presently, North Carolina has five (5) Substance Use Disorder Regional Residential facilities operational including the following: (1) Swain Recovery Center is a five-bed facility located in the western part of the state; (2) Youth Focus Adolescent Substance Abuse Program is a 10-bed facility in north central North Carolina; (3) PORT Aberdeen is a 10-bed facility in south central North Carolina; (4) PORT Greenville is a 10- bed facility in the eastern part of the state and (5) Port Burgaw, another 10-bed facility in the southeastern area of the state.

These programs are monitored by both the LME/MCO and the State. Each program is monitored locally by the LME/MCO. However, the state conducts quarterly meetings and yearly site visits to ensure the programs operate within the compliance guidelines for treatment services.

The duration of services is based upon ASAM criteria for level of care and special continued service and discharge criteria. The average length of stay ranges from 90 to 120 days.

The Department of Public Safety is preparing for "Raise the Age" which will welcome 16 and 17-year-old into the Juvenile Justice system beginning December 1, 2019. Many of these youths will be referred to the behavioral health system for assessment and treatment. Beyond "Raise the Age," there is also legislation that could drive 14,000 youth involved with the Juvenile Justice system into

the behavioral health system for comprehensive assessments. The aforementioned state level Behavioral Health Juvenile Justice team has been working through a series of cross-system service barriers. The State team has also collaborated in sharing specific concerns/recommendations about meeting the behavioral needs of youth involved with juvenile justice system to the national consultant firm that is designing the new behavioral health system in the Medicaid Managed Care reform.

State Opioid Treatment Authority/Medication Assisted Treatment

Overview

The road to recovery is unique to everyone, and treatment for an individual may consist of any combination of services at different points in time. Treatment with medications is the standard of care for an opioid use disorder and substantially reduces overdose, transmission of infectious diseases such as HIV and hepatitis C, crime and unemployment.

The NC Opioid Treatment Program (OTP) system of care strives to be accessible, evidence-based, individualized and comprehensive by offering FDA-approved medications, as well as various levels of clinical care in order to best serve those with varying degrees of necessity.

The majority of OTPs in North Carolina are involved in their communities. Critical opportunities to initiate care are taking place in the jail system, in the prison system and in hospital emergency departments.

The mission of the North Carolina State Opioid Treatment Authority (SOTA) is to reduce the impact of opioid use disorder, in North Carolina communities and promote excellence in Opioid Treatment Programs. The State Opioid Treatment Authority Administrator and two field staff provide technical assistance and monitoring of the 74 opioid treatment programs in North Carolina serving 19,346 patients with an OUD. With a capacity of approximately 26,000 patients, capacity management, guest dosing and emergency management (in the event of natural disasters) functions are managed through a contract with an outside central registry vendor. **Please see the map of all OTPs in NC in the Attachments section.**

To date, the State Opioid Treatment Authority (SOTA), located within the Addictions and Management Operations section of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, has been primarily involved with the opioid treatment programs. As with many other states, North Carolina has seen substantial growth in the number of agencies opening programs. The certification process is lengthy and involves various other agencies, including the Division of Health Services Regulation, the Division's Drug Control Unit, the DEA and SAMHSA. Each OTP operating in NC is approved by the North Carolina State Opioid Treatment Authority which is responsible for program approval, for monitoring compliance with the regulations related to scope of staff, and operations, as per 10A NCAC 27G.3604.

North Carolina's OTPs are operated as either for-profit businesses or nonprofit organizations, as well as through the state's three state-run facilities (Walter B. Jones Alcohol and Drug Abuse Treatment Center located in Greenville, Julian F. Keith located in Black Mountain and RJ Blackley located in Butner). More than two-thirds of the OTPs in North Carolina receive state and federal dollars; the remainder are cash pay.

NC State Opioid Treatment Authority (SOTA) Responsibilities include the following:

1) Clinical and administrative on-site review and monitoring of approximately 74 local Opioid Treatment Programs (OTPs) on a daily basis, including consultation and technical assistance, with emphasis on safety and quality of care issues related to program leadership, staffing, supervision, scope of practice, admission and discharge protocols, medication ordering and administration, specialty patient treatment such as pregnant women and justice involved patients, and incident reviews, including deaths, non-fatal overdoses and injuries, and serious medication errors, and implementation of program policies and procedures in accordance with federal and state regulations, standards of care, NC-TOPPS patient and program outcomes evaluation and capacity management using Lighthouse Central Registry.

2) Clinical and administrative review on a daily basis of Opioid Treatment Program (OTP) patient incidents and complaints, including patient deaths, non-fatal overdoses, accidents, serious medication errors, admissions concerns, patient management issues, administrative discharges, medication diversion, and other adverse incidents involving patient, family, and community health and safety, and complaints about patient respect and dignity, program performance, and quality of care issues.

3) Coordination with the Center for Substance Abuse Treatment (CSAT) - Division of Pharmacological (DPT) Therapies and the Drug Enforcement Administration (DEA) regarding local program approval, monitoring, and program practices involving implementation of federal regulations, guidelines, advisories, and national accreditation standards.

4) Coordination with the NC Division of Health Service Regulation (DHSR) and the DMHDDSAS Drug Control Unit regarding local program approval, monitoring, and program practices regarding the implementation of federal and state regulations, guidelines, advisories, and national accreditation standards.

5) Clinical review and approval of daily individual patient and program take-home medication exception requests through the SAMHSA Center for Substance Abuse Treatment (CSAT) Opioid Treatment Program (OTP) Extranet System for take-home privileges for methadone and buprenorphine in accordance with 42 CFR Part 8.

6) Coordination with the NC Division of Medical Assistance (DMA) and LME-MCOs in the development and implementation of statewide policies regarding Medication-Assisted Treatment (MAT) utilizing methadone and buprenorphine, and the support of LME-MCOs in local Opioid Treatment Program credentialing, contracting, access, service authorization, monitoring, and program practices involving implementation of best practice guidelines and

standards of care, as well as federal and state regulations, guidelines, advisories, and national accreditation standards.

7) Coordination with the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and other national groups regarding the development and promotion of state, regional, and national approaches to addressing current and emerging issues in practice, including the development and implementation of prescription monitoring programs (PMPs), such as the NC CSRS, responses to the continuing threat posed by prescription drug use and heroin use, and the support of harm reduction approaches such as the distribution and utilization of Narcan overdose kits among at risk populations.

8) Development and implementation of specialized provider training, consultation, and networking opportunities with emphasis on OTP physicians, PAs, NPs, and Program Directors, through such vehicles as monthly physician/PA/NP group case consultation phone calls, quarterly meetings with program directors, annual regional training seminars for physicians/PAs/NPs, and targeted specialty OTP sessions in the annual Addiction Medicine Conference.

Patients entering medication assisted treatment are required to be seen by a physician (face-to-face) prior to the provision of medication. All patients are assessed based on ASAM criteria, which determines the recommended level of care. North Carolina Administrative Code (10a NCAC 27g.0205) requires that each facility counselor, in partnership with the patient, develops a treatment plan that includes anticipated outcomes to be achieved by the services, projected achievement dates, treatment plan strategies and the manner in which the achievement of outcomes will be measured. The plan must be developed with the patient and the patient must acknowledge his/her participation and agreement by signing the document. At a minimum, each OTP clinic is required to develop and implement systems to ensure each patient receives minimally two counseling sessions a month within the first year of treatment and once monthly thereafter.

There are a large number of office-based opioid treatment providers (OBOTs) in North Carolina as well. LME/MCOs have been encouraged to open their networks to these certified providers in areas where an OTP does not exist, but a need has been identified.

As with many states, addressing the opioid epidemic is a top priority for North Carolina. We intend to continue our efforts and will work in partnership with our providers and through stakeholder engagement to determine the most effective, efficient, and impactful ways to deploy these funds in accordance with our North Carolina Opioid Action Plan, which was updated in June 2019. We will utilize the funds to further implement the comprehensive strategies identified in the Action Plan to reduce opioid addiction and overdose death. **See the Attachments section for the Opioid Action Plan 2.0.**

Veterans and Military Families

According to *Governing*, North Carolina is home to the fourth largest active duty and reserve members of the military in the country. This population is comprised of each branch of the military: Army, Marines, Navy, Air Force and Coast Guard. Of the total, over 91,000 are active military and

nearly 22,000 serve in the Reserve forces. North Carolina's veteran population comprises about 8.3% of the total state population, with an unemployment rate of 3.8%.

More than 100,000 children and adolescents of active members/National Guard/Reserves live in North Carolina and about 35% of the state's population is in the military, a veteran, spouse, survivor, parent or dependent of someone connected to the military. *(Honoring Their Service: A Report of the NC Institute of Medicine Task Force on Behavioral Health Services for the Military and Their Families, January 2011).*

The Governor's Working Group on Veterans, Service Members and Their Families is a collaborative intradepartmental work group focused on job creation, workforce enrichment, health and wellness, suicide prevention, legal and financial services and benefits for veterans. This monthly working group is jointly chaired by the following agencies: NC Department of Military and Veterans Affairs, NC Department of Commerce, NC DHHS DMH/DD/SAS, as well as the Veterans Administration Management from the Veterans Health Administration (VHA VISN-6) and the Veterans Benefits Administration (VBA). Regular participants in this collaborative forum include; Department of Public Instruction, Department of Public Safety, other DHHS Divisions, the North Carolina Institute of Medicine (NCIOM) NCNG, UNC System and NC Community College System schools, AHECs and members of the NC General Assembly.

The GWG has grown to become a nationally recognized forum, which hosts a monthly meeting, newsletter, and website (http://ncgwg.org), as well as a YouTube Channel (https://www.youtube.com/watch?v=p2CwZHXzho4&feature=youtu.be). Facebook LIVESTREAM has expanded viewership to a 2019 average of 4,000 per meeting. This real-time referral and collaboration network cuts red tape by linking decision makers, service providers, and military members (current and former) and their families together in a best-practices sharing environment.

Charged with facilitating collaboration and coordination among ALL federal, State, local, and non-profit partners who work with North Carolina's nearly Veterans and their families, monthly sessions highlight:

- Health and Wellness, including Behavioral Health, especially for those in recovery
- Transitional Services
- Veterans Benefits and Claims
- Community-based Services and Supports
- Housing Resources
- Education and GI Bill
- Job Creation and Workforce Enrichment
- Legal and Financial Services

Functioning collaborations fostered at the GWG sessions include:

- NC STRIVE (Student Transition Resources Initiative for Veterans Education)
- Operation HOME: Ending Veterans Homelessness Task Force
- Women Veterans Summit and Expo
- NC Practice Improvement Collaborative (NC PIC) to Reduce Veteran Suicide

In North Carolina, significant gaps were identified in coordinated service delivery for Veterans and their families. NCServes provides the coordinated networks, with associated technology (UniteUS), needed to connect Veterans and their families to the resources they need, while allowing the tracking of system-wide outcomes that support system improvement. Built with private, philanthropic support from national organizations, through the Institute for Veterans and Military Families (IVMF) at Syracuse University, AmericaServes has sponsored the creation of four (4) regional network coordination centers, each housed in an existing community provider, operating in 74 of 100 counties:

- NCServes Metrolina: (https://charlotte.americaserves.org/) Veterans Bridge Home in Charlotte serves eight (8) North Carolina counties;
- NCServes Western: (https://western.americaserves.org/) Veterans Services of the Carolinas, through the Asheville-Buncombe Community Christian Ministry (ABCCM) coordinates services in 16 Counties;
- NCServes Central: (https://raleigh.americaserves.org/) the USO of North Carolina provides coordinated network management in 21 counties;
- NCServes Coastal: (https://coastal.americaserves.org/) Eastern Carolina Human Services Agency (ECHSA) coordinates care in 20 eastern counties.

Additionally, the United Way of South Hampton Roads, VA (https://unitedwayshr.org/what-we-do/mission- united/) provides network coordination services in 10 North Carolina counties (not funded by North Carolina).

These networks have provided a model of coordinated care that has informed the adoption of the NCCARE360, the first statewide coordinated care network to electronically connect those with identified needs to community resources and allow for a feedback loop on the outcome of that connection. Participation and reporting via NCServes is required of all community partners in this section. NCServes provides a strategic opportunity for North Carolina to continue to improve access across the social determinants of health that contribute to:

1.Reductions of homelessness;
2.Improved quality of life;
3.Improved health and well-being because of NCServes' community-level coordinated care model.

Deaf Services

NC DMH/DD/SAS has been providing specialized services to Deaf, Hard of Hearing and Deaf-Blind individuals since 1992. These services stem from one of the earliest ADA complaints filed in NC, alleging Deaf individuals were not receiving appropriate care in the public mental health system. While the original complaint was resolved long ago, the state continues to show commitment to providing language accessible and culturally competent MH/SUD services to this population.
In SFY17, the state started contracting directly with RHA Behavioral Health to provide MH/SUD services to this population across the state. This direct service contract allows the Division to achieve budget efficiencies and ensure services are provided evenly across the state. Prior to SFY17, these services were managed and contracted out through the LME-MCOs.

RHA employs full time licensed clinicians, Outreach Consultants (3 are certified Peer Support Specialists), a program director, business manager and a part-time administrative assistant. All staff

are sign language fluent as measured by the Sign Language Proficiency Interview (SLPI). About 60% of RHA program staff are deaf. Funds from the SABG support sign language proficient workers to accompany deaf individuals to mutual aid support groups, as well as formal clinical treatment services if SLP staff are not available. The Addictions team is currently working with RHA to develop Substance Abuse Intensive Outpatient Programs in one or more locations to better meet the needs of deaf individuals who are in need of this level of care.

DMHDDSAS hosts a Deaf Mental Health Advisory Council (MHAC) to advise the Division on services and provide feedback related to programming. The 13-member Council meets four times per year in Raleigh. Most of the Council members are deaf and some identify as being in recovery. Further, the Division hosts three Community Listening Sessions each year at selected sites across the state to obtain feedback about programming and services.

Tuberculosis Services

Screening for tuberculosis has been incorporated into each provider's comprehensive clinical assessment tool and/or assessment process for a number of years. As the Division's intermediaries, LME/MCOs are required to assure tuberculosis screening and referral for care (if indicated) are carried out by SABG designated providers. Division staff monitor and review sample records annually to ascertain these activities are conducted and issue plans of correction if such screenings do not occur.

In accordance with 10A NCAC 27A .0213 and 10A NCAC 27A .0216, TB screenings are required with the aim of identifying individuals who are at high risk of becoming infected with Tuberculosis. Persons with substance use issues and with limited access to medical care are at increased risk for Tuberculosis infection. North Carolina has required those involved in treatment programs as well as individuals who inject drugs to be screened for possible infection. Providers are to query service recipients about their health history as it relates to TB signs and symptoms. The Division of MH/DD/SAS has required certain elements to be included in the provider's screening documentation:

- Medical treatment in the past three months,
- Current place of residence (jail, streets, shelter, etc.),
- History of TB tests (prior positive skin tests, proximity to others diagnosed with TB in the past year),
- Physical/visible symptoms of TB, such as night sweats, prolonged cough, shortness of breath, and unexplained weight loss.

A sample screening tool and accompanying guidance can be found in the Attachments section. Based upon an individual's positive responses to symptoms in the screening tool, a referral must be made to the local county health department or the individual's medical practitioner for follow-up testing and care. Those who have been found to be infected with TB must be referred to the appropriate State official for follow-up treatment.

Cultural Competency

The Division of MH/DD/SA Services has a staff member who is dedicated to providing cultural competency training and technical assistance to LME/MCOs and providers on a regular basis. This

training helps to assure LME/MCOs and providers are appropriately staffed, trained and equipped to serve racial and ethnic minorities and successfully address health disparities.

Numerous trainings are offered, including Removing the Elephants in the Room and Broadening Your Cultural Lens, both which explore cultural issues North Carolina's behavioral health system faces, by examining the Cultural Formation section of the DSM-5 and the ethical principles that govern licensed professionals.

1. **Removing the Elephants in the Room** - 30+ trainings; began February 2015, continues with most recent training offered December 2018, including LME-MCOs and provider agencies with staff at all levels, State & Local CFAC members, family members, advocates.
2. **Broadening Your Cultural Lens -** 15+ trainings; began May 2017; continues with most recent training offered December 2018. Also, Mental Health First Aid instructors, court counselors, juvenile justice professionals, school staff, law enforcement, probation, child welfare.
3. **Broadening Your Cultural Lens: Social Determinants and Health Disparities -** This is phase 2 of the previous trainings and began January 2018, explores ways in which social determinants of health and culture intersect.

LME/MCOs and provider agencies often develop their own cultural competency related activities, tools and trainings, influenced by DMH/DD/SAS-related trainings. The Division does not develop or direct the development of cultural competency trainings; however, its work often influences LME/MCO and provider outputs in this regard. Examples include: (1) Cultural Competency Plan; (2) Cultural Competency Review Tool; (3) Cultural Competency Assessment; (4) Cultural Competence Provider Council; (5) Online trainings; and (6) Instructor-led trainings.

The fundamental precepts of cultural competence include developing respect for differences; cultivating successful approaches to diversity; increasing awareness of one's self and of unstated institutional cultural norms and practices; and having a working knowledge of the history, culture, beliefs, values and needs of diverse people and communities. A culturally competent approach to services requires the system to examine and potentially transform each component of mental health, intellectual and developmental disability and substance use services.

The 26 Perinatal/Maternal and CASAWORKs programs have implemented strategies to assure participants in these programs are served competently. Annually each program completes a "cross-site evaluation" and reports on specific questions related to cultural competency, which are then reviewed and/or evaluated by Division staff. A sampling of those questions includes the following:

1. Describe the level of diversity of your agency's staffing in terms of race, gender and language.
2. Describe how your agency's environment is conducive for providing culturally competent treatment services.
3. Please describe any challenges you may have faced recruiting a culturally diverse clinical team.
4. How are issues of culture addressed in individual clinical supervision?
5. What strategies are you employing to assure all women in need of your services have access to care?

Data Collection

The North Carolina Treatment Outcomes and Program Performance System (NCTOPPS) is the program by which the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services measures the quality of substance use disorder and mental health services and their impact on consumers' lives. By capturing key information on a consumer's service needs and life situation during a current episode of care, NCTOPPS aids in developing appropriate treatment plans and evaluating the impact of services on a consumer's life. It supports LME/MCOs in their responsibility for monitoring service outcomes in each LME/MCO's catchment area. The data generated through NCTOPPS helps the DMH/DD/SAS, LME/MCOs and provider agencies improve the quality of services. In addition, NCTOPPS provides data for meeting federal performance and outcome measurement requirements, which allows North Carolina to evaluate its service system in comparison to other states.

NCTOPPS began as a pilot study funded through a 1997 federal Center for Substance Abuse Treatment (CSAT) grant. North Carolina was one of 14 States that received the CSAT grant. This initiative was a partnership between the federal government and grantees to prepare States for development of a system to monitor and evaluate substance use disorder treatment services. Based on information gathered during the pilot period lasting approximately two years, the Division transitioned the pilot program into an on-going data collection, feedback and planning system. NCTOPPS later became a statewide system. Assessment instruments were built on research findings and field practice. Individual assessment items were discussed and agreed upon by participating programs and State Addictions team staff.

In the spring of 2004, the Division decided to expand the NCTOPPS web-based data collection system into the mental health arena. A participatory, collaborative and consensus-building process, similar to the process used for substance abuse assessments, was established involving mental health providers, Local Management Entities, researchers and consumers to develop and improve measures for mental health. On July 1, 2005, NCTOPPS became the statewide method of collecting information necessary for accountability, quality improvement and tracking outcomes for consumers of the State's substance abuse and mental health treatment services.

As a web-based system, NCTOPPS today can be used on most laptops, tablets and cell phones. Through regular consumer-to-clinician interviews during an episode of care at intake and months three, six, 12, 18, 24, etc., NCTOPPS captures information about an individual's current situation, including such topics as symptoms, well-being, family and social relations, housing, employment, and legal system involvement. It also gathers consumers' perspectives on the system, including barriers to treatment, choice of providers, timeliness of care and involvement in treatment planning. NCTOPPS gives providers information to develop person-centered plans and track goal attainment. It gives LME/MCOs information to evaluate consumer needs and improve local service quality. Furthermore, it gives State decision-makers, NC residents and the federal government information to help evaluate and improve the effectiveness of the service system.

Interview information provides one method for collection of the Division's consumer functional outcomes data. Consumer functional outcomes data are the Division's source of information to monitor the impact of services. These data are also used to respond to departmental, legislative, and federal reporting requirements. NCTOPPS accountability measures based on outcomes along with other performance measures are used for both the MHBG and the SABG reporting. In addition, the

system provides data to meet SAMHSA's reporting requirements for the National Outcome Measures (NOMs) and the Treatment Episode Data System (TEDS) data as requested. The Division has the ability to modify or add questions as needed; as such, questions specific to sexual orientation and transgenderedness were added in 2016. Division staff will monitor the results of this data to determine the percentage of transgendered, gay and lesbian individuals are accessing care.

The NCTOPPS system provides information on outcomes and program performance that can be used to improve service delivery and, ultimately, the quality of life for people with mental health and substance use disorder needs who are served in the public service system. The following NCTOPPS links are provided:

- NCTOPPS Login: https://nctopps.ncdmh.net/Nctopps2/Login.aspx
- Public Dashboard: https://nctopps.ncdmh.net/ProviderQuery/Index.aspx
- Website: https://www.ncdhhs.gov/providers/provider-info/mental-health/nc-treatment-outcomes-and-program-performance-system

Sample "simple query" reports can be found in the Attachments section.

Contracts

In addition to contracting with the seven LME/MCOs for the delivery of prevention, treatment and recovery services, the Division also contracts with several other entities to address needs and gaps within the system. Following are some examples of those contracts:

- ***Governor's Institute on Substance Abuse*** – the primary objective of this contract is to increase access to and improve the quality of services provided in the state by: (1) expanding the use of evidence-based/best practices; (2) promoting the integration of behavioral healthcare with primary healthcare in two regions of North Carolina and the rest of the state; (3) improving physician understanding of addictions; and (4) enhancing the quality of the workforce and provider agencies in the state, with a special emphasis on service members, veterans and their families. Specific initiatives include: (1) Physician and Prescriber Initiatives - These initiatives cover important practice areas relevant to both addiction medicine providers as well as psychiatrists and other primary care providers. SUDs are often overlooked in many clinical practice settings for a variety of reasons including inadequate knowledge and skills on the part of clinicians in identifying, intervening, and managing SUDs and related psychiatric comorbidities. The GI initiatives include CME and other training events on integrated care and a range of addiction medicine topics including SBIRT, pain management and safer opioid prescribing, medication assisted treatment including office based opioid treatment, and other relevant topic areas. (2) Substance Use Disorder Higher Education Consortium / Graduate Scholarship Initiative - This program seeks to engage students and faculty at Criteria C Universities (as defined by the NC Substance Abuse Professional Practice Board in the state of North Carolina creating a cross institution environment for communication and collaboration with experts on the cutting edge of the substance use disorder prevention, treatment and recovery field. The program will provide funds to Criteria C Universities for scholarships to individuals who are working to complete graduate-level education. (3) Professional Addiction Workforce and Counselor Continuing

Education - The goal of this program is to identify and engage emerging leaders in the Substance Use Disorders field. Those awarded scholarships must be currently working within public substance use disorder prevention, treatment and recovery services and be in good standing with their organization. Assistance includes but is not limited to standardized test reimbursement, and registration fees for various substance use disorder conferences and trainings. (4) Focus on SAMHSA-Supported Services to Military Service Members, Veterans, and Their Families - On behalf of DMH/DD/SAS, staff and contract support will continue to be provided to this ongoing initiative. The project includes other divisions within the NC Department of Health and Human Services, the US Department of Veterans Affairs, the NC National Guard, the NC Department of Military and Veterans Affairs, the NC Department of Commerce, as well as several other state agencies, active duty and reserve components, higher education, non-profit organizations, advocates, and others who are working together to meet the needs of veterans, service members, and their families in North Carolina. (5) Community Engagement Through Targeted Communications - This program will advocate and promote systems of health and human services that affirm hope for prevention, treatment, recovery, exemplify a strength-based orientation, and offer a wide spectrum of services and supports aimed at engaging people with mental health and substance use conditions into care and promoting their resilience and long-term recovery. (6) The Family Smoking Prevention and Tobacco Control Act – The Family Smoking Prevention and Tobacco Control Act authorizes FDA to contract with States, U.S. Territories, and Indian tribes to assist with compliance and enforcement with respect to tobacco product retailers. In our state, the FDA Tobacco Compliance Program is managed through the Department of Health and Human Services under the Division of Mental Health Developmental Disabilities Substance Abuse Services. DHHS is responsible for the program's implementation, management and oversight including but not limited; to coordinating undercover purchase attempts in retail locations across the entire state. Other areas managed include training of inspectors, monitoring of field inspections, evidence labeling and collection, adapting to evolving training protocols, conducting advertising and labeling inspections, providing monthly updated status reports to the US FDA, hiring and training of new personnel, managing work related equipment and data monitoring. (7) Program evaluation and technical assistance for the SABG Women's Set Aside funded statewide Perinatal and Maternal Substance Use and CASAWORKS for Families Residential Initiatives.

As noted above, the Governor's Institute focuses on training and education of physicians and other medical staff providing SUD treatment services, particularly in opioid treatment programs. It hosts an annual Addiction Medicine Conference with an attendance of over 300 participants each year, some from as far away as Canada, as well as an annual two-day workshop on Addiction Medicine Essentials.

- ***Oxford House, Inc.*** – this contract allows for the continuation of substance use recovery home management services by opening new houses, administering loans and serving and mentoring re-entering substance users in their transition from incarceration. There are

currently 265 homes in North Carolina with more than 1800 beds. In 2017, Oxford House opened its first house for men with dependent children and has long focused on the re-entry population.

- ***NC State University, Center for Urban Affairs and Community Services*** – this contract provides for the management of the web-based Treatment Outcomes and Program Performance System (NCTOPPS) which allows Local Management Entities/Managed Care Organizations (LME/MCOs) and their contracted network service providers to submit initial and periodic updates, as well as episode completion interview information for all consumers within specified substance abuse and mental health populations. Data entered into the system is then used in developing accountability measures for both the Mental Health and Substance Abuse Block Grants.

- ***University of North Carolina, School of Social Work, Springboard*** - the primary goal of this contract is to increase access to and improve the quality of prevention, treatment and recovery support services by: (1) expanding the use of prevention, treatment and recovery support services for substance abuse that demonstrate success in improving outcomes and/or supporting recovery; (2) enhancing the quality of the workforce providing prevention, treatment and recovery support services; (3) enhancing the ability of provider agencies to determine the ongoing effectiveness of substance use prevention, treatment and recovery support services; and (4) planning the implementation of new, expanded or enhanced services within the state. UNC Springboard is the contracted vendor responsible for conducting Independent Peer Review for SABG-funded agencies annually and also supports the development of North Carolina's certified peer support specialist workforce. Additionally, UNC Springboard is funded for a position that works in coordination with and supervision of the DMHDDSAS Women's Services Coordinator to support the statewide Work First/CPS Substance Use Initiative, Reproductive Life Planning Project, Infant Plan of Safe Care policy work, and technical assistance and training related to women's SUD services including pregnancy and opioid use.

- ***NC Division of Public Health*** – The DMH/DD/SAS and DPH have an interagency memorandum of agreement in place to jointly fund a licensed Perinatal Substance Use Specialist to provide capacity management, training and technical assistance regarding pregnant and parenting women with SUD and their children. This position is contracted through the Alcohol/Drug Council of North Carolina (ADCNC). The Perinatal Substance Use position is housed at DPH, DMHDDSAS and ADCNC throughout the week and is clinically supervised by the DMH/DD/SAS Women's Services Coordinator.

- ***Alcohol/Drug Council of North Carolina*** – this contract provides information and referral services, as well as public education related to substance use and addiction across the entire

state. This agency is also responsible for the Perinatal Substance Use Project, which includes screening, telephone hot-line, information and appropriate referrals for women throughout North Carolina who are pregnant or parenting and using substances. The project provides information on bed availability for substance use services in the NC Perinatal/Maternal Substance Use and CASAWORKS for Families Residential Initiatives on a weekly basis, as well as training and technical assistance to agencies working with women who are pregnant or parenting on issues related to substance use.

- ***UNC – General Administration*** – this vendor provides fiscal oversight to nine (9) universities that receive funding for collegiate recovery programs and services. This initiative was established by then Governor McCrory in 2015 due to concerns over alcohol consumption by college students and the need to provide a college atmosphere that is not "recovery hostile." Collegiate recovery programs have been developed at the following schools: UNC-Charlotte, UNC-Chapel Hill, UNC-Greensboro, UNC-Wilmington, East Carolina University and NC A&T, Appalachian State University, North Carolina Central University and North Carolina State University.

- ***Addiction Professionals of North Carolina (APNC)*** – this contract was executed to advance policy, services, and professional development that reflect the highest standards of the prevention and treatment profession, strengthen its value to the community and promote the values of its members. This agency also employs a Director of Scholastic Recovery that works directly with the above nine campuses on collegiate recovery programming and sustainability, as well as other grass roots collegiate recovery programs in several other universities, colleges and community colleges across North Carolina. Current initiatives also include focus on the identification and potential implementation of one or more secondary school recovery programs. Other initiatives include the following: (1) Substance Use Disorders Provider Training and Technical Assistance - The goal of this program is to keep substance use disorder prevention, treatment, and recovery providers informed and provide technical assistance to ensure continuous improvement in the quality of care provided as the continuum of care evolves in the state. (2) Substance Use Disorders Policy Education - This program will assist substance use disorder prevention, treatment, and recovery stakeholders in reviewing and evaluating policy positions. Providers will be given training and technical assistance on interacting with and providing information to elected officials at the state and local level. (3) Recovery Support Services (RSS) Outreach Coordinator for Western North Carolina - This program is tasked with building collaborative partnerships across interdisciplinary teams with stakeholders focused on promoting community-based recovery supports and opportunities for people living with substance use disorder in the western region of North Carolina to achieve Enhanced Recovery. (4) Substance Abuse Prevention - This initiative will identify and provide the necessary support for knowledge and implementation of the NC Strategic Prevention Framework-Partnership for Success program (SPF-PFS). APNC will support the following goals: Prevent the onset and reduce the progression of underage alcohol use, vaping, marijuana use, and their related problems;

Strengthen the prevention infrastructure capacity to use the Strategic Prevention Framework to facilitate local and state-level change in substance abuse and its consequences; and utilize evaluation results of the project to make prevention efforts effective. (5) Health Policy/Funding Technical Assistance - The goal of this program is to provide substance use disorder treatment, prevention and recovery providers operations level technical assistance in implementing emerging best practices in service delivery, business operations (including necessary changes related to Medicaid transformation), assurances of confidentiality and patient protections with transition to NC Health Connex and understanding allowable exemptions, and new funding models that would assist in the long-term sustainability of their programs.

- ***UNC-Chapel Hill Addiction Medicine Fellowship -*** It has been well established that the signs and symptoms of addiction present in every aspect of healthcare, yet they are often overlooked and under-treated due to a deficit in education and training of the workforce, minimal coordination and integration between healthcare services and community partners, and general lack of health literacy in the community. North Carolina is a predominately rural state with 96/100 counties designated as Medically Under-Served or as a Health Professional Shortage Area (designated by the Health Resources and Services Administration (HRSA)). Reports indicate that the healthcare workforce (current and future) is not adequately educated and trained in substance use disorders, particularly in primary acute and long-term care settings, in large part due to the stigma of addiction. The Addiction Medicine Fellowship at the University of North Carolina offers a wide array of training opportunities in addiction medicine with goal of teaching fellows about systems of care and collaborating across disciplines and professions. The fellows work with physicians in Family Medicine, Anesthesia, Psychiatry, Pediatrics, OB/GYN and Preventive Medicine, while also working alongside Peer Support Specialists, Nurse Practitioners, Nurses, Psychologists and Case Managers.

- ***NC Prevention Training and Technical Assistance Center*** - this contract identifies and supports needed for the prevention workforce on an ongoing basis. They conduct a workforce study to identify areas of concern for providers and the state system. The need for increased emphasis on prevention certification and additional support around retaining and recruiting prevention workforce has been an ongoing identified need.

- ***Community Impact NC -*** this contract identifies and provides support to alcohol, tobacco and other drug prevention coalitions and connects with the existing training, technical assistance and evaluation contractors to provide support in starting and successfully maintaining coalitions with communities and block grant providers who are a part of substance misuse coalitions.

- ***Wake Forest University -*** this contract provides evaluation support to the prevention block grant providers, supports data-driven decision making and information and makes

recommendations to the state for continuation/discontinuation of evidence-based prevention programming.

- ***JBS and Associates*** - Nationally recognized experts providing ongoing technical assistance and recommendations regarding Synar survey protocols, best practices, analysis and reporting for Annual Synar survey work submitted to SAMHSA to assist North Carolina prevention state staff in ensuring our retail violation rate remains under the 20% threshold.

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the State's application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) of the North Carolina Department of Health and Human Services is the Single State Agency for the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the State Mental Health Agency for the Community Mental Health Services (CMHS) Block Grant. The Division consists of the Director's Office and five (5) sections, each of which contains one or more teams. The position of Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services has been vacant for over one year and is still in the recruiting process. The Deputy Director of DMH/DD/SAS and the Division of State Operated Health Facilities has been the Interim Director during this time.

The overall structure of DMH/DD/SAS is both functional in nature as well as disability-specific. Sections include Policy and Program Design, System Performance, Operations, Engagement and the Chief Medical Officer's section. **Please see the DMH/DD/SAS organizational chart in the Attachments section.**

The Assistant Director for Policy and Program Design is responsible for the largest number of sections and teams within the Division. Those teams consist of the Addictions and Management Operations team, the Prevention and Wellness team, the Transitioning Populations team and the Drug Control team, as well as the Mental Health team and the Intellectual/Developmental Disabilities team. The Mental Health, Addictions and Management Operations and Intellectual/Developmental Disabilities sections have staff with expertise in each of the populations of focus, who are further specialized along the developmental stages of early childhood (0-5), later childhood (6-12), youth (13-17) and adulthood.

The Addictions and Management Operations team is primarily responsible for SUD treatment and recovery services. It is comprised of the Section Chief, the Women's Services Coordinator, the State Opioid Treatment Authority Administrator (SOTA) and two field staff who provide technical assistance and monitoring of the 75 opioid treatment programs in North Carolina, a recovery-oriented systems of care specialist and an adolescent services specialist. Additional time-limited staff

function as Project Directors for several federal discretionary grants, including the Medication Assisted Treatment-Prescription Drug and Opioid Abuse (MAT-PDOA) grant, the Pregnant and Post-Partum Women Pilot (PPW-PLT) grant and the State Opioid Response (SOR) and State Opioid Response (SOR) Supplement grant.

Primary prevention services are currently housed in the Prevention and Wellness team. This team is comprised of the Section Chief and staff that are responsible for SUD primary prevention initiatives under the block grant, including programmatic and financial compliance, monitoring and reporting, training and technical assistance, interagency relationships, coordination and planning, needs assessment and the utilization of evidenced based programs, policies and practices. Other areas of focus include underage drinking, as well as Synar/FDA compliance and the prevention components of the State Opioid Response grant. Time-limited staff oversee the SPF-Rx grant focusing on prescription drug use/misuse and the Partnership for Success grant, which focuses on the prevention of underage drinking ages 9-20, marijuana and e-cigarettes.

The Drug Control Unit is responsible for the Controlled Substances Reporting System, North Carolina's prescription drug monitoring program (PDMP), and criminal and juvenile justice programming, such as TASC and the Behavioral Health Juvenile Justice Partnership (BHJJP).

The Assistant Director for System Performance oversees the Quality Management team, the Program Integrity team, the Financial Audit team, the Systems Information team, the LME/MCO Liaisons team, the DWI team and the System Advocacy team.

The Assistant Director of Operations oversees the Consumer Rights team, the Budget and Finance team, the Legislative and Regulatory Affairs team and Human Resources.

The Assistant Director of Consumer Policy oversees the Consumer Engagement and Empowerment team, and Military and Veterans Services. The Consumer Empowerment section provides consumer advocacy leadership and ensures that state-operated healthcare facilities and community-based systems are in compliance with rights' protections for individuals served through the system.

The Chief Medical Office oversees the PASSAR team as well as various medical and pharmacy personnel in both DMH/DD/SAS and DSOHF.

Substance use disorder treatment and prevention and mental health services were formerly provided directly by service providers (individuals) employed by area/county programs. With the 2001 Mental Health Reform legislation passed by the NC General Assembly, the focus of area programs shifted from direct service provision to the management of the local service delivery system. These Local Management Entities (LMEs) began contracting with providers for the delivery of services in their catchment areas. Between 2001 and 2010, the number of LMEs was incrementally reduced from 48 to 23. In April 2005, the state piloted the 1915 (b) Freedom of Choice Waiver/(c) Innovations Home and Community Based Services (HCBS) Managed Care Waiver with one LME. Under these waivers, Medicaid services are funded through capitated Pre-paid Inpatient Health Plans (PIHP) that allow the MCO to have more flexibility in service delivery. Due to the success of the pilot, in December 2009, DHHS submitted a waiver amendment to CMS designed to expand the 1915 (b)/(c) waiver statewide over a period of several years. Numerous mergers between LMEs have occurred since then, resulting to date in seven (7) LME/MCOs covering all 100 counties. DMH/DD/SAS

and the Division of Health Benefits (also called NC Medicaid) jointly administer the LME/MCOs. The Division is primarily responsible for the oversight of services delivered by Local Management Entities/Managed Care Organizations (LME/MCOs), as they are the Division's intermediaries at the local level. **Please see the map in the Attachments section for the counties covered by each LME/MCO.**

More recently, in October 2018, the federal Centers for Medicare and Medicaid Services (CMS) approved North Carolina's 1115 Demonstration Waiver application submitted in November 2017. The approval is effective January 1, 2019 through October 31, 2024. The amended waiver is the result of collaboration among DHHS, beneficiaries and their families, advocates, health care providers, health plans and associations, lawmakers and other stakeholders throughout North Carolina. Beginning in November 2019, the Department of Health and Human Services will enroll most Medicaid beneficiaries into integrated managed care products called Standard Plans that will cover physical health, behavioral health and pharmacy services. Later in 2021, individuals with significant behavioral health disorders, intellectual and developmental disabilities (I/DD) and traumatic brain injuries (TBI) will be enrolled into Behavioral Health and Intellectual and Developmental Disability (I/DD) Tailored Plans, which are specialized managed care products targeting the needs of these populations. This final policy guidance describes detailed eligibility criteria and processes to guide enrollment into Behavioral Health I/DD Tailored Plans, including transitions of these beneficiaries across health plans and delivery systems. In developing these criteria and processes, the Department relied on the following key principles:

- **Enroll Beneficiaries in the Managed Care Product that Best Meets Their Needs.** Standard Plans and Behavioral Health I/DD Tailored Plans will offer integrated physical health, behavioral health and pharmacy services but Behavioral Health I/DD Tailored Plans will offer a more robust set of behavioral health, I/DD and TBI benefits, and specialized care management. The Department will leverage available data to enroll beneficiaries in the product best suited to meet their needs.
- **Minimize Barriers to Access.** The Department will strive to minimize barriers for beneficiaries who need to transition between plans to access a benefit only available in a Behavioral Health I/DD Tailored Plan. This includes making sure there is a clear process for beneficiaries who are not identified as meeting Behavioral Health I/DD Tailored Plan eligibility through available data.
- **Comply with Legislation.** The Department will ensure that Behavioral Health I/DD Tailored Plan eligibility criteria and benefits meet the North Carolina General Assembly's vision for Behavioral Health I/DD Tailored Plans as articulated in legislation.
- **Be Responsible Stewards of Public Funds.** The Department will ensure that only beneficiaries who will benefit from more intensive behavioral health, I/DD, and TBI services and specialized care management enroll in a Behavioral Health I/DD Tailored Plan, and other beneficiaries who do not meet the level of need do not unnecessarily enroll in the higher cost Behavioral Health I/DD Tailored Plan.

The above information speaks to the department's commitment to transform the Medicaid system to one that addresses both medical and non-medical drivers of health. During the current long

session of the North Carolina General Assembly, Medicaid expansion has been a frequent topic. House Bill 655 would allow for people who earn too much to qualify for Medicaid and too little to receive subsidies on the health insurance online marketplace to get access to insurance through the Medicaid program. The Health Care for Working Families Act would charge people who fall into the "coverage gap," earning between 50 and 133 percent of the federal poverty level (from about $6,200 to $16,611 per year for an individual) to pay small premiums and copays in order to receive coverage. Although this bill has passed the House Health Committee, it has not been heard in the Senate, so the outcome, as well as final version of the bill, is uncertain.

Additionally, as part of its commitment to expand access to treatment for substance use disorders (SUDs), North Carolina's Department of Health and Human Services has been approved for an 1115 SUD Demonstration waiver to strengthen its SUD delivery system by:

- Expanding its SUD benefits to offer the complete American Society of Addiction Medicine (ASAM) continuum of SUD services;
- Obtaining a waiver of the Medicaid institution for mental diseases (IMD) exclusion for SUD services;
- Ensuring that providers and services meet evidence-based program and licensure standards;
- Building SUD provider capacity;
- Strengthening care coordination and care management for individuals with SUDs; and
- Improving North Carolina's prescription drug monitoring program (PDMP).

Please see the attached document titled ***North Carolina Substance Use Disorder Implementation Plan Protocol*** for more details.

The SSA supports a comprehensive system of care to enable individuals that it serves to live in communities of their choosing and avoid inpatient hospitalization and institutionalization to the greatest extent possible. The array of available services includes basic outpatient services (assessment, individual therapy, group therapy, family therapy), enhanced services (Substance Abuse Intensive Outpatient Program, Substance Abuse Comprehensive Outpatient Treatment, Community Support Team, Intensive In-Home, Adolescent Day Treatment), opioid/medication assisted treatment, halfway house and supported housing services, Work First services and Treatment Accountability for Safer Communities (TASC) for people involved in the criminal justice system. A robust array of gender-specific/gender responsive services are available for women, including women who are pregnant and/or have dependent children. In addition, mobile and walk-in crisis services, various levels of detoxification, residential and inpatient treatment services are available throughout the state. Over the last few years, the Division has focused on more fully developing and implementing its recovery-oriented system of care philosophy. Funding is provided for recovery community organizations that work with several funded and grass-roots recovery community centers and collegiate recovery programs.

Utilization of peer supports, recovery coaching and mentoring are becoming more embedded in services as integral components of treatment and recovery success, including in emergency departments, prisons and jails. DMHDDSAS and the Division of health Benefits have been working together to develop a statewide Peer Supports service definition. The state-funded service definition became effective August 1, 2019, and the Medicaid-funded peer support will soon be

added to the State Plan Amendment. Please see the section on Recovery Services for more detailed information.

A Cross Area Service Program (CASP) is a Division designated specialty service program that is funded by the Division through federal and/or state funds to address the distinctive needs of an identified age and disability consumer and family special population. A CASP is designated by the Division as a result of a critical federal grant initiative or a priority state service initiative.

Dedicated federal and/or state one-time and continuation funding is directed by the Division and allocated to an identified sponsoring LME/MCO in a three-way partnership with a Division designated or approved provider. Funds are intended to address comprehensive statewide service needs, most commonly across multiple Local Management Entity/Managed Care Organizations (LME/MCOs). This sponsoring LME/MCO partners with the Division and a designated provider in implementing a specific age and disability based initiative, in accordance with Division established requirements, guidelines, and parameters. CASP services are planned, contracted, authorized, reimbursed, and evaluated by the LME/MCO, in consultation with the Division. Most CASPs are intended to be able to serve consumers, providers and LME/MCOs from any region of the state. This better assures that availability for services is adequate, as some populations, such as adolescents or pregnant women, may access any program or level of care across the state if local programs are at capacity.

Examples of Cross Area Services Programs include opioid treatment programs (OTPs), juvenile detention centers, regional residential treatment programs for adolescents with substance use disorders, CASAWORKS programs, residential treatment programs for women who are pregnant and parenting and their children, initiatives for preventing underage drinking, etc.

Prevention and Wellness Services

LME/MCOs currently subcontract to local prevention providers in their catchment areas to deliver services across the state. There are 26 local prevention providers across 7 LME/MCO catchment areas. They implement the SPF in each of their assigned counties, identifying needs, resources, and capabilities. Local prevention agencies plan and address local needs and implement evidence based prevention strategies. They receive support from the NC Training and Technical Assistance Center, who participates in a Statewide Prevention Consortium that consists of training and TA agencies, discretionary grant leads, prevention evaluation center, and other statewide prevention resources. This oversight ensures effective implementation and high-quality prevention services, delivered in alignment with state business policies for the prevention system.

The state has contracted with Prospectus Group to utilize their ECCO system for capturing primary prevention implementation plans and reporting. The state communicates policies and procedures for the delivery of primary prevention services every six months during regional statewide meetings and are published with support from the North Carolina Training and Technical Assistance Center (NCTTA). NCTTA is independent of provider agencies and provides coordinated training and technical assistance to prevention block grant providers across the state.

Strengths of the state' s substance abuse prevention program include long and strong relationships with the NC Commission on Indian Affairs, NC Department of Public Instruction, NC Office of Juvenile

Justice and Delinquency Prevention, NC Teen Pregnancy Prevention Program, NC Department of Social Services, NC Office of Youth Advocacy, NC Highway Safety Program , Wake Forest University, East Carolina University, Research Triangle Institute, Pacific Institute for Research and Evaluation Southeast CAPT, CADCA and statewide substance abuse prevention partnerships, alliances, collaboratives and coalitions who have contributed time, resources, effort, and passion to ensure the delivery of quality and effective substance abuse prevention services to youth, their families and communities.

North Carolina has transitioned our prevention system to one that requires providers to utilize the Strategic Prevention Framework to assess local needs, build community capacity, plan strategically, and implement evidence-based strategies for the prevention of alcohol, tobacco, and other drugs, with a majority of funds (approximately 80%) expended for universal, population-based strategies. To that end we have recently provided administrative data for all 100 counties for the completion of a needs assessment in FY18 and will do so again in FY20, have administered a statewide youth prevention survey in FY18 with plans for another survey in FY21. We have also issued a contract for evaluation services to Wake Forest University since FY18.

The SUD contract prevention providers are dedicated to the delivery of appropriate and quality services. There are several partnerships, alliances, coalitions and collaboratives providing individual and population-based strategies to communities throughout NC. The LME/MCOs contract with local prevention providers to deliver primary prevention activities throughout the 100 counties across the state. The LME/MCO receives guidance from the state office prevention staff about federal substance abuse prevention guidelines and policies. Local contract prevention providers conduct community need assessments to determine services and activities. The LME/MCO and prevention provider enter into a contract agreement that outlines specific prevention activities including target population and use of evidence-based curriculum. The LME/MCO is responsible for monitoring, reporting, and participation in any evaluation of the local prevention providers. The LME/MCO is required to conduct a needs assessment and gap analysis of their service area. Each LME/MCO works with the contract substance abuse prevention provider to assist with identifying target populations and services based on the results. Local contract prevention providers infuse cultural diversity policies into all prevention activities.

For data collection, the state requires prevention providers to complete a needs assessment to determine populations in need of primary prevention services including racial, ethnic, sexual and gender minorities as well as American Indian and Alaskan Native populations, and the specific intervening variables that should be targeted for each population. Providers are required to capture substance use prevention consumption, consequences, and intervening variables for every county in the state. They are further given guidance on identifying disparately impacted populations. The state has developed a data dashboard, providing a wide cross section of administrative data available at the county level, and conducted a youth prevention survey to support prevention providers in this effort. They have also provided training in assessment, including data collection methods and follow-up technical assistance, to provide a theoretical understanding of the process, hands on application, and then individually tailored assistance with the assessment process.

The NC Prevention System operates a Behavioral Health Equity Initiative to serve as a resource to further address behavioral health disparities. This Initiative provides training and guidance, through

the NC Prevention Consortium to ensure adequate planning and identification of disparities across the state including racial, ethnic, sexual and gender minorities as well as American Indian and Alaskan Native populations. This is a project that serves as a framework that is used to provide guidance statewide. Identification of and planning for behavioral health disparities is built into the SPF process that every prevention agency implements.

Women's and Children's SUD Services

The mission of Women's and Children's Substance Use Services is to provide comprehensive gender-specific, family-centered substance use disorder treatment and recovery services and supports to pregnant and parenting women with substance use disorders and their children. The major Initiatives address the treatment, health, and safety needs of a high risk group of women and children, reducing the impact of maternal and parental substance use on the health and wellbeing of women and their children and families through provision of gender specific, trauma informed, and evidence based or evidence informed treatment and health care services. Evidence based, evidence informed, and best practices for this population have been found in national clinical trials to reduce symptoms of neonatal abstinence syndrome for prenatally exposed infants, improve the health and wellbeing of children and their mothers, and reduce risk of criminal justice or child welfare involvement for families, thus having a positive impact on family wellbeing and reducing societal costs. Families involved in the programs have a wide range of needs to be addressed as part of recovery, health and stability for their families. Many of the needs that are met outside the scope of the initiatives' direct services, are accomplished through linkages and active coordination with other services and programs. The following are examples of the current Initiatives:

1. **Alcohol/Drug Council of NC (ADCNC): Perinatal Substance Use Project:** The NC Division of MH/DD/SAS and the NC Division Public Health jointly fund a Substance Use Specialist position housed at ADCNC. The Substance Use Specialist can be reached at 1-800-688-4232 or through the 1-800-FOR-BABY hotline, Monday through Friday, from 8 am to 5 pm. Services are available to the public and professionals to provide support in accessing gender-specific substance abuse treatment services statewide. Technical assistance, training and education regarding screening and referral for pregnant women with a substance use disorder are also available. A capacity management (bed availability) listing of residential substance use disorder treatment services for pregnant and parenting women and their children is maintained to assist the public and professionals to identify appropriate and available services statewide.

2. **North Carolina Perinatal and Maternal Substance Use & NC CASAWORKS for Families Residential Initiative:** The Perinatal and Maternal Substance Use Initiative is composed of 19 specialized programs for pregnant and parenting women with a primary substance use disorder and their children. These programs provide comprehensive gender-responsive substance use disorder treatment services that include, but are not limited to, the following: screening, assessment, case management, out-patient substance use disorder and mental health services, parenting skills, residential services, referrals for primary and preventative health care, and referrals for appropriate interventions for the children. The children also

benefit from the services provided by the local health departments (pediatric care), early intervention programs and care coordination for children (CC4C).

The NC CASAWORKS for Families Residential Initiative supports seven (7) comprehensive residential substance use disorder programs for women a primary substance use disorder and their children. The CASAWORKS for Families model was developed by the Center for the Study of Addiction and Substance Abuse (CASA) at Columbia University in response to the impact of welfare reform on families who are substance use involved. The model proposes that the best way to help families receiving TANF become economically self-sufficient is to provide an integrated and concurrent gender specific substance use disorder and co-occurring treatment and job readiness, training, and employment program.

The residential services that are a part of the NC Perinatal and Maternal Substance Use Initiative and the CASAWORKS for Families Residential Initiative are considered Cross Area Service Programs and are available to any pregnant or parenting women and her children who meet medical necessity for the services based on ASAM criteria. The outpatient only programs are offered to pregnant and parenting women who meet the ASAM criteria for this level of care in the specific LME/MCO catchment area.

3. **Work First/CPS Substance Use Initiative:** The Work First/CPS Substance Use Initiative is a joint initiative of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the North Carolina's Division of Social Services (DSS). The two Divisions have an interagency memorandum of agreement in place delineating the roles and responsibilities of each entity. This Initiative provides appropriate assessment, treatment referral, and case coordination for eligible Work First (TANF), Class H or I Controlled Substance Felons eligible for Food and Nutrition Services (FNS) and certain categories of recipients of Child Protection Services (CPS). The goal of the Work First/CPS Substance Use Initiative is to provide early identification and connection to treatment, of Work First recipients and eligible Food and Nutrition Services recipients who have substance use problems severe enough to affect their ability to become self-sufficient. The program also assists parents who have substance use problems and who are involved with CPS engage in appropriate treatment. Each of the county department of social services has access to a Qualified Professional in Substance Abuse (QPSA), contracted by the Local Management Entity -Managed Care Organization (LME/MCO). Generally, QPSAs are located in local county departments of social services and are easily accessible to families and social services staff. Each LME/MCO establishes a local MOA between county DSS and LME/MCO and/or QPSA provider, which is reviewed annually. The LME/MCO is responsible for submitting quarterly reports to DMH/DD/SAS. These reports reflect the numbers of individuals who have had assessments completed, delineated by referral source or cause (Work First, CPS, H or I felon). The number of individuals that a QPSA is coordinating services for, per quarter, is also reflected on this report. Quarterly statewide Initiative meetings with the QPSAs and LME/MCOs occur to review the aggregate quarterly data and discuss the barriers and successes that each county is experiencing in serving these populations. Monitoring of the Initiative occurs annually at the state level of both the LME/MCO's management of the

Initiative and of the individual cases. The LME/MCO's are responsible for local monitoring of the community providers that have been contracted for the QPSA positions. Ongoing technical assistance is provided to the LME/MCOs, DSSs, and QPSAs by DMH/DD/SAS.

4. **NC Plan of Safe Care Interagency Collaborative:** 2016 CARA federal legislation, and within it, CAPTA, has impacted North Carolina policies as they relate to infants who have been born exposed to substances during pregnancy. The goal of the federal legislation and subsequent state policies are to support the health and wellbeing of the infant, mother and family. North Carolina policies went into effect August 1, 2017. The intentions of North Carolina policies are:
    - To include infants, children and families in the Plans of Safe Care.
    - To support the health of the infant and mother, not to penalize the mother and family.
    - To increase access to treatment and support for all women with a substance use disorder and their children. To provide access to appropriate screening and surveillance, assessment and intervention services for infants determined to be affected by substance abuse, withdrawal or Fetal Alcohol Spectrum Disorders (FASD).

    The following agencies have been meeting since January 2017, as the NC Plan of Safe Care Interagency Collaborative (NC POSCIC), to develop the required policies, procedures and implementation:

    - Division of Mental Health, Developmental Disabilities and Substance Abuse Services
    - Division of Public Health
    - Division of Social Services
    - Division of Medical Assistance
    - Community Care of North Carolina
    - North Carolina Hospital Association
    - North Carolina Obstetrics and Gynecological Society
    - North Carolina Commission on Indian Affairs

    The Infant Plan of Safe Care itself, is simply a referral of an identified infant to Care Coordination for Children (CC4C) from Child Welfare, that includes services and linkages that the infant and family may benefit from. All infants identified as meeting criteria as 'affected by substance abuse' have a notification go to their local county Child Welfare, who screen and then universally refer to CC4C for ongoing support services. Approximately 70% of the notifications statewide result in child welfare assessments.

5. **Reproductive Life Planning and Substance Use Disorder Treatment Project:** The North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) has partnered with the North Carolina Division of Public Health (NCDPH) Family Planning and Reproductive Health Unit to provide training to the staff of perinatal and maternal substance use and opioid treatment programs in our statewide initiatives.

Participants include staff from the Federal Title X funded Local Health Departments (LHDs) corresponding to the identified treatment programs.

The cross disciplinary training on reproductive life planning and substance use disorders promotes the local partnerships of the identified substance use disorder treatment programs and their Local Health Departments. These partnerships will impact effective support of individuals with substance use disorders, and in recovery, in their reproductive life plans. It is specifically intended to be non-coercive and non-judgmental in the provision of the information and connection to services. Training objectives Include:

- Increase knowledge about the key components of reproductive life planning.
- Increase or review knowledge about addiction and the importance of language when work with individuals with substance use disorder.
- Increase or review knowledge about reproductive biology and sexually transmitted diseases.
- Increase awareness about the importance of counseling all individuals of reproductive age with substance use disorder about reproductive life planning.
- Improve reproductive life planning counseling skills.
- Facilitate local partnerships.

The SUD treatment programs track the occurrences of individual and group reproductive life planning specific sessions and referrals, reporting on the aggregate data quarterly. Also included in the quarterly report data are the numbers of individuals who required transportation assistance to necessary appointments related to reproductive life planning.

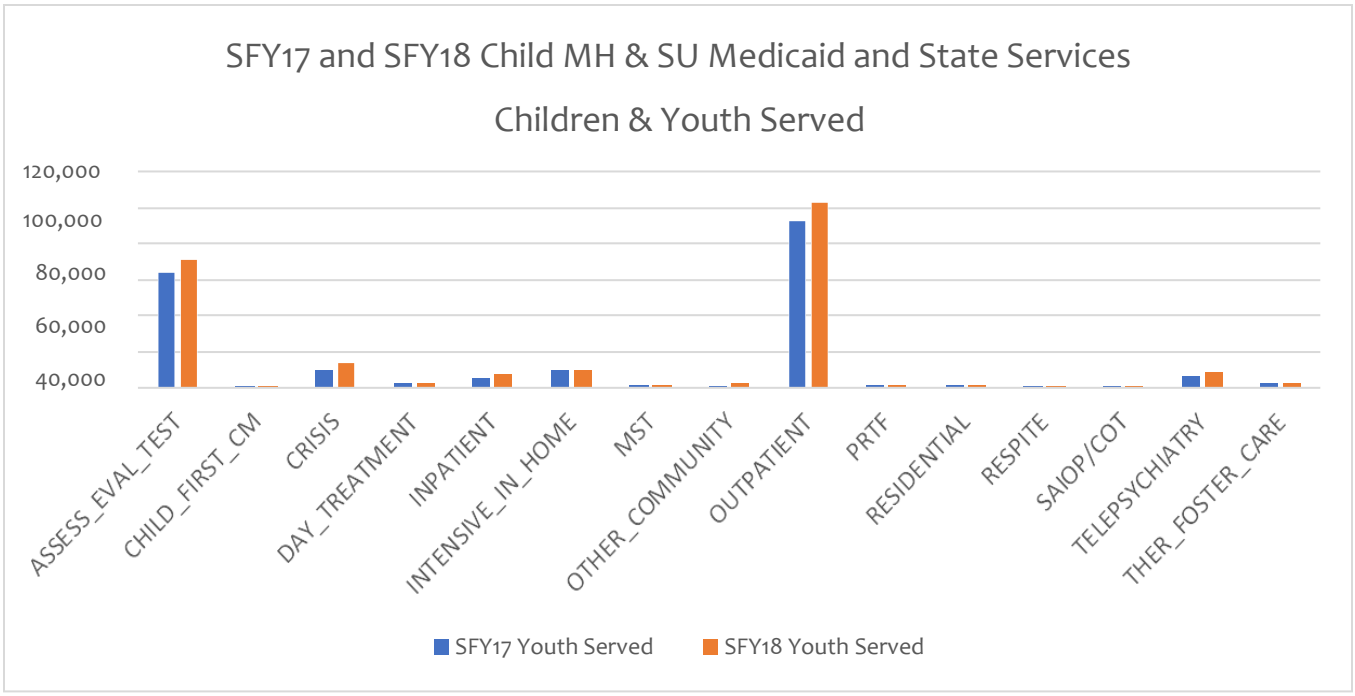
Monthly meetings to support the implementation of the RLP-SUD practices include the state partners and the community level SUD treatment programs and the LHD professionals. These meetings include deidentified case presentations and specific topics that are covered through didactic and discussion. Technical assistance is available to the SUD treatment programs and the Title X LHD on an ongoing basis from the state partners.

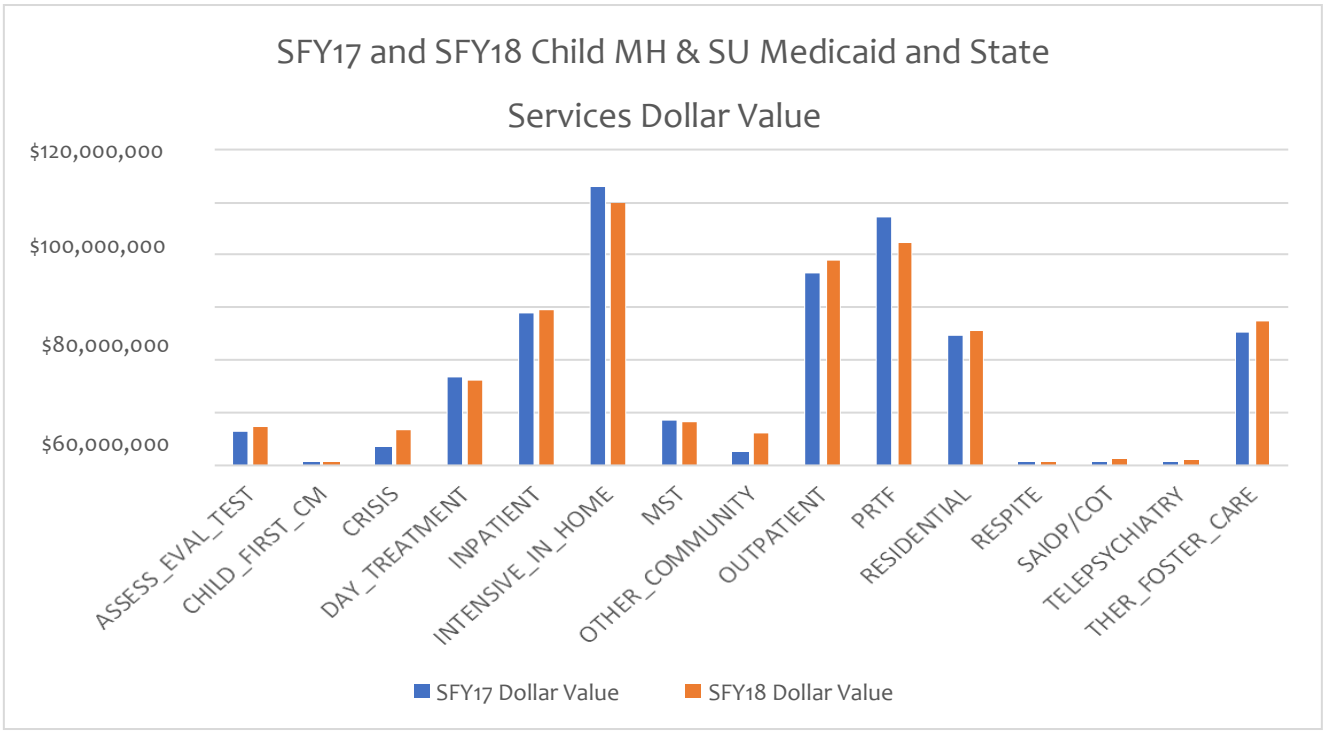
Adolescent Substance Use Disorder Services

Services available for youth, who are often diagnosed with other behavioral or mental health disorders, in addition to substance use, include:

- Outpatient Therapy
- Outpatient Therapy Plus (some LME/MCOs)
- Day Treatment
- SA Intensive Outpatient
- Intensive In-Home Services
- Multisystemic Therapy

The charts below provide a comparison for child services for state fiscal years 2017 and 2018 for both Medicaid and state-funded (including block grant) services by type of service and dollar value.





In addition to the above, the Adolescent Substance Use Disorder Regional Residential Program Initiative was created to ensure the availability of SUD residential services for adolescents in every region of the State of North Carolina. The mission is to provide medium-term residential services and

public education to prepare individuals under 18 years old with Substance Use Disorders, and other co-occurring problems, for ongoing community- based recovery services.

All programs under this initiative admit youth from anywhere in the state, serving all 100 counties, giving them the distinction of Cross Area Service Programs (CASPs). All programs use proven evidence- based SUD models at their facilities. These programs provide 24-hour residential services through supervised living or similar licensure and intensive outpatient or day treatment services. The majority of sites provide public education through local teachers assigned to the program by the local education authority or Department of Public Instruction.

These programs provide evidence-based SUD treatment services that include counseling to assist youth and their families in becoming actively involved in their own recovery. This is achieved through comprehensive assessment, treatment planning, group therapy, individual therapy and continued care planning. A Child and Family Team is constructed for every youth and family. The team has the responsibility of developing and updating the youth's Person Centered Plan (PCP) for recovery. This also includes discharge planning and care coordination for when youth return to their homes and community to ensure continuing treatment through their local community outpatient treatment programs, and other community resources.

The youth receive psychological services that include the provision of diagnostic testing and specialized psychotherapy for youth when appropriate. Psychiatric evaluation and medication-management are also available to youth. Family services are offered to family members and other significant people in the youth's life, and include weekly individual, and multi-group sessions.

Therapeutic Recreation Services are provided daily, and programs use their own recreation facilities on site along with community facilities such as the YMCA. Each program develops internal incentives to teach and encourage the youth while in the program. Each adolescent Substance Use Disorder Regional Residential Program is unique; therefore, there are some variations in the services offered by the individual programs across the state.

Presently, North Carolina has five (5) Substance Use Disorder Regional Residential facilities operational including the following: (1) Swain Recovery Center is a five-bed facility located in the western part of the state; (2) Youth Focus Adolescent Substance Abuse Program is a 10-bed facility in north central North Carolina; (3) PORT Aberdeen is a 10-bed facility in south central North Carolina; (4) PORT Greenville is a 10- bed facility in the eastern part of the state and (5) Port Burgaw, another 10-bed facility in the southeastern area of the state.

These programs are monitored by both the LME/MCO and the State. Each program is monitored locally by the LME/MCO. However, the state conducts quarterly meetings and yearly site visits to ensure the programs operate within the compliance guidelines for treatment services.

The duration of services is based upon ASAM criteria for level of care and special continued service and discharge criteria. The average length of stay ranges from 90 to 120 days.

The Department of Public Safety is preparing for "Raise the Age" which will welcome 16 and 17-year-old into the Juvenile Justice system beginning December 1, 2019. Many of these youths will be referred to the behavioral health system for assessment and treatment. Beyond "Raise the Age," there is also legislation that could drive 14,000 youth involved with the Juvenile Justice system into

the behavioral health system for comprehensive assessments. The aforementioned state level Behavioral Health Juvenile Justice team has been working through a series of cross-system service barriers. The State team has also collaborated in sharing specific concerns/recommendations about meeting the behavioral needs of youth involved with juvenile justice system to the national consultant firm that is designing the new behavioral health system in the Medicaid Managed Care reform.

State Opioid Treatment Authority/Medication Assisted Treatment

Overview

The road to recovery is unique to everyone, and treatment for an individual may consist of any combination of services at different points in time. Treatment with medications is the standard of care for an opioid use disorder and substantially reduces overdose, transmission of infectious diseases such as HIV and hepatitis C, crime and unemployment.

The NC Opioid Treatment Program (OTP) system of care strives to be accessible, evidence-based, individualized and comprehensive by offering FDA-approved medications, as well as various levels of clinical care in order to best serve those with varying degrees of necessity.

The majority of OTPs in North Carolina are involved in their communities. Critical opportunities to initiate care are taking place in the jail system, in the prison system and in hospital emergency departments.

The mission of the North Carolina State Opioid Treatment Authority (SOTA) is to reduce the impact of opioid use disorder, in North Carolina communities and promote excellence in Opioid Treatment Programs. The State Opioid Treatment Authority Administrator and two field staff provide technical assistance and monitoring of the 74 opioid treatment programs in North Carolina serving 19,346 patients with an OUD. With a capacity of approximately 26,000 patients, capacity management, guest dosing and emergency management (in the event of natural disasters) functions are managed through a contract with an outside central registry vendor. **Please see the map of all OTPs in NC in the Attachments section.**

To date, the State Opioid Treatment Authority (SOTA), located within the Addictions and Management Operations section of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, has been primarily involved with the opioid treatment programs. As with many other states, North Carolina has seen substantial growth in the number of agencies opening programs. The certification process is lengthy and involves various other agencies, including the Division of Health Services Regulation, the Division's Drug Control Unit, the DEA and SAMHSA. Each OTP operating in NC is approved by the North Carolina State Opioid Treatment Authority which is responsible for program approval, for monitoring compliance with the regulations related to scope of staff, and operations, as per 10A NCAC 27G.3604.

North Carolina's OTPs are operated as either for-profit businesses or nonprofit organizations, as well as through the state's three state-run facilities (Walter B. Jones Alcohol and Drug Abuse Treatment Center located in Greenville, Julian F. Keith located in Black Mountain and RJ Blackley located in Butner). More than two-thirds of the OTPs in North Carolina receive state and federal dollars; the remainder are cash pay.

NC State Opioid Treatment Authority (SOTA) Responsibilities include the following:

1) Clinical and administrative on-site review and monitoring of approximately 74 local Opioid Treatment Programs (OTPs) on a daily basis, including consultation and technical assistance, with emphasis on safety and quality of care issues related to program leadership, staffing, supervision, scope of practice, admission and discharge protocols, medication ordering and administration, specialty patient treatment such as pregnant women and justice involved patients, and incident reviews, including deaths, non-fatal overdoses and injuries, and serious medication errors, and implementation of program policies and procedures in accordance with federal and state regulations, standards of care, NC-TOPPS patient and program outcomes evaluation and capacity management using Lighthouse Central Registry.

2) Clinical and administrative review on a daily basis of Opioid Treatment Program (OTP) patient incidents and complaints, including patient deaths, non-fatal overdoses, accidents, serious medication errors, admissions concerns, patient management issues, administrative discharges, medication diversion, and other adverse incidents involving patient, family, and community health and safety, and complaints about patient respect and dignity, program performance, and quality of care issues.

3) Coordination with the Center for Substance Abuse Treatment (CSAT) - Division of Pharmacological (DPT) Therapies and the Drug Enforcement Administration (DEA) regarding local program approval, monitoring, and program practices involving implementation of federal regulations, guidelines, advisories, and national accreditation standards.

4) Coordination with the NC Division of Health Service Regulation (DHSR) and the DMHDDSAS Drug Control Unit regarding local program approval, monitoring, and program practices regarding the implementation of federal and state regulations, guidelines, advisories, and national accreditation standards.

5) Clinical review and approval of daily individual patient and program take-home medication exception requests through the SAMHSA Center for Substance Abuse Treatment (CSAT) Opioid Treatment Program (OTP) Extranet System for take-home privileges for methadone and buprenorphine in accordance with 42 CFR Part 8.

6) Coordination with the NC Division of Medical Assistance (DMA) and LME-MCOs in the development and implementation of statewide policies regarding Medication-Assisted Treatment (MAT) utilizing methadone and buprenorphine, and the support of LME-MCOs in local Opioid Treatment Program credentialing, contracting, access, service authorization, monitoring, and program practices involving implementation of best practice guidelines and

standards of care, as well as federal and state regulations, guidelines, advisories, and national accreditation standards.

7) Coordination with the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and other national groups regarding the development and promotion of state, regional, and national approaches to addressing current and emerging issues in practice, including the development and implementation of prescription monitoring programs (PMPs), such as the NC CSRS, responses to the continuing threat posed by prescription drug use and heroin use, and the support of harm reduction approaches such as the distribution and utilization of Narcan overdose kits among at risk populations.

8) Development and implementation of specialized provider training, consultation, and networking opportunities with emphasis on OTP physicians, PAs, NPs, and Program Directors, through such vehicles as monthly physician/PA/NP group case consultation phone calls, quarterly meetings with program directors, annual regional training seminars for physicians/PAs/NPs, and targeted specialty OTP sessions in the annual Addiction Medicine Conference.

Patients entering medication assisted treatment are required to be seen by a physician (face-to-face) prior to the provision of medication. All patients are assessed based on ASAM criteria, which determines the recommended level of care. North Carolina Administrative Code (10a NCAC 27g.0205) requires that each facility counselor, in partnership with the patient, develops a treatment plan that includes anticipated outcomes to be achieved by the services, projected achievement dates, treatment plan strategies and the manner in which the achievement of outcomes will be measured. The plan must be developed with the patient and the patient must acknowledge his/her participation and agreement by signing the document. At a minimum, each OTP clinic is required to develop and implement systems to ensure each patient receives minimally two counseling sessions a month within the first year of treatment and once monthly thereafter.

There are a large number of office-based opioid treatment providers (OBOTs) in North Carolina as well. LME/MCOs have been encouraged to open their networks to these certified providers in areas where an OTP does not exist, but a need has been identified.

As with many states, addressing the opioid epidemic is a top priority for North Carolina. We intend to continue our efforts and will work in partnership with our providers and through stakeholder engagement to determine the most effective, efficient, and impactful ways to deploy these funds in accordance with our North Carolina Opioid Action Plan, which was updated in June 2019. We will utilize the funds to further implement the comprehensive strategies identified in the Action Plan to reduce opioid addiction and overdose death. **See the Attachments section for the Opioid Action Plan 2.0.**

Veterans and Military Families

According to *Governing*, North Carolina is home to the fourth largest active duty and reserve members of the military in the country. This population is comprised of each branch of the military: Army, Marines, Navy, Air Force and Coast Guard. Of the total, over 91,000 are active military and

nearly 22,000 serve in the Reserve forces. North Carolina's veteran population comprises about 8.3% of the total state population, with an unemployment rate of 3.8%.

More than 100,000 children and adolescents of active members/National Guard/Reserves live in North Carolina and about 35% of the state's population is in the military, a veteran, spouse, survivor, parent or dependent of someone connected to the military. *(Honoring Their Service: A Report of the NC Institute of Medicine Task Force on Behavioral Health Services for the Military and Their Families, January 2011).*

The Governor's Working Group on Veterans, Service Members and Their Families is a collaborative intradepartmental work group focused on job creation, workforce enrichment, health and wellness, suicide prevention, legal and financial services and benefits for veterans. This monthly working group is jointly chaired by the following agencies: NC Department of Military and Veterans Affairs, NC Department of Commerce, NC DHHS DMH/DD/SAS, as well as the Veterans Administration Management from the Veterans Health Administration (VHA VISN-6) and the Veterans Benefits Administration (VBA). Regular participants in this collaborative forum include; Department of Public Instruction, Department of Public Safety, other DHHS Divisions, the North Carolina Institute of Medicine (NCIOM) NCNG, UNC System and NC Community College System schools, AHECs and members of the NC General Assembly.

The GWG has grown to become a nationally recognized forum, which hosts a monthly meeting, newsletter, and website (http://ncgwg.org), as well as a YouTube Channel (https://www.youtube.com/watch?v=p2CwZHXzho4&feature=youtu.be). Facebook LIVESTREAM has expanded viewership to a 2019 average of 4,000 per meeting. This real-time referral and collaboration network cuts red tape by linking decision makers, service providers, and military members (current and former) and their families together in a best-practices sharing environment.

Charged with facilitating collaboration and coordination among ALL federal, State, local, and non-profit partners who work with North Carolina's nearly Veterans and their families, monthly sessions highlight:

- Health and Wellness, including Behavioral Health, especially for those in recovery
- Transitional Services
- Veterans Benefits and Claims
- Community-based Services and Supports
- Housing Resources
- Education and GI Bill
- Job Creation and Workforce Enrichment
- Legal and Financial Services

Functioning collaborations fostered at the GWG sessions include:

- NC STRIVE (Student Transition Resources Initiative for Veterans Education)
- Operation HOME: Ending Veterans Homelessness Task Force
- Women Veterans Summit and Expo
- NC Practice Improvement Collaborative (NC PIC) to Reduce Veteran Suicide

In North Carolina, significant gaps were identified in coordinated service delivery for Veterans and their families. NCServes provides the coordinated networks, with associated technology (UniteUS), needed to connect Veterans and their families to the resources they need, while allowing the tracking of system-wide outcomes that support system improvement. Built with private, philanthropic support from national organizations, through the Institute for Veterans and Military Families (IVMF) at Syracuse University, AmericaServes has sponsored the creation of four (4) regional network coordination centers, each housed in an existing community provider, operating in 74 of 100 counties:

- NCServes Metrolina: (https://charlotte.americaserves.org/) Veterans Bridge Home in Charlotte serves eight (8) North Carolina counties;
- NCServes Western: (https://western.americaserves.org/) Veterans Services of the Carolinas, through the Asheville-Buncombe Community Christian Ministry (ABCCM) coordinates services in 16 Counties;
- NCServes Central: (https://raleigh.americaserves.org/) the USO of North Carolina provides coordinated network management in 21 counties;
- NCServes Coastal: (https://coastal.americaserves.org/) Eastern Carolina Human Services Agency (ECHSA) coordinates care in 20 eastern counties.

Additionally, the United Way of South Hampton Roads, VA (https://unitedwayshr.org/what-we-do/mission- united/) provides network coordination services in 10 North Carolina counties (not funded by North Carolina).

These networks have provided a model of coordinated care that has informed the adoption of the NCCARE360, the first statewide coordinated care network to electronically connect those with identified needs to community resources and allow for a feedback loop on the outcome of that connection. Participation and reporting via NCServes is required of all community partners in this section. NCServes provides a strategic opportunity for North Carolina to continue to improve access across the social determinants of health that contribute to:

1.Reductions of homelessness;
2.Improved quality of life;
3.Improved health and well-being because of NCServes' community-level coordinated care model.

Deaf Services

NC DMH/DD/SAS has been providing specialized services to Deaf, Hard of Hearing and Deaf-Blind individuals since 1992. These services stem from one of the earliest ADA complaints filed in NC, alleging Deaf individuals were not receiving appropriate care in the public mental health system. While the original complaint was resolved long ago, the state continues to show commitment to providing language accessible and culturally competent MH/SUD services to this population.
In SFY17, the state started contracting directly with RHA Behavioral Health to provide MH/SUD services to this population across the state. This direct service contract allows the Division to achieve budget efficiencies and ensure services are provided evenly across the state. Prior to SFY17, these services were managed and contracted out through the LME-MCOs.

RHA employs full time licensed clinicians, Outreach Consultants (3 are certified Peer Support Specialists), a program director, business manager and a part-time administrative assistant. All staff

are sign language fluent as measured by the Sign Language Proficiency Interview (SLPI). About 60% of RHA program staff are deaf. Funds from the SABG support sign language proficient workers to accompany deaf individuals to mutual aid support groups, as well as formal clinical treatment services if SLP staff are not available. The Addictions team is currently working with RHA to develop Substance Abuse Intensive Outpatient Programs in one or more locations to better meet the needs of deaf individuals who are in need of this level of care.

DMHDDSAS hosts a Deaf Mental Health Advisory Council (MHAC) to advise the Division on services and provide feedback related to programming. The 13-member Council meets four times per year in Raleigh. Most of the Council members are deaf and some identify as being in recovery. Further, the Division hosts three Community Listening Sessions each year at selected sites across the state to obtain feedback about programming and services.

Tuberculosis Services

Screening for tuberculosis has been incorporated into each provider's comprehensive clinical assessment tool and/or assessment process for a number of years. As the Division's intermediaries, LME/MCOs are required to assure tuberculosis screening and referral for care (if indicated) are carried out by SABG designated providers. Division staff monitor and review sample records annually to ascertain these activities are conducted and issue plans of correction if such screenings do not occur.

In accordance with 10A NCAC 27A .0213 and 10A NCAC 27A .0216, TB screenings are required with the aim of identifying individuals who are at high risk of becoming infected with Tuberculosis. Persons with substance use issues and with limited access to medical care are at increased risk for Tuberculosis infection. North Carolina has required those involved in treatment programs as well as individuals who inject drugs to be screened for possible infection. Providers are to query service recipients about their health history as it relates to TB signs and symptoms. The Division of MH/DD/SAS has required certain elements to be included in the provider's screening documentation:

- Medical treatment in the past three months,
- Current place of residence (jail, streets, shelter, etc.),
- History of TB tests (prior positive skin tests, proximity to others diagnosed with TB in the past year),
- Physical/visible symptoms of TB, such as night sweats, prolonged cough, shortness of breath, and unexplained weight loss.

A sample screening tool and accompanying guidance can be found in the Attachments section. Based upon an individual's positive responses to symptoms in the screening tool, a referral must be made to the local county health department or the individual's medical practitioner for follow-up testing and care. Those who have been found to be infected with TB must be referred to the appropriate State official for follow-up treatment.

Cultural Competency

The Division of MH/DD/SA Services has a staff member who is dedicated to providing cultural competency training and technical assistance to LME/MCOs and providers on a regular basis. This

training helps to assure LME/MCOs and providers are appropriately staffed, trained and equipped to serve racial and ethnic minorities and successfully address health disparities.

Numerous trainings are offered, including Removing the Elephants in the Room and Broadening Your Cultural Lens, both which explore cultural issues North Carolina's behavioral health system faces, by examining the Cultural Formation section of the DSM-5 and the ethical principles that govern licensed professionals.

1. **Removing the Elephants in the Room** - 30+ trainings; began February 2015, continues with most recent training offered December 2018, including LME-MCOs and provider agencies with staff at all levels, State & Local CFAC members, family members, advocates.
2. **Broadening Your Cultural Lens -** 15+ trainings; began May 2017; continues with most recent training offered December 2018. Also, Mental Health First Aid instructors, court counselors, juvenile justice professionals, school staff, law enforcement, probation, child welfare.
3. **Broadening Your Cultural Lens: Social Determinants and Health Disparities -** This is phase 2 of the previous trainings and began January 2018, explores ways in which social determinants of health and culture intersect.

LME/MCOs and provider agencies often develop their own cultural competency related activities, tools and trainings, influenced by DMH/DD/SAS-related trainings. The Division does not develop or direct the development of cultural competency trainings; however, its work often influences LME/MCO and provider outputs in this regard. Examples include: (1) Cultural Competency Plan; (2) Cultural Competency Review Tool; (3) Cultural Competency Assessment; (4) Cultural Competence Provider Council; (5) Online trainings; and (6) Instructor-led trainings.

The fundamental precepts of cultural competence include developing respect for differences; cultivating successful approaches to diversity; increasing awareness of one's self and of unstated institutional cultural norms and practices; and having a working knowledge of the history, culture, beliefs, values and needs of diverse people and communities. A culturally competent approach to services requires the system to examine and potentially transform each component of mental health, intellectual and developmental disability and substance use services.

The 26 Perinatal/Maternal and CASAWORKs programs have implemented strategies to assure participants in these programs are served competently. Annually each program completes a "cross-site evaluation" and reports on specific questions related to cultural competency, which are then reviewed and/or evaluated by Division staff. A sampling of those questions includes the following:

1. Describe the level of diversity of your agency's staffing in terms of race, gender and language.
2. Describe how your agency's environment is conducive for providing culturally competent treatment services.
3. Please describe any challenges you may have faced recruiting a culturally diverse clinical team.
4. How are issues of culture addressed in individual clinical supervision?
5. What strategies are you employing to assure all women in need of your services have access to care?

Data Collection

The North Carolina Treatment Outcomes and Program Performance System (NCTOPPS) is the program by which the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services measures the quality of substance use disorder and mental health services and their impact on consumers' lives. By capturing key information on a consumer's service needs and life situation during a current episode of care, NCTOPPS aids in developing appropriate treatment plans and evaluating the impact of services on a consumer's life. It supports LME/MCOs in their responsibility for monitoring service outcomes in each LME/MCO's catchment area. The data generated through NCTOPPS helps the DMH/DD/SAS, LME/MCOs and provider agencies improve the quality of services. In addition, NCTOPPS provides data for meeting federal performance and outcome measurement requirements, which allows North Carolina to evaluate its service system in comparison to other states.

NCTOPPS began as a pilot study funded through a 1997 federal Center for Substance Abuse Treatment (CSAT) grant. North Carolina was one of 14 States that received the CSAT grant. This initiative was a partnership between the federal government and grantees to prepare States for development of a system to monitor and evaluate substance use disorder treatment services. Based on information gathered during the pilot period lasting approximately two years, the Division transitioned the pilot program into an on-going data collection, feedback and planning system. NCTOPPS later became a statewide system. Assessment instruments were built on research findings and field practice. Individual assessment items were discussed and agreed upon by participating programs and State Addictions team staff.

In the spring of 2004, the Division decided to expand the NCTOPPS web-based data collection system into the mental health arena. A participatory, collaborative and consensus-building process, similar to the process used for substance abuse assessments, was established involving mental health providers, Local Management Entities, researchers and consumers to develop and improve measures for mental health. On July 1, 2005, NCTOPPS became the statewide method of collecting information necessary for accountability, quality improvement and tracking outcomes for consumers of the State's substance abuse and mental health treatment services.

As a web-based system, NCTOPPS today can be used on most laptops, tablets and cell phones. Through regular consumer-to-clinician interviews during an episode of care at intake and months three, six, 12, 18, 24, etc., NCTOPPS captures information about an individual's current situation, including such topics as symptoms, well-being, family and social relations, housing, employment, and legal system involvement. It also gathers consumers' perspectives on the system, including barriers to treatment, choice of providers, timeliness of care and involvement in treatment planning. NCTOPPS gives providers information to develop person-centered plans and track goal attainment. It gives LME/MCOs information to evaluate consumer needs and improve local service quality. Furthermore, it gives State decision-makers, NC residents and the federal government information to help evaluate and improve the effectiveness of the service system.

Interview information provides one method for collection of the Division's consumer functional outcomes data. Consumer functional outcomes data are the Division's source of information to monitor the impact of services. These data are also used to respond to departmental, legislative, and federal reporting requirements. NCTOPPS accountability measures based on outcomes along with other performance measures are used for both the MHBG and the SABG reporting. In addition, the

system provides data to meet SAMHSA's reporting requirements for the National Outcome Measures (NOMs) and the Treatment Episode Data System (TEDS) data as requested. The Division has the ability to modify or add questions as needed; as such, questions specific to sexual orientation and transgenderedness were added in 2016. Division staff will monitor the results of this data to determine the percentage of transgendered, gay and lesbian individuals are accessing care.

The NCTOPPS system provides information on outcomes and program performance that can be used to improve service delivery and, ultimately, the quality of life for people with mental health and substance use disorder needs who are served in the public service system. The following NCTOPPS links are provided:

- NCTOPPS Login: https://nctopps.ncdmh.net/Nctopps2/Login.aspx
- Public Dashboard: https://nctopps.ncdmh.net/ProviderQuery/Index.aspx
- Website: https://www.ncdhhs.gov/providers/provider-info/mental-health/nc-treatment-outcomes-and-program-performance-system

Sample "simple query" reports can be found in the Attachments section.

Contracts

In addition to contracting with the seven LME/MCOs for the delivery of prevention, treatment and recovery services, the Division also contracts with several other entities to address needs and gaps within the system. Following are some examples of those contracts:

- ***Governor's Institute on Substance Abuse*** – the primary objective of this contract is to increase access to and improve the quality of services provided in the state by: (1) expanding the use of evidence-based/best practices; (2) promoting the integration of behavioral healthcare with primary healthcare in two regions of North Carolina and the rest of the state; (3) improving physician understanding of addictions; and (4) enhancing the quality of the workforce and provider agencies in the state, with a special emphasis on service members, veterans and their families. Specific initiatives include: (1) Physician and Prescriber Initiatives - These initiatives cover important practice areas relevant to both addiction medicine providers as well as psychiatrists and other primary care providers. SUDs are often overlooked in many clinical practice settings for a variety of reasons including inadequate knowledge and skills on the part of clinicians in identifying, intervening, and managing SUDs and related psychiatric comorbidities. The GI initiatives include CME and other training events on integrated care and a range of addiction medicine topics including SBIRT, pain management and safer opioid prescribing, medication assisted treatment including office based opioid treatment, and other relevant topic areas. (2) Substance Use Disorder Higher Education Consortium / Graduate Scholarship Initiative - This program seeks to engage students and faculty at Criteria C Universities (as defined by the NC Substance Abuse Professional Practice Board in the state of North Carolina creating a cross institution environment for communication and collaboration with experts on the cutting edge of the substance use disorder prevention, treatment and recovery field. The program will provide funds to Criteria C Universities for scholarships to individuals who are working to complete graduate-level education. (3) Professional Addiction Workforce and Counselor Continuing

Education - The goal of this program is to identify and engage emerging leaders in the Substance Use Disorders field. Those awarded scholarships must be currently working within public substance use disorder prevention, treatment and recovery services and be in good standing with their organization. Assistance includes but is not limited to standardized test reimbursement, and registration fees for various substance use disorder conferences and trainings. (4) Focus on SAMHSA-Supported Services to Military Service Members, Veterans, and Their Families - On behalf of DMH/DD/SAS, staff and contract support will continue to be provided to this ongoing initiative. The project includes other divisions within the NC Department of Health and Human Services, the US Department of Veterans Affairs, the NC National Guard, the NC Department of Military and Veterans Affairs, the NC Department of Commerce, as well as several other state agencies, active duty and reserve components, higher education, non-profit organizations, advocates, and others who are working together to meet the needs of veterans, service members, and their families in North Carolina. (5) Community Engagement Through Targeted Communications - This program will advocate and promote systems of health and human services that affirm hope for prevention, treatment, recovery, exemplify a strength-based orientation, and offer a wide spectrum of services and supports aimed at engaging people with mental health and substance use conditions into care and promoting their resilience and long-term recovery. (6) The Family Smoking Prevention and Tobacco Control Act – The Family Smoking Prevention and Tobacco Control Act authorizes FDA to contract with States, U.S. Territories, and Indian tribes to assist with compliance and enforcement with respect to tobacco product retailers. In our state, the FDA Tobacco Compliance Program is managed through the Department of Health and Human Services under the Division of Mental Health Developmental Disabilities Substance Abuse Services. DHHS is responsible for the program's implementation, management and oversight including but not limited; to coordinating undercover purchase attempts in retail locations across the entire state. Other areas managed include training of inspectors, monitoring of field inspections, evidence labeling and collection, adapting to evolving training protocols, conducting advertising and labeling inspections, providing monthly updated status reports to the US FDA, hiring and training of new personnel, managing work related equipment and data monitoring. (7) Program evaluation and technical assistance for the SABG Women's Set Aside funded statewide Perinatal and Maternal Substance Use and CASAWORKS for Families Residential Initiatives.

As noted above, the Governor's Institute focuses on training and education of physicians and other medical staff providing SUD treatment services, particularly in opioid treatment programs. It hosts an annual Addiction Medicine Conference with an attendance of over 300 participants each year, some from as far away as Canada, as well as an annual two-day workshop on Addiction Medicine Essentials.

- ***Oxford House, Inc.*** – this contract allows for the continuation of substance use recovery home management services by opening new houses, administering loans and serving and mentoring re-entering substance users in their transition from incarceration. There are

currently 265 homes in North Carolina with more than 1800 beds. In 2017, Oxford House opened its first house for men with dependent children and has long focused on the re-entry population.

- ***NC State University, Center for Urban Affairs and Community Services*** – this contract provides for the management of the web-based Treatment Outcomes and Program Performance System (NCTOPPS) which allows Local Management Entities/Managed Care Organizations (LME/MCOs) and their contracted network service providers to submit initial and periodic updates, as well as episode completion interview information for all consumers within specified substance abuse and mental health populations. Data entered into the system is then used in developing accountability measures for both the Mental Health and Substance Abuse Block Grants.

- ***University of North Carolina, School of Social Work, Springboard*** - the primary goal of this contract is to increase access to and improve the quality of prevention, treatment and recovery support services by: (1) expanding the use of prevention, treatment and recovery support services for substance abuse that demonstrate success in improving outcomes and/or supporting recovery; (2) enhancing the quality of the workforce providing prevention, treatment and recovery support services; (3) enhancing the ability of provider agencies to determine the ongoing effectiveness of substance use prevention, treatment and recovery support services; and (4) planning the implementation of new, expanded or enhanced services within the state. UNC Springboard is the contracted vendor responsible for conducting Independent Peer Review for SABG-funded agencies annually and also supports the development of North Carolina's certified peer support specialist workforce. Additionally, UNC Springboard is funded for a position that works in coordination with and supervision of the DMHDDSAS Women's Services Coordinator to support the statewide Work First/CPS Substance Use Initiative, Reproductive Life Planning Project, Infant Plan of Safe Care policy work, and technical assistance and training related to women's SUD services including pregnancy and opioid use.

- ***NC Division of Public Health*** – The DMH/DD/SAS and DPH have an interagency memorandum of agreement in place to jointly fund a licensed Perinatal Substance Use Specialist to provide capacity management, training and technical assistance regarding pregnant and parenting women with SUD and their children. This position is contracted through the Alcohol/Drug Council of North Carolina (ADCNC). The Perinatal Substance Use position is housed at DPH, DMHDDSAS and ADCNC throughout the week and is clinically supervised by the DMH/DD/SAS Women's Services Coordinator.

- ***Alcohol/Drug Council of North Carolina*** – this contract provides information and referral services, as well as public education related to substance use and addiction across the entire

state. This agency is also responsible for the Perinatal Substance Use Project, which includes screening, telephone hot-line, information and appropriate referrals for women throughout North Carolina who are pregnant or parenting and using substances. The project provides information on bed availability for substance use services in the NC Perinatal/Maternal Substance Use and CASAWORKS for Families Residential Initiatives on a weekly basis, as well as training and technical assistance to agencies working with women who are pregnant or parenting on issues related to substance use.

- ***UNC – General Administration*** – this vendor provides fiscal oversight to nine (9) universities that receive funding for collegiate recovery programs and services. This initiative was established by then Governor McCrory in 2015 due to concerns over alcohol consumption by college students and the need to provide a college atmosphere that is not "recovery hostile." Collegiate recovery programs have been developed at the following schools: UNC-Charlotte, UNC-Chapel Hill, UNC-Greensboro, UNC-Wilmington, East Carolina University and NC A&T, Appalachian State University, North Carolina Central University and North Carolina State University.

- ***Addiction Professionals of North Carolina (APNC)*** – this contract was executed to advance policy, services, and professional development that reflect the highest standards of the prevention and treatment profession, strengthen its value to the community and promote the values of its members. This agency also employs a Director of Scholastic Recovery that works directly with the above nine campuses on collegiate recovery programming and sustainability, as well as other grass roots collegiate recovery programs in several other universities, colleges and community colleges across North Carolina. Current initiatives also include focus on the identification and potential implementation of one or more secondary school recovery programs. Other initiatives include the following: (1) Substance Use Disorders Provider Training and Technical Assistance - The goal of this program is to keep substance use disorder prevention, treatment, and recovery providers informed and provide technical assistance to ensure continuous improvement in the quality of care provided as the continuum of care evolves in the state. (2) Substance Use Disorders Policy Education - This program will assist substance use disorder prevention, treatment, and recovery stakeholders in reviewing and evaluating policy positions. Providers will be given training and technical assistance on interacting with and providing information to elected officials at the state and local level. (3) Recovery Support Services (RSS) Outreach Coordinator for Western North Carolina - This program is tasked with building collaborative partnerships across interdisciplinary teams with stakeholders focused on promoting community-based recovery supports and opportunities for people living with substance use disorder in the western region of North Carolina to achieve Enhanced Recovery. (4) Substance Abuse Prevention - This initiative will identify and provide the necessary support for knowledge and implementation of the NC Strategic Prevention Framework-Partnership for Success program (SPF-PFS). APNC will support the following goals: Prevent the onset and reduce the progression of underage alcohol use, vaping, marijuana use, and their related problems;

Strengthen the prevention infrastructure capacity to use the Strategic Prevention Framework to facilitate local and state-level change in substance abuse and its consequences; and utilize evaluation results of the project to make prevention efforts effective. (5) Health Policy/Funding Technical Assistance - The goal of this program is to provide substance use disorder treatment, prevention and recovery providers operations level technical assistance in implementing emerging best practices in service delivery, business operations (including necessary changes related to Medicaid transformation), assurances of confidentiality and patient protections with transition to NC Health Connex and understanding allowable exemptions, and new funding models that would assist in the long-term sustainability of their programs.

- ***UNC-Chapel Hill Addiction Medicine Fellowship -*** It has been well established that the signs and symptoms of addiction present in every aspect of healthcare, yet they are often overlooked and under-treated due to a deficit in education and training of the workforce, minimal coordination and integration between healthcare services and community partners, and general lack of health literacy in the community. North Carolina is a predominately rural state with 96/100 counties designated as Medically Under-Served or as a Health Professional Shortage Area (designated by the Health Resources and Services Administration (HRSA)). Reports indicate that the healthcare workforce (current and future) is not adequately educated and trained in substance use disorders, particularly in primary acute and long-term care settings, in large part due to the stigma of addiction. The Addiction Medicine Fellowship at the University of North Carolina offers a wide array of training opportunities in addiction medicine with goal of teaching fellows about systems of care and collaborating across disciplines and professions. The fellows work with physicians in Family Medicine, Anesthesia, Psychiatry, Pediatrics, OB/GYN and Preventive Medicine, while also working alongside Peer Support Specialists, Nurse Practitioners, Nurses, Psychologists and Case Managers.

- ***NC Prevention Training and Technical Assistance Center*** - this contract identifies and supports needed for the prevention workforce on an ongoing basis. They conduct a workforce study to identify areas of concern for providers and the state system. The need for increased emphasis on prevention certification and additional support around retaining and recruiting prevention workforce has been an ongoing identified need.

- ***Community Impact NC -*** this contract identifies and provides support to alcohol, tobacco and other drug prevention coalitions and connects with the existing training, technical assistance and evaluation contractors to provide support in starting and successfully maintaining coalitions with communities and block grant providers who are a part of substance misuse coalitions.

- ***Wake Forest University -*** this contract provides evaluation support to the prevention block grant providers, supports data-driven decision making and information and makes

recommendations to the state for continuation/discontinuation of evidence-based prevention programming.

- ***JBS and Associates*** - Nationally recognized experts providing ongoing technical assistance and recommendations regarding Synar survey protocols, best practices, analysis and reporting for Annual Synar survey work submitted to SAMHSA to assist North Carolina prevention state staff in ensuring our retail violation rate remains under the 20% threshold.

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the State's application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) of the North Carolina Department of Health and Human Services is the Single State Agency for the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the State Mental Health Agency for the Community Mental Health Services (CMHS) Block Grant. The Division consists of the Director's Office and five (5) sections, each of which contains one or more teams. The position of Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services has been vacant for over one year and is still in the recruiting process. The Deputy Director of DMH/DD/SAS and the Division of State Operated Health Facilities has been the Interim Director during this time.

The overall structure of DMH/DD/SAS is both functional in nature as well as disability-specific. Sections include Policy and Program Design, System Performance, Operations, Engagement and the Chief Medical Officer's section. **Please see the DMH/DD/SAS organizational chart in the Attachments section.**

The Assistant Director for Policy and Program Design is responsible for the largest number of sections and teams within the Division. Those teams consist of the Addictions and Management Operations team, the Prevention and Wellness team, the Transitioning Populations team and the Drug Control team, as well as the Mental Health team and the Intellectual/Developmental Disabilities team. The Mental Health, Addictions and Management Operations and Intellectual/Developmental Disabilities sections have staff with expertise in each of the populations of focus, who are further specialized along the developmental stages of early childhood (0-5), later childhood (6-12), youth (13-17) and adulthood.

The Addictions and Management Operations team is primarily responsible for SUD treatment and recovery services. It is comprised of the Section Chief, the Women's Services Coordinator, the State Opioid Treatment Authority Administrator (SOTA) and two field staff who provide technical assistance and monitoring of the 75 opioid treatment programs in North Carolina, a recovery-oriented systems of care specialist and an adolescent services specialist. Additional time-limited staff

function as Project Directors for several federal discretionary grants, including the Medication Assisted Treatment-Prescription Drug and Opioid Abuse (MAT-PDOA) grant, the Pregnant and Post-Partum Women Pilot (PPW-PLT) grant and the State Opioid Response (SOR) and State Opioid Response (SOR) Supplement grant.

Primary prevention services are currently housed in the Prevention and Wellness team. This team is comprised of the Section Chief and staff that are responsible for SUD primary prevention initiatives under the block grant, including programmatic and financial compliance, monitoring and reporting, training and technical assistance, interagency relationships, coordination and planning, needs assessment and the utilization of evidenced based programs, policies and practices. Other areas of focus include underage drinking, as well as Synar/FDA compliance and the prevention components of the State Opioid Response grant. Time-limited staff oversee the SPF-Rx grant focusing on prescription drug use/misuse and the Partnership for Success grant, which focuses on the prevention of underage drinking ages 9-20, marijuana and e-cigarettes.

The Drug Control Unit is responsible for the Controlled Substances Reporting System, North Carolina's prescription drug monitoring program (PDMP), and criminal and juvenile justice programming, such as TASC and the Behavioral Health Juvenile Justice Partnership (BHJJP).

The Assistant Director for System Performance oversees the Quality Management team, the Program Integrity team, the Financial Audit team, the Systems Information team, the LME/MCO Liaisons team, the DWI team and the System Advocacy team.

The Assistant Director of Operations oversees the Consumer Rights team, the Budget and Finance team, the Legislative and Regulatory Affairs team and Human Resources.

The Assistant Director of Consumer Policy oversees the Consumer Engagement and Empowerment team, and Military and Veterans Services. The Consumer Empowerment section provides consumer advocacy leadership and ensures that state-operated healthcare facilities and community-based systems are in compliance with rights' protections for individuals served through the system.

The Chief Medical Office oversees the PASSAR team as well as various medical and pharmacy personnel in both DMH/DD/SAS and DSOHF.

Substance use disorder treatment and prevention and mental health services were formerly provided directly by service providers (individuals) employed by area/county programs. With the 2001 Mental Health Reform legislation passed by the NC General Assembly, the focus of area programs shifted from direct service provision to the management of the local service delivery system. These Local Management Entities (LMEs) began contracting with providers for the delivery of services in their catchment areas. Between 2001 and 2010, the number of LMEs was incrementally reduced from 48 to 23. In April 2005, the state piloted the 1915 (b) Freedom of Choice Waiver/(c) Innovations Home and Community Based Services (HCBS) Managed Care Waiver with one LME. Under these waivers, Medicaid services are funded through capitated Pre-paid Inpatient Health Plans (PIHP) that allow the MCO to have more flexibility in service delivery. Due to the success of the pilot, in December 2009, DHHS submitted a waiver amendment to CMS designed to expand the 1915 (b)/(c) waiver statewide over a period of several years. Numerous mergers between LMEs have occurred since then, resulting to date in seven (7) LME/MCOs covering all 100 counties. DMH/DD/SAS

and the Division of Health Benefits (also called NC Medicaid) jointly administer the LME/MCOs. The Division is primarily responsible for the oversight of services delivered by Local Management Entities/Managed Care Organizations (LME/MCOs), as they are the Division's intermediaries at the local level. **Please see the map in the Attachments section for the counties covered by each LME/MCO.**

More recently, in October 2018, the federal Centers for Medicare and Medicaid Services (CMS) approved North Carolina's 1115 Demonstration Waiver application submitted in November 2017. The approval is effective January 1, 2019 through October 31, 2024. The amended waiver is the result of collaboration among DHHS, beneficiaries and their families, advocates, health care providers, health plans and associations, lawmakers and other stakeholders throughout North Carolina. Beginning in November 2019, the Department of Health and Human Services will enroll most Medicaid beneficiaries into integrated managed care products called Standard Plans that will cover physical health, behavioral health and pharmacy services. Later in 2021, individuals with significant behavioral health disorders, intellectual and developmental disabilities (I/DD) and traumatic brain injuries (TBI) will be enrolled into Behavioral Health and Intellectual and Developmental Disability (I/DD) Tailored Plans, which are specialized managed care products targeting the needs of these populations. This final policy guidance describes detailed eligibility criteria and processes to guide enrollment into Behavioral Health I/DD Tailored Plans, including transitions of these beneficiaries across health plans and delivery systems. In developing these criteria and processes, the Department relied on the following key principles:

- **Enroll Beneficiaries in the Managed Care Product that Best Meets Their Needs.** Standard Plans and Behavioral Health I/DD Tailored Plans will offer integrated physical health, behavioral health and pharmacy services but Behavioral Health I/DD Tailored Plans will offer a more robust set of behavioral health, I/DD and TBI benefits, and specialized care management. The Department will leverage available data to enroll beneficiaries in the product best suited to meet their needs.
- **Minimize Barriers to Access.** The Department will strive to minimize barriers for beneficiaries who need to transition between plans to access a benefit only available in a Behavioral Health I/DD Tailored Plan. This includes making sure there is a clear process for beneficiaries who are not identified as meeting Behavioral Health I/DD Tailored Plan eligibility through available data.
- **Comply with Legislation.** The Department will ensure that Behavioral Health I/DD Tailored Plan eligibility criteria and benefits meet the North Carolina General Assembly's vision for Behavioral Health I/DD Tailored Plans as articulated in legislation.
- **Be Responsible Stewards of Public Funds.** The Department will ensure that only beneficiaries who will benefit from more intensive behavioral health, I/DD, and TBI services and specialized care management enroll in a Behavioral Health I/DD Tailored Plan, and other beneficiaries who do not meet the level of need do not unnecessarily enroll in the higher cost Behavioral Health I/DD Tailored Plan.

The above information speaks to the department's commitment to transform the Medicaid system to one that addresses both medical and non-medical drivers of health. During the current long

session of the North Carolina General Assembly, Medicaid expansion has been a frequent topic. House Bill 655 would allow for people who earn too much to qualify for Medicaid and too little to receive subsidies on the health insurance online marketplace to get access to insurance through the Medicaid program. The Health Care for Working Families Act would charge people who fall into the "coverage gap," earning between 50 and 133 percent of the federal poverty level (from about $6,200 to $16,611 per year for an individual) to pay small premiums and copays in order to receive coverage. Although this bill has passed the House Health Committee, it has not been heard in the Senate, so the outcome, as well as final version of the bill, is uncertain.

Additionally, as part of its commitment to expand access to treatment for substance use disorders (SUDs), North Carolina's Department of Health and Human Services has been approved for an 1115 SUD Demonstration waiver to strengthen its SUD delivery system by:

- Expanding its SUD benefits to offer the complete American Society of Addiction Medicine (ASAM) continuum of SUD services;
- Obtaining a waiver of the Medicaid institution for mental diseases (IMD) exclusion for SUD services;
- Ensuring that providers and services meet evidence-based program and licensure standards;
- Building SUD provider capacity;
- Strengthening care coordination and care management for individuals with SUDs; and
- Improving North Carolina's prescription drug monitoring program (PDMP).

Please see the attached document titled ***North Carolina Substance Use Disorder Implementation Plan Protocol*** for more details.

The SSA supports a comprehensive system of care to enable individuals that it serves to live in communities of their choosing and avoid inpatient hospitalization and institutionalization to the greatest extent possible. The array of available services includes basic outpatient services (assessment, individual therapy, group therapy, family therapy), enhanced services (Substance Abuse Intensive Outpatient Program, Substance Abuse Comprehensive Outpatient Treatment, Community Support Team, Intensive In-Home, Adolescent Day Treatment), opioid/medication assisted treatment, halfway house and supported housing services, Work First services and Treatment Accountability for Safer Communities (TASC) for people involved in the criminal justice system. A robust array of gender-specific/gender responsive services are available for women, including women who are pregnant and/or have dependent children. In addition, mobile and walk-in crisis services, various levels of detoxification, residential and inpatient treatment services are available throughout the state. Over the last few years, the Division has focused on more fully developing and implementing its recovery-oriented system of care philosophy. Funding is provided for recovery community organizations that work with several funded and grass-roots recovery community centers and collegiate recovery programs.

Utilization of peer supports, recovery coaching and mentoring are becoming more embedded in services as integral components of treatment and recovery success, including in emergency departments, prisons and jails. DMHDDSAS and the Division of health Benefits have been working together to develop a statewide Peer Supports service definition. The state-funded service definition became effective August 1, 2019, and the Medicaid-funded peer support will soon be

added to the State Plan Amendment. Please see the section on Recovery Services for more detailed information.

A Cross Area Service Program (CASP) is a Division designated specialty service program that is funded by the Division through federal and/or state funds to address the distinctive needs of an identified age and disability consumer and family special population. A CASP is designated by the Division as a result of a critical federal grant initiative or a priority state service initiative.

Dedicated federal and/or state one-time and continuation funding is directed by the Division and allocated to an identified sponsoring LME/MCO in a three-way partnership with a Division designated or approved provider. Funds are intended to address comprehensive statewide service needs, most commonly across multiple Local Management Entity/Managed Care Organizations (LME/MCOs). This sponsoring LME/MCO partners with the Division and a designated provider in implementing a specific age and disability based initiative, in accordance with Division established requirements, guidelines, and parameters. CASP services are planned, contracted, authorized, reimbursed, and evaluated by the LME/MCO, in consultation with the Division. Most CASPs are intended to be able to serve consumers, providers and LME/MCOs from any region of the state. This better assures that availability for services is adequate, as some populations, such as adolescents or pregnant women, may access any program or level of care across the state if local programs are at capacity.

Examples of Cross Area Services Programs include opioid treatment programs (OTPs), juvenile detention centers, regional residential treatment programs for adolescents with substance use disorders, CASAWORKS programs, residential treatment programs for women who are pregnant and parenting and their children, initiatives for preventing underage drinking, etc.

Prevention and Wellness Services

LME/MCOs currently subcontract to local prevention providers in their catchment areas to deliver services across the state. There are 26 local prevention providers across 7 LME/MCO catchment areas. They implement the SPF in each of their assigned counties, identifying needs, resources, and capabilities. Local prevention agencies plan and address local needs and implement evidence based prevention strategies. They receive support from the NC Training and Technical Assistance Center, who participates in a Statewide Prevention Consortium that consists of training and TA agencies, discretionary grant leads, prevention evaluation center, and other statewide prevention resources. This oversight ensures effective implementation and high-quality prevention services, delivered in alignment with state business policies for the prevention system.

The state has contracted with Prospectus Group to utilize their ECCO system for capturing primary prevention implementation plans and reporting. The state communicates policies and procedures for the delivery of primary prevention services every six months during regional statewide meetings and are published with support from the North Carolina Training and Technical Assistance Center (NCTTA). NCTTA is independent of provider agencies and provides coordinated training and technical assistance to prevention block grant providers across the state.

Strengths of the state' s substance abuse prevention program include long and strong relationships with the NC Commission on Indian Affairs, NC Department of Public Instruction, NC Office of Juvenile

Justice and Delinquency Prevention, NC Teen Pregnancy Prevention Program, NC Department of Social Services, NC Office of Youth Advocacy, NC Highway Safety Program , Wake Forest University, East Carolina University, Research Triangle Institute, Pacific Institute for Research and Evaluation Southeast CAPT, CADCA and statewide substance abuse prevention partnerships, alliances, collaboratives and coalitions who have contributed time, resources, effort, and passion to ensure the delivery of quality and effective substance abuse prevention services to youth, their families and communities.

North Carolina has transitioned our prevention system to one that requires providers to utilize the Strategic Prevention Framework to assess local needs, build community capacity, plan strategically, and implement evidence-based strategies for the prevention of alcohol, tobacco, and other drugs, with a majority of funds (approximately 80%) expended for universal, population-based strategies. To that end we have recently provided administrative data for all 100 counties for the completion of a needs assessment in FY18 and will do so again in FY20, have administered a statewide youth prevention survey in FY18 with plans for another survey in FY21. We have also issued a contract for evaluation services to Wake Forest University since FY18.

The SUD contract prevention providers are dedicated to the delivery of appropriate and quality services. There are several partnerships, alliances, coalitions and collaboratives providing individual and population-based strategies to communities throughout NC. The LME/MCOs contract with local prevention providers to deliver primary prevention activities throughout the 100 counties across the state. The LME/MCO receives guidance from the state office prevention staff about federal substance abuse prevention guidelines and policies. Local contract prevention providers conduct community need assessments to determine services and activities. The LME/MCO and prevention provider enter into a contract agreement that outlines specific prevention activities including target population and use of evidence-based curriculum. The LME/MCO is responsible for monitoring, reporting, and participation in any evaluation of the local prevention providers. The LME/MCO is required to conduct a needs assessment and gap analysis of their service area. Each LME/MCO works with the contract substance abuse prevention provider to assist with identifying target populations and services based on the results. Local contract prevention providers infuse cultural diversity policies into all prevention activities.

For data collection, the state requires prevention providers to complete a needs assessment to determine populations in need of primary prevention services including racial, ethnic, sexual and gender minorities as well as American Indian and Alaskan Native populations, and the specific intervening variables that should be targeted for each population. Providers are required to capture substance use prevention consumption, consequences, and intervening variables for every county in the state. They are further given guidance on identifying disparately impacted populations. The state has developed a data dashboard, providing a wide cross section of administrative data available at the county level, and conducted a youth prevention survey to support prevention providers in this effort. They have also provided training in assessment, including data collection methods and follow-up technical assistance, to provide a theoretical understanding of the process, hands on application, and then individually tailored assistance with the assessment process.

The NC Prevention System operates a Behavioral Health Equity Initiative to serve as a resource to further address behavioral health disparities. This Initiative provides training and guidance, through

the NC Prevention Consortium to ensure adequate planning and identification of disparities across the state including racial, ethnic, sexual and gender minorities as well as American Indian and Alaskan Native populations. This is a project that serves as a framework that is used to provide guidance statewide. Identification of and planning for behavioral health disparities is built into the SPF process that every prevention agency implements.

Women's and Children's SUD Services

The mission of Women's and Children's Substance Use Services is to provide comprehensive gender-specific, family-centered substance use disorder treatment and recovery services and supports to pregnant and parenting women with substance use disorders and their children. The major Initiatives address the treatment, health, and safety needs of a high risk group of women and children, reducing the impact of maternal and parental substance use on the health and wellbeing of women and their children and families through provision of gender specific, trauma informed, and evidence based or evidence informed treatment and health care services. Evidence based, evidence informed, and best practices for this population have been found in national clinical trials to reduce symptoms of neonatal abstinence syndrome for prenatally exposed infants, improve the health and wellbeing of children and their mothers, and reduce risk of criminal justice or child welfare involvement for families, thus having a positive impact on family wellbeing and reducing societal costs. Families involved in the programs have a wide range of needs to be addressed as part of recovery, health and stability for their families. Many of the needs that are met outside the scope of the initiatives' direct services, are accomplished through linkages and active coordination with other services and programs. The following are examples of the current Initiatives:

1. **Alcohol/Drug Council of NC (ADCNC): Perinatal Substance Use Project:** The NC Division of MH/DD/SAS and the NC Division Public Health jointly fund a Substance Use Specialist position housed at ADCNC. The Substance Use Specialist can be reached at 1-800-688-4232 or through the 1-800-FOR-BABY hotline, Monday through Friday, from 8 am to 5 pm. Services are available to the public and professionals to provide support in accessing gender-specific substance abuse treatment services statewide. Technical assistance, training and education regarding screening and referral for pregnant women with a substance use disorder are also available. A capacity management (bed availability) listing of residential substance use disorder treatment services for pregnant and parenting women and their children is maintained to assist the public and professionals to identify appropriate and available services statewide.

2. **North Carolina Perinatal and Maternal Substance Use & NC CASAWORKS for Families Residential Initiative:** The Perinatal and Maternal Substance Use Initiative is composed of 19 specialized programs for pregnant and parenting women with a primary substance use disorder and their children. These programs provide comprehensive gender-responsive substance use disorder treatment services that include, but are not limited to, the following: screening, assessment, case management, out-patient substance use disorder and mental health services, parenting skills, residential services, referrals for primary and preventative health care, and referrals for appropriate interventions for the children. The children also

benefit from the services provided by the local health departments (pediatric care), early intervention programs and care coordination for children (CC4C).

The NC CASAWORKS for Families Residential Initiative supports seven (7) comprehensive residential substance use disorder programs for women a primary substance use disorder and their children. The CASAWORKS for Families model was developed by the Center for the Study of Addiction and Substance Abuse (CASA) at Columbia University in response to the impact of welfare reform on families who are substance use involved. The model proposes that the best way to help families receiving TANF become economically self-sufficient is to provide an integrated and concurrent gender specific substance use disorder and co-occurring treatment and job readiness, training, and employment program.

The residential services that are a part of the NC Perinatal and Maternal Substance Use Initiative and the CASAWORKS for Families Residential Initiative are considered Cross Area Service Programs and are available to any pregnant or parenting women and her children who meet medical necessity for the services based on ASAM criteria. The outpatient only programs are offered to pregnant and parenting women who meet the ASAM criteria for this level of care in the specific LME/MCO catchment area.

3. **Work First/CPS Substance Use Initiative:** The Work First/CPS Substance Use Initiative is a joint initiative of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the North Carolina's Division of Social Services (DSS). The two Divisions have an interagency memorandum of agreement in place delineating the roles and responsibilities of each entity. This Initiative provides appropriate assessment, treatment referral, and case coordination for eligible Work First (TANF), Class H or I Controlled Substance Felons eligible for Food and Nutrition Services (FNS) and certain categories of recipients of Child Protection Services (CPS). The goal of the Work First/CPS Substance Use Initiative is to provide early identification and connection to treatment, of Work First recipients and eligible Food and Nutrition Services recipients who have substance use problems severe enough to affect their ability to become self-sufficient. The program also assists parents who have substance use problems and who are involved with CPS engage in appropriate treatment. Each of the county department of social services has access to a Qualified Professional in Substance Abuse (QPSA), contracted by the Local Management Entity -Managed Care Organization (LME/MCO). Generally, QPSAs are located in local county departments of social services and are easily accessible to families and social services staff. Each LME/MCO establishes a local MOA between county DSS and LME/MCO and/or QPSA provider, which is reviewed annually. The LME/MCO is responsible for submitting quarterly reports to DMH/DD/SAS. These reports reflect the numbers of individuals who have had assessments completed, delineated by referral source or cause (Work First, CPS, H or I felon). The number of individuals that a QPSA is coordinating services for, per quarter, is also reflected on this report. Quarterly statewide Initiative meetings with the QPSAs and LME/MCOs occur to review the aggregate quarterly data and discuss the barriers and successes that each county is experiencing in serving these populations. Monitoring of the Initiative occurs annually at the state level of both the LME/MCO's management of the

Initiative and of the individual cases. The LME/MCO's are responsible for local monitoring of the community providers that have been contracted for the QPSA positions. Ongoing technical assistance is provided to the LME/MCOs, DSSs, and QPSAs by DMH/DD/SAS.

4. **NC Plan of Safe Care Interagency Collaborative:** 2016 CARA federal legislation, and within it, CAPTA, has impacted North Carolina policies as they relate to infants who have been born exposed to substances during pregnancy. The goal of the federal legislation and subsequent state policies are to support the health and wellbeing of the infant, mother and family. North Carolina policies went into effect August 1, 2017. The intentions of North Carolina policies are:
    - To include infants, children and families in the Plans of Safe Care.
    - To support the health of the infant and mother, not to penalize the mother and family.
    - To increase access to treatment and support for all women with a substance use disorder and their children. To provide access to appropriate screening and surveillance, assessment and intervention services for infants determined to be affected by substance abuse, withdrawal or Fetal Alcohol Spectrum Disorders (FASD).

    The following agencies have been meeting since January 2017, as the NC Plan of Safe Care Interagency Collaborative (NC POSCIC), to develop the required policies, procedures and implementation:

    - Division of Mental Health, Developmental Disabilities and Substance Abuse Services
    - Division of Public Health
    - Division of Social Services
    - Division of Medical Assistance
    - Community Care of North Carolina
    - North Carolina Hospital Association
    - North Carolina Obstetrics and Gynecological Society
    - North Carolina Commission on Indian Affairs

    The Infant Plan of Safe Care itself, is simply a referral of an identified infant to Care Coordination for Children (CC4C) from Child Welfare, that includes services and linkages that the infant and family may benefit from. All infants identified as meeting criteria as 'affected by substance abuse' have a notification go to their local county Child Welfare, who screen and then universally refer to CC4C for ongoing support services. Approximately 70% of the notifications statewide result in child welfare assessments.

5. **Reproductive Life Planning and Substance Use Disorder Treatment Project:** The North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) has partnered with the North Carolina Division of Public Health (NCDPH) Family Planning and Reproductive Health Unit to provide training to the staff of perinatal and maternal substance use and opioid treatment programs in our statewide initiatives.

Participants include staff from the Federal Title X funded Local Health Departments (LHDs) corresponding to the identified treatment programs.

The cross disciplinary training on reproductive life planning and substance use disorders promotes the local partnerships of the identified substance use disorder treatment programs and their Local Health Departments. These partnerships will impact effective support of individuals with substance use disorders, and in recovery, in their reproductive life plans. It is specifically intended to be non-coercive and non-judgmental in the provision of the information and connection to services. Training objectives Include:

- Increase knowledge about the key components of reproductive life planning.
- Increase or review knowledge about addiction and the importance of language when work with individuals with substance use disorder.
- Increase or review knowledge about reproductive biology and sexually transmitted diseases.
- Increase awareness about the importance of counseling all individuals of reproductive age with substance use disorder about reproductive life planning.
- Improve reproductive life planning counseling skills.
- Facilitate local partnerships.

The SUD treatment programs track the occurrences of individual and group reproductive life planning specific sessions and referrals, reporting on the aggregate data quarterly. Also included in the quarterly report data are the numbers of individuals who required transportation assistance to necessary appointments related to reproductive life planning.

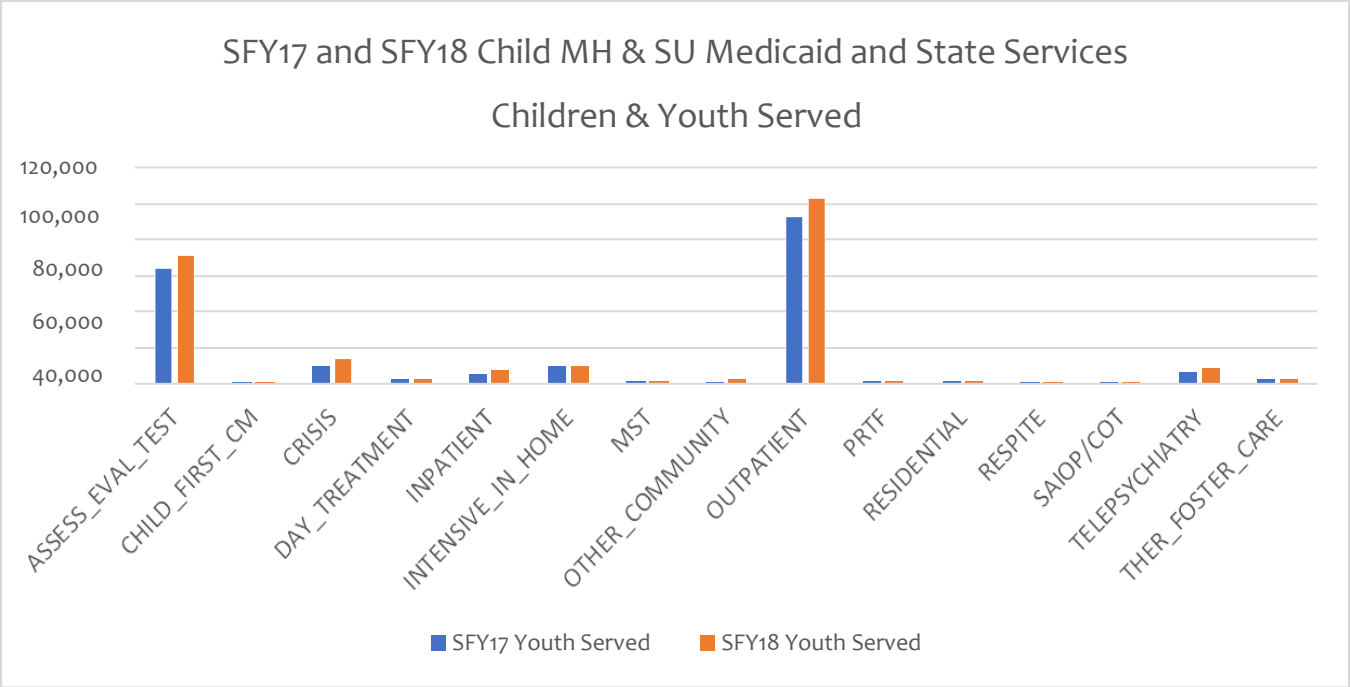
Monthly meetings to support the implementation of the RLP-SUD practices include the state partners and the community level SUD treatment programs and the LHD professionals. These meetings include deidentified case presentations and specific topics that are covered through didactic and discussion. Technical assistance is available to the SUD treatment programs and the Title X LHD on an ongoing basis from the state partners.

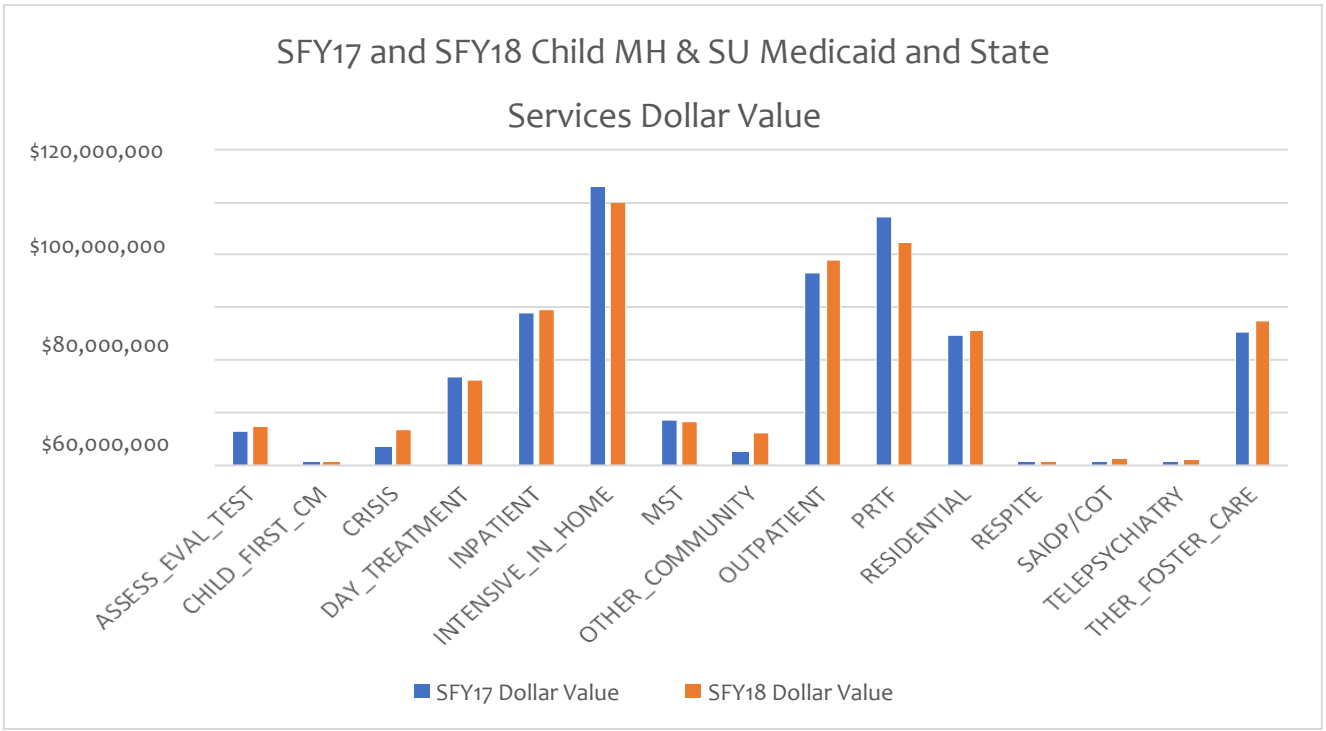
Adolescent Substance Use Disorder Services

Services available for youth, who are often diagnosed with other behavioral or mental health disorders, in addition to substance use, include:

- Outpatient Therapy
- Outpatient Therapy Plus (some LME/MCOs)
- Day Treatment
- SA Intensive Outpatient
- Intensive In-Home Services
- Multisystemic Therapy

The charts below provide a comparison for child services for state fiscal years 2017 and 2018 for both Medicaid and state-funded (including block grant) services by type of service and dollar value.





In addition to the above, the Adolescent Substance Use Disorder Regional Residential Program Initiative was created to ensure the availability of SUD residential services for adolescents in every region of the State of North Carolina. The mission is to provide medium-term residential services and

public education to prepare individuals under 18 years old with Substance Use Disorders, and other co-occurring problems, for ongoing community- based recovery services.

All programs under this initiative admit youth from anywhere in the state, serving all 100 counties, giving them the distinction of Cross Area Service Programs (CASPs). All programs use proven evidence- based SUD models at their facilities. These programs provide 24-hour residential services through supervised living or similar licensure and intensive outpatient or day treatment services. The majority of sites provide public education through local teachers assigned to the program by the local education authority or Department of Public Instruction.

These programs provide evidence-based SUD treatment services that include counseling to assist youth and their families in becoming actively involved in their own recovery. This is achieved through comprehensive assessment, treatment planning, group therapy, individual therapy and continued care planning. A Child and Family Team is constructed for every youth and family. The team has the responsibility of developing and updating the youth's Person Centered Plan (PCP) for recovery. This also includes discharge planning and care coordination for when youth return to their homes and community to ensure continuing treatment through their local community outpatient treatment programs, and other community resources.

The youth receive psychological services that include the provision of diagnostic testing and specialized psychotherapy for youth when appropriate. Psychiatric evaluation and medication-management are also available to youth. Family services are offered to family members and other significant people in the youth's life, and include weekly individual, and multi-group sessions.

Therapeutic Recreation Services are provided daily, and programs use their own recreation facilities on site along with community facilities such as the YMCA. Each program develops internal incentives to teach and encourage the youth while in the program. Each adolescent Substance Use Disorder Regional Residential Program is unique; therefore, there are some variations in the services offered by the individual programs across the state.

Presently, North Carolina has five (5) Substance Use Disorder Regional Residential facilities operational including the following: (1) Swain Recovery Center is a five-bed facility located in the western part of the state; (2) Youth Focus Adolescent Substance Abuse Program is a 10-bed facility in north central North Carolina; (3) PORT Aberdeen is a 10-bed facility in south central North Carolina; (4) PORT Greenville is a 10- bed facility in the eastern part of the state and (5) Port Burgaw, another 10-bed facility in the southeastern area of the state.

These programs are monitored by both the LME/MCO and the State. Each program is monitored locally by the LME/MCO. However, the state conducts quarterly meetings and yearly site visits to ensure the programs operate within the compliance guidelines for treatment services.

The duration of services is based upon ASAM criteria for level of care and special continued service and discharge criteria. The average length of stay ranges from 90 to 120 days.

The Department of Public Safety is preparing for "Raise the Age" which will welcome 16 and 17-year-old into the Juvenile Justice system beginning December 1, 2019. Many of these youths will be referred to the behavioral health system for assessment and treatment. Beyond "Raise the Age," there is also legislation that could drive 14,000 youth involved with the Juvenile Justice system into

the behavioral health system for comprehensive assessments. The aforementioned state level Behavioral Health Juvenile Justice team has been working through a series of cross-system service barriers. The State team has also collaborated in sharing specific concerns/recommendations about meeting the behavioral needs of youth involved with juvenile justice system to the national consultant firm that is designing the new behavioral health system in the Medicaid Managed Care reform.

State Opioid Treatment Authority/Medication Assisted Treatment

Overview

The road to recovery is unique to everyone, and treatment for an individual may consist of any combination of services at different points in time. Treatment with medications is the standard of care for an opioid use disorder and substantially reduces overdose, transmission of infectious diseases such as HIV and hepatitis C, crime and unemployment.

The NC Opioid Treatment Program (OTP) system of care strives to be accessible, evidence-based, individualized and comprehensive by offering FDA-approved medications, as well as various levels of clinical care in order to best serve those with varying degrees of necessity.

The majority of OTPs in North Carolina are involved in their communities. Critical opportunities to initiate care are taking place in the jail system, in the prison system and in hospital emergency departments.

The mission of the North Carolina State Opioid Treatment Authority (SOTA) is to reduce the impact of opioid use disorder, in North Carolina communities and promote excellence in Opioid Treatment Programs. The State Opioid Treatment Authority Administrator and two field staff provide technical assistance and monitoring of the 74 opioid treatment programs in North Carolina serving 19,346 patients with an OUD. With a capacity of approximately 26,000 patients, capacity management, guest dosing and emergency management (in the event of natural disasters) functions are managed through a contract with an outside central registry vendor. **Please see the map of all OTPs in NC in the Attachments section.**

To date, the State Opioid Treatment Authority (SOTA), located within the Addictions and Management Operations section of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, has been primarily involved with the opioid treatment programs. As with many other states, North Carolina has seen substantial growth in the number of agencies opening programs. The certification process is lengthy and involves various other agencies, including the Division of Health Services Regulation, the Division's Drug Control Unit, the DEA and SAMHSA. Each OTP operating in NC is approved by the North Carolina State Opioid Treatment Authority which is responsible for program approval, for monitoring compliance with the regulations related to scope of staff, and operations, as per 10A NCAC 27G.3604.

North Carolina's OTPs are operated as either for-profit businesses or nonprofit organizations, as well as through the state's three state-run facilities (Walter B. Jones Alcohol and Drug Abuse Treatment Center located in Greenville, Julian F. Keith located in Black Mountain and RJ Blackley located in Butner). More than two-thirds of the OTPs in North Carolina receive state and federal dollars; the remainder are cash pay.

NC State Opioid Treatment Authority (SOTA) Responsibilities include the following:

1) Clinical and administrative on-site review and monitoring of approximately 74 local Opioid Treatment Programs (OTPs) on a daily basis, including consultation and technical assistance, with emphasis on safety and quality of care issues related to program leadership, staffing, supervision, scope of practice, admission and discharge protocols, medication ordering and administration, specialty patient treatment such as pregnant women and justice involved patients, and incident reviews, including deaths, non-fatal overdoses and injuries, and serious medication errors, and implementation of program policies and procedures in accordance with federal and state regulations, standards of care, NC-TOPPS patient and program outcomes evaluation and capacity management using Lighthouse Central Registry.

2) Clinical and administrative review on a daily basis of Opioid Treatment Program (OTP) patient incidents and complaints, including patient deaths, non-fatal overdoses, accidents, serious medication errors, admissions concerns, patient management issues, administrative discharges, medication diversion, and other adverse incidents involving patient, family, and community health and safety, and complaints about patient respect and dignity, program performance, and quality of care issues.

3) Coordination with the Center for Substance Abuse Treatment (CSAT) - Division of Pharmacological (DPT) Therapies and the Drug Enforcement Administration (DEA) regarding local program approval, monitoring, and program practices involving implementation of federal regulations, guidelines, advisories, and national accreditation standards.

4) Coordination with the NC Division of Health Service Regulation (DHSR) and the DMHDDSAS Drug Control Unit regarding local program approval, monitoring, and program practices regarding the implementation of federal and state regulations, guidelines, advisories, and national accreditation standards.

5) Clinical review and approval of daily individual patient and program take-home medication exception requests through the SAMHSA Center for Substance Abuse Treatment (CSAT) Opioid Treatment Program (OTP) Extranet System for take-home privileges for methadone and buprenorphine in accordance with 42 CFR Part 8.

6) Coordination with the NC Division of Medical Assistance (DMA) and LME-MCOs in the development and implementation of statewide policies regarding Medication-Assisted Treatment (MAT) utilizing methadone and buprenorphine, and the support of LME-MCOs in local Opioid Treatment Program credentialing, contracting, access, service

authorization, monitoring, and program practices involving implementation of best practice guidelines and standards of care, as well as federal and state regulations, guidelines, advisories, and national accreditation standards.

7) Coordination with the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and other national groups regarding the development and promotion of state, regional, and national approaches to addressing current and emerging issues in practice, including the development and implementation of prescription monitoring programs (PMPs), such as the NC CSRS, responses to the continuing threat posed by prescription drug use and heroin use, and the support of harm reduction approaches such as the distribution and utilization of Narcan overdose kits among at risk populations.

8) Development and implementation of specialized provider training, consultation, and networking opportunities with emphasis on OTP physicians, PAs, NPs, and Program Directors, through such vehicles as monthly physician/PA/NP group case consultation phone calls, quarterly meetings with program directors, annual regional training seminars for physicians/PAs/NPs, and targeted specialty OTP sessions in the annual Addiction Medicine Conference.

Patients entering medication assisted treatment are required to be seen by a physician (face-to-face) prior to the provision of medication. All patients are assessed based on ASAM criteria, which determines the recommended level of care. North Carolina Administrative Code (10a NCAC 27g.0205) requires that each facility counselor, in partnership with the patient, develops a treatment plan that includes anticipated outcomes to be achieved by the services, projected achievement dates, treatment plan strategies and the manner in which the achievement of outcomes will be measured. The plan must be developed with the patient and the patient must acknowledge his/her participation and agreement by signing the document. At a minimum, each OTP clinic is required to develop and implement systems to ensure each patient receives minimally two counseling sessions a month within the first year of treatment and once monthly thereafter.

There are a large number of office-based opioid treatment providers (OBOTs) in North Carolina as well. LME/MCOs have been encouraged to open their networks to these certified providers in areas where an OTP does not exist, but a need has been identified.

As with many states, addressing the opioid epidemic is a top priority for North Carolina. We intend to continue our efforts and will work in partnership with our providers and through stakeholder engagement to determine the most effective, efficient, and impactful ways to deploy these funds in accordance with our North Carolina Opioid Action Plan, which was updated in June 2019. We will utilize the funds to further implement the comprehensive strategies identified in the Action Plan to reduce opioid addiction and overdose death. **See the Attachments section for the Opioid Action Plan 2.0.**

Persons Who Inject Drugs (PWID)

North Carolina assures priority admission preference for individuals who inject drugs through its contract with the seven (7) LME/MCOs. All LME/MCOs operate a 24/7/365 crisis line that performs various services. These Access/Customer Services call centers provide information about providers and community resources, accept complaints, and perform screening, triage and referral, including

telephonic crisis intervention. The LME/MCO is required to publicize priority preference for substance use disorder admission and treatment for individuals who are injecting drugs and substance using pregnant women. The function of screening, triage and referral is required to be completed by a Qualified Professional and /or by a licensed professional. A licensed clinician will be available for consultation. If the call is determined to be clinical in nature such as an individual needing a screening and triage either in routine, urgent or emergent type call, the customer call center staff will do a warm line transfer to an available qualified professional for screening, triage and referral.

Also, per the contract, each LME/MCO shall adopt and publish annually the benefit plan for non-Medicaid services that defines the available services and eligibility criteria for individuals in each DMH/DD/SAS benefit plan. The benefit plan shall be flexible to maximize the services that consumers may receive as an adequate service array, within available resources. LME/MCOs authorize non-Medicaid funds for medically necessary services for DMH/DD/SAS-specified priority populations with mental health, intellectual or developmental disabilities or substance use disorders. The contract includes a list of all priority populations for which the LME/MCO must assure adequate service selection and availability.

Additionally, each LME/MCO develops a Member Handbook which is made electronically available to persons receiving State-funded services. The Handbook is designed to assist individuals in understanding the North Carolina public MH/IDD/SA system, member rights and responsibilities, complaint processes and information about the non-Medicaid benefit plan. The LME/MCO is required to publicize this information either through its website, targeted brochures, the Member Handbook or other means, that individuals injecting drugs and substance using pregnant women have program admission priority.

The Division requires each LME/MCO to complete the *Semi-Annual SABG Compliance Report* which contains sections for policies and practices related to PWID, both in terms of priority admission, as well as capacity management and interim services, as evidenced from the following excerpted sections of the *Compliance Report*:

Section V: Priority Admission Preference for Women Who are Pregnant and Injecting Drugs, Women Who are Pregnant and Using Substances and Other Individuals Who are Injecting Drugs

Part A. LME-MCO Policies and Practices for Assuring Priority Admission Preference

Describe your **LME-MCO program policies and practices assuring priority admission preference** for all women who are pregnant and injecting drugs, pregnant and using substances and other individuals who are injecting drugs in all LME-MCO programs and contract agencies. Describe your LME-MCO's contract management and monitoring, training, technical assistance and quality management practices that ensure that all LME-MCO and contract agency direct services staff provide Priority Admission Preference for all women who are pregnant and injecting drugs, pregnant and using substances and other individuals who are injecting drugs.

Part B. Documentation of Efforts to Publicize Priority Admission
Document and/or attach evidence of satisfactory efforts of your **LME-MCO** to advertise and publicize priority admission policies **in the current fiscal year** assuring admission to all women who are pregnant and injecting drugs, pregnant and using substances and other individuals who are injecting drugs.

Section VI: Capacity of Treatment for Individuals Who are Injecting Drugs

Part A. LME-MCO Policies and Practices for Assuring Timely Admission
Describe your **LME-MCO's policies and practices that ensure that individuals who are injecting drugs** are admitted for services within 14 days of the request for services, or if at capacity, within 120 days of the request for services, with the provision of interim services within 48 hours after the request for care if admission within 14 days is not possible. If the LME-MCO maintains a waiting list, or contracts with providers that may maintain a waiting list, please provide additional information on how the wait list is managed.

It should be noted that the Division requires that all individuals screened as having a substance use disorder be provided a referral to treatment/appointment within 48 hours of calling an LME/MCO Access line.

While North Carolina does not utilize any of its SABG funds for syringe services programs, syringe exchange programs became legal in North Carolina on July 11, 2016, when the Legislature passed NC General Statute 90-113.27. As of July 1, 2017, local funds may be used to purchase syringes, needles and other injection supplies. Programs are still prohibited from spending state or federal funds on these supplies. All public funds may be used for other program development and operation costs (rent, salaries and stipends, testing resources, naloxone training and distribution, etc.).

Syringe exchange programs are financially practical ways to reduce costs associated with treating HIV and hepatitis C infections. According to the Harm Reduction Coalition, approximately 20 percent of AIDS cases and upwards of 55 percent of hepatitis C cases can be attributed to injection drug use, which underscores the viability of syringe exchange programs (SEPs) as a tool in the fight against HIV/AIDS. Cost-effectiveness addresses the relationship between the cost of intervention and the number of new infections prevented. SEPs are not only successful at reducing HIV and Hepatitis viral infections, but have repeatedly been shown to be cost-effective, yielding a significant cost savings. Many studies have confirmed the cost efficiency of syringe exchange programs as a prevention effort to reduce the spread of HIV, hepatitis C and other bloodborne illnesses.

Syringe exchanges are important for public safety. Fear or hesitation to disclose syringe possession puts law enforcement officers and other emergency responders are at risk of needle stick injuries from used syringes. In addition to providing limited immunity for possession of drug paraphernalia (including used syringes), syringe exchange laws authorize places to safely and securely dispose of used syringes, limiting risk of harm to others. Furthermore, by investing in relationships with their

communities, exchanges can alert public health agencies about observed changes in drug use, new health risks, and spread of infectious diseases.

Providing new syringes and disposing of used ones is foundational for syringe exchange programs, but it is not usually the only service they provide. Many also offer supplies for safer injection (cotton filters, tourniquets, cookers or steel spoons, sometimes collectively referred to as "works"), alcohol swabs and other wound care supplies (antibiotic wipes and ointment, bandages), bleach kits, acidifiers, and safer sex supplies (internal [female] and external [male] condoms, lubricants, finger cots, dental dams). Programs should also provide information about safer injection practices, preventative health, safer sex practices, mental health services and other issues affecting people who inject or otherwise use drugs. Exchanges may offer HIV and hepatitis C testing, wound care, hygiene kits, case management services, and nutrition or community meal programs. They provide information about HIV care, medication assisted treatment (including all FDA-approved medications), detox and treatment programs, and other medical and social services, and connect participants to these services as requested. There are currently over 30 established syringe services programs in North Carolina.

As mentioned in the previous section, North Carolina has 74 opioid treatment programs, with capacity to serve 26,000 individuals on a daily basis. As many individuals who begin using opioids progress to injection drug use, these programs typically have availability and capacity to serve more participants.

Veterans and Military Families

According to *Governing,* North Carolina is home to the fourth largest active duty and reserve members of the military in the country. This population is comprised of each branch of the military: Army, Marines, Navy, Air Force and Coast Guard. Of the total, over 91,000 are active military and nearly 22,000 serve in the Reserve forces. North Carolina's veteran population comprises about 8.3% of the total state population, with an unemployment rate of 3.8%.

More than 100,000 children and adolescents of active members/National Guard/Reserves live in North Carolina and about 35% of the state's population is in the military, a veteran, spouse, survivor, parent or dependent of someone connected to the military. *(Honoring Their Service: A Report of the NC Institute of Medicine Task Force on Behavioral Health Services for the Military and Their Families, January 2011).*

The Governor's Working Group on Veterans, Service Members and Their Families is a collaborative intradepartmental work group focused on job creation, workforce enrichment, health and wellness, suicide prevention, legal and financial services and benefits for veterans. This monthly working group is jointly chaired by the following agencies: NC Department of Military and Veterans Affairs, NC Department of Commerce, NC DHHS DMH/DD/SAS, as well as the Veterans Administration Management from the Veterans Health Administration (VHA VISN-6) and the Veterans Benefits Administration (VBA). Regular participants in this collaborative forum include; Department of Public Instruction, Department of Public Safety, other DHHS Divisions, the North Carolina Institute of Medicine (NCIOM) NCNG, UNC System and NC Community College System schools, AHECs and members of the NC General Assembly.

The GWG has grown to become a nationally recognized forum, which hosts a monthly meeting, newsletter, and website (http://ncgwg.org), as well as a YouTube Channel (https://www.youtube.com/watch?v=p2CwZHXzho4&feature=youtu.be). Facebook LIVESTREAM has expanded viewership to a 2019 average of 4,000 per meeting. This real-time referral and collaboration network cuts red tape by linking decision makers, service providers, and military members (current and former) and their families together in a best-practices sharing environment.

Charged with facilitating collaboration and coordination among ALL federal, State, local, and non-profit partners who work with North Carolina's nearly Veterans and their families, monthly sessions highlight:

- Health and Wellness, including Behavioral Health, especially for those in recovery
- Transitional Services
- Veterans Benefits and Claims
- Community-based Services and Supports
- Housing Resources
- Education and GI Bill
- Job Creation and Workforce Enrichment
- Legal and Financial Services

Functioning collaborations fostered at the GWG sessions include:

- NC STRIVE (Student Transition Resources Initiative for Veterans Education)
- Operation HOME: Ending Veterans Homelessness Task Force
- Women Veterans Summit and Expo
- NC Practice Improvement Collaborative (NC PIC) to Reduce Veteran Suicide

In North Carolina, significant gaps were identified in coordinated service delivery for Veterans and their families. NCServes provides the coordinated networks, with associated technology (UniteUS), needed to connect Veterans and their families to the resources they need, while allowing the tracking of system-wide outcomes that support system improvement. Built with private, philanthropic support from national organizations, through the Institute for Veterans and Military Families (IVMF) at Syracuse University, AmericaServes has sponsored the creation of four (4) regional network coordination centers, each housed in an existing community provider, operating in 74 of 100 counties:

- NCServes Metrolina: (https://charlotte.americaserves.org/) Veterans Bridge Home in Charlotte serves eight (8) North Carolina counties;
- NCServes Western: (https://western.americaserves.org/) Veterans Services of the Carolinas, through the Asheville-Buncombe Community Christian Ministry (ABCCM) coordinates services in 16 Counties;
- NCServes Central: (https://raleigh.americaserves.org/) the USO of North Carolina provides coordinated network management in 21 counties;
- NCServes Coastal: (https://coastal.americaserves.org/) Eastern Carolina Human Services Agency (ECHSA) coordinates care in 20 eastern counties.

Additionally, the United Way of South Hampton Roads, VA (https://unitedwayshr.org/what-we-do/mission- united/) provides network coordination services in 10 North Carolina counties (not funded by North Carolina).

These networks have provided a model of coordinated care that has informed the adoption of the NCCARE360, the first statewide coordinated care network to electronically connect those with identified needs to community resources and allow for a feedback loop on the outcome of that connection. Participation and reporting via NCServes is required of all community partners in this section. NCServes provides a strategic opportunity for North Carolina to continue to improve access across the social determinants of health that contribute to:

1.Reductions of homelessness;
2.Improved quality of life;
3.Improved health and well-being because of NCServes' community-level coordinated care model.

Deaf Services

NC DMH/DD/SAS has been providing specialized services to Deaf, Hard of Hearing and Deaf-Blind individuals since 1992. These services stem from one of the earliest ADA complaints filed in NC, alleging Deaf individuals were not receiving appropriate care in the public mental health system. While the original complaint was resolved long ago, the state continues to show commitment to providing language accessible and culturally competent MH/SUD services to this population.
In SFY17, the state started contracting directly with RHA Behavioral Health to provide MH/SUD services to this population across the state. This direct service contract allows the Division to achieve budget efficiencies and ensure services are provided evenly across the state. Prior to SFY17, these services were managed and contracted out through the LME-MCOs.

RHA employs full time licensed clinicians, Outreach Consultants (3 are certified Peer Support Specialists), a program director, business manager and a part-time administrative assistant. All staff are sign language fluent as measured by the Sign Language Proficiency Interview (SLPI). About 60% of RHA program staff are deaf. Funds from the SABG support sign language proficient workers to accompany deaf individuals to mutual aid support groups, as well as formal clinical treatment services if SLP staff are not available. The Addictions team is currently working with RHA to develop Substance Abuse Intensive Outpatient Programs in one or more locations to better meet the needs of deaf individuals who are in need of this level of care.

DMHDDSAS hosts a Deaf Mental Health Advisory Council (MHAC) to advise the Division on services and provide feedback related to programming. The 13-member Council meets four times per year in Raleigh. Most of the Council members are deaf and some identify as being in recovery. Further, the Division hosts three Community Listening Sessions each year at selected sites across the state to obtain feedback about programming and services.

Tuberculosis Services

Screening for tuberculosis has been incorporated into each provider's comprehensive clinical assessment tool and/or assessment process for a number of years. As the Division's intermediaries, LME/MCOs are required to assure tuberculosis screening and referral for care (if indicated) are carried out by SABG designated providers. Division staff monitor and review sample records

annually to ascertain these activities are conducted and issue plans of correction if such screenings do not occur.

In accordance with 10A NCAC 27A .0213 and 10A NCAC 27A .0216, TB screenings are required with the aim of identifying individuals who are at high risk of becoming infected with Tuberculosis. Persons with substance use issues and with limited access to medical care are at increased risk for Tuberculosis infection. North Carolina has required those involved in treatment programs as well as individuals who inject drugs to be screened for possible infection. Providers are to query service recipients about their health history as it relates to TB signs and symptoms. The Division of MH/DD/SAS has required certain elements to be included in the provider's screening documentation:

- Medical treatment in the past three months,
- Current place of residence (jail, streets, shelter, etc.),
- History of TB tests (prior positive skin tests, proximity to others diagnosed with TB in the past year),
- Physical/visible symptoms of TB, such as night sweats, prolonged cough, shortness of breath, and unexplained weight loss.

A sample screening tool and accompanying guidance can be found in the Attachments section. Based upon an individual's positive responses to symptoms in the screening tool, a referral must be made to the local county health department or the individual's medical practitioner for follow-up testing and care. Those who have been found to be infected with TB must be referred to the appropriate State official for follow-up treatment.

Cultural Competency

The Division of MH/DD/SA Services has a staff member who is dedicated to providing cultural competency training and technical assistance to LME/MCOs and providers on a regular basis. This training helps to assure LME/MCOs and providers are appropriately staffed, trained and equipped to serve racial and ethnic minorities and successfully address health disparities.

Numerous trainings are offered, including Removing the Elephants in the Room and Broadening Your Cultural Lens, both which explore cultural issues North Carolina's behavioral health system faces, by examining the Cultural Formation section of the DSM-5 and the ethical principles that govern licensed professionals.

1. **Removing the Elephants in the Room** - 30+ trainings; began February 2015, continues with most recent training offered December 2018, including LME-MCOs and provider agencies with staff at all levels, State & Local CFAC members, family members, advocates.
2. **Broadening Your Cultural Lens -** 15+ trainings; began May 2017; continues with most recent training offered December 2018. Also, Mental Health First Aid instructors, court counselors, juvenile justice professionals, school staff, law enforcement, probation, child welfare.
3. **Broadening Your Cultural Lens: Social Determinants and Health Disparities -** This is phase 2 of the previous trainings and began January 2018, explores ways in which social determinants of health and culture intersect.

LME/MCOs and provider agencies often develop their own cultural competency related activities, tools and trainings, influenced by DMH/DD/SAS-related trainings. The Division does not develop or

direct the development of cultural competency trainings; however, its work often influences LME/MCO and provider outputs in this regard. Examples include: (1) Cultural Competency Plan; (2) Cultural Competency Review Tool; (3) Cultural Competency Assessment; (4) Cultural Competence Provider Council; (5) Online trainings; and (6) Instructor-led trainings.

The fundamental precepts of cultural competence include developing respect for differences; cultivating successful approaches to diversity; increasing awareness of one's self and of unstated institutional cultural norms and practices; and having a working knowledge of the history, culture, beliefs, values and needs of diverse people and communities. A culturally competent approach to services requires the system to examine and potentially transform each component of mental health, intellectual and developmental disability and substance use services.

The 26 Perinatal/Maternal and CASAWORKs programs have implemented strategies to assure participants in these programs are served competently. Annually each program completes a "cross-site evaluation" and reports on specific questions related to cultural competency, which are then reviewed and/or evaluated by Division staff. A sampling of those questions includes the following:

1. Describe the level of diversity of your agency's staffing in terms of race, gender and language.
2. Describe how your agency's environment is conducive for providing culturally competent treatment services.
3. Please describe any challenges you may have faced recruiting a culturally diverse clinical team.
4. How are issues of culture addressed in individual clinical supervision?
5. What strategies are you employing to assure all women in need of your services have access to care?

Data Collection

The North Carolina Treatment Outcomes and Program Performance System (NCTOPPS) is the program by which the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services measures the quality of substance use disorder and mental health services and their impact on consumers' lives. By capturing key information on a consumer's service needs and life situation during a current episode of care, NCTOPPS aids in developing appropriate treatment plans and evaluating the impact of services on a consumer's life. It supports LME/MCOs in their responsibility for monitoring service outcomes in each LME/MCO's catchment area. The data generated through NCTOPPS helps the DMH/DD/SAS, LME/MCOs and provider agencies improve the quality of services. In addition, NCTOPPS provides data for meeting federal performance and outcome measurement requirements, which allows North Carolina to evaluate its service system in comparison to other states.

NCTOPPS began as a pilot study funded through a 1997 federal Center for Substance Abuse Treatment (CSAT) grant. North Carolina was one of 14 States that received the CSAT grant. This initiative was a partnership between the federal government and grantees to prepare States for development of a system to monitor and evaluate substance use disorder treatment services. Based on information gathered during the pilot period lasting approximately two years, the Division transitioned the pilot program into an on-going data collection, feedback and planning system. NCTOPPS later became a statewide system. Assessment instruments were built on research findings

and field practice. Individual assessment items were discussed and agreed upon by participating programs and State Addictions team staff.

In the spring of 2004, the Division decided to expand the NCTOPPS web-based data collection system into the mental health arena. A participatory, collaborative and consensus-building process, similar to the process used for substance abuse assessments, was established involving mental health providers, Local Management Entities, researchers and consumers to develop and improve measures for mental health. On July 1, 2005, NCTOPPS became the statewide method of collecting information necessary for accountability, quality improvement and tracking outcomes for consumers of the State's substance abuse and mental health treatment services.

As a web-based system, NCTOPPS today can be used on most laptops, tablets and cell phones. Through regular consumer-to-clinician interviews during an episode of care at intake and months three, six, 12, 18, 24, etc., NCTOPPS captures information about an individual's current situation, including such topics as symptoms, well-being, family and social relations, housing, employment, and legal system involvement. It also gathers consumers' perspectives on the system, including barriers to treatment, choice of providers, timeliness of care and involvement in treatment planning. NCTOPPS gives providers information to develop person-centered plans and track goal attainment. It gives LME/MCOs information to evaluate consumer needs and improve local service quality. Furthermore, it gives State decision-makers, NC residents and the federal government information to help evaluate and improve the effectiveness of the service system.

Interview information provides one method for collection of the Division's consumer functional outcomes data. Consumer functional outcomes data are the Division's source of information to monitor the impact of services. These data are also used to respond to departmental, legislative, and federal reporting requirements. NCTOPPS accountability measures based on outcomes along with other performance measures are used for both the MHBG and the SABG reporting. In addition, the system provides data to meet SAMHSA's reporting requirements for the National Outcome Measures (NOMs) and the Treatment Episode Data System (TEDS) data as requested. The Division has the ability to modify or add questions as needed; as such, questions specific to sexual orientation and transgenderedness were added in 2016. Division staff will monitor the results of this data to determine the percentage of transgendered, gay and lesbian individuals are accessing care.

The NCTOPPS system provides information on outcomes and program performance that can be used to improve service delivery and, ultimately, the quality of life for people with mental health and substance use disorder needs who are served in the public service system. The following NCTOPPS links are provided:

- NCTOPPS Login: https://nctopps.ncdmh.net/Nctopps2/Login.aspx
- Public Dashboard: https://nctopps.ncdmh.net/ProviderQuery/Index.aspx
- Website: https://www.ncdhhs.gov/providers/provider-info/mental-health/nc-treatment-outcomes-and-program-performance-system

Sample "simple query" reports can be found in the Attachments section.

Contracts

In addition to contracting with the seven LME/MCOs for the delivery of prevention, treatment and recovery services, the Division also contracts with several other entities to address needs and gaps within the system. Following are some examples of those contracts:

- ***Governor's Institute on Substance Abuse*** – the primary objective of this contract is to increase access to and improve the quality of services provided in the state by: (1) expanding the use of evidence-based/best practices; (2) promoting the integration of behavioral healthcare with primary healthcare in two regions of North Carolina and the rest of the state; (3) improving physician understanding of addictions; and (4) enhancing the quality of the workforce and provider agencies in the state, with a special emphasis on service members, veterans and their families. Specific initiatives include: (1) Physician and Prescriber Initiatives - These initiatives cover important practice areas relevant to both addiction medicine providers as well as psychiatrists and other primary care providers. SUDs are often overlooked in many clinical practice settings for a variety of reasons including inadequate knowledge and skills on the part of clinicians in identifying, intervening, and managing SUDs and related psychiatric comorbidities. The GI initiatives include CME and other training events on integrated care and a range of addiction medicine topics including SBIRT, pain management and safer opioid prescribing, medication assisted treatment including office based opioid treatment, and other relevant topic areas. (2) Substance Use Disorder Higher Education Consortium / Graduate Scholarship Initiative - This program seeks to engage students and faculty at Criteria C Universities (as defined by the NC Substance Abuse Professional Practice Board in the state of North Carolina creating a cross institution environment for communication and collaboration with experts on the cutting edge of the substance use disorder prevention, treatment and recovery field. The program will provide funds to Criteria C Universities for scholarships to individuals who are working to complete graduate-level education. (3) Professional Addiction Workforce and Counselor Continuing Education - The goal of this program is to identify and engage emerging leaders in the Substance Use Disorders field. Those awarded scholarships must be currently working within public substance use disorder prevention, treatment and recovery services and be in good standing with their organization. Assistance includes but is not limited to standardized test reimbursement, and registration fees for various substance use disorder conferences and trainings. (4) Focus on SAMHSA-Supported Services to Military Service Members, Veterans, and Their Families - On behalf of DMH/DD/SAS, staff and contract support will continue to be provided to this ongoing initiative. The project includes other divisions within the NC Department of Health and Human Services, the US Department of Veterans Affairs, the NC National Guard, the NC Department of Military and Veterans Affairs, the NC Department of Commerce, as well as several other state agencies, active duty and reserve components, higher education, non-profit organizations, advocates, and others who are working together to meet the needs of veterans, service members, and their families in North Carolina. (5) Community Engagement Through Targeted Communications - This program will advocate and promote systems of health and human services that affirm hope for prevention, treatment, recovery, exemplify a strength-based orientation, and offer a wide spectrum of

services and supports aimed at engaging people with mental health and substance use conditions into care and promoting their resilience and long-term recovery. (6) The Family Smoking Prevention and Tobacco Control Act – The Family Smoking Prevention and Tobacco Control Act authorizes FDA to contract with States, U.S. Territories, and Indian tribes to assist with compliance and enforcement with respect to tobacco product retailers. In our state, the FDA Tobacco Compliance Program is managed through the Department of Health and Human Services under the Division of Mental Health Developmental Disabilities Substance Abuse Services. DHHS is responsible for the program's implementation, management and oversight including but not limited; to coordinating undercover purchase attempts in retail locations across the entire state. Other areas managed include training of inspectors, monitoring of field inspections, evidence labeling and collection, adapting to evolving training protocols, conducting advertising and labeling inspections, providing monthly updated status reports to the US FDA, hiring and training of new personnel, managing work related equipment and data monitoring. (7) Program evaluation and technical assistance for the SABG Women's Set Aside funded statewide Perinatal and Maternal Substance Use and CASAWORKS for Families Residential Initiatives.

As noted above, the Governor's Institute focuses on training and education of physicians and other medical staff providing SUD treatment services, particularly in opioid treatment programs. It hosts an annual Addiction Medicine Conference with an attendance of over 300 participants each year, some from as far away as Canada, as well as an annual two-day workshop on Addiction Medicine Essentials.

- ***Oxford House, Inc.*** – this contract allows for the continuation of substance use recovery home management services by opening new houses, administering loans and serving and mentoring re-entering substance users in their transition from incarceration. There are currently 265 homes in North Carolina with more than 1800 beds. In 2017, Oxford House opened its first house for men with dependent children and has long focused on the re-entry population.

- ***NC State University, Center for Urban Affairs and Community Services*** – this contract provides for the management of the web-based Treatment Outcomes and Program Performance System (NCTOPPS) which allows Local Management Entities/Managed Care Organizations (LME/MCOs) and their contracted network service providers to submit initial and periodic updates, as well as episode completion interview information for all consumers within specified substance abuse and mental health populations. Data entered into the system is then used in developing accountability measures for both the Mental Health and Substance Abuse Block Grants.

- ***University of North Carolina, School of Social Work, Springboard*** - the primary goal of this contract is to increase access to and improve the quality of prevention, treatment and recovery support services by: (1) expanding the use of prevention, treatment and recovery

support services for substance abuse that demonstrate success in improving outcomes and/or supporting recovery; (2) enhancing the quality of the workforce providing prevention, treatment and recovery support services; (3) enhancing the ability of provider agencies to determine the ongoing effectiveness of substance use prevention, treatment and recovery support services; and (4) planning the implementation of new, expanded or enhanced services within the state. UNC Springboard is the contracted vendor responsible for conducting Independent Peer Review for SABG-funded agencies annually and also supports the development of North Carolina's certified peer support specialist workforce. Additionally, UNC Springboard is funded for a position that works in coordination with and supervision of the DMHDDSAS Women's Services Coordinator to support the statewide Work First/CPS Substance Use Initiative, Reproductive Life Planning Project, Infant Plan of Safe Care policy work, and technical assistance and training related to women's SUD services including pregnancy and opioid use.

- ***NC Division of Public Health*** – The DMH/DD/SAS and DPH have an interagency memorandum of agreement in place to jointly fund a licensed Perinatal Substance Use Specialist to provide capacity management, training and technical assistance regarding pregnant and parenting women with SUD and their children. This position is contracted through the Alcohol/Drug Council of North Carolina (ADCNC). The Perinatal Substance Use position is housed at DPH, DMHDDSAS and ADCNC throughout the week and is clinically supervised by the DMH/DD/SAS Women's Services Coordinator.

- ***Alcohol/Drug Council of North Carolina*** – this contract provides information and referral services, as well as public education related to substance use and addiction across the entire state. This agency is also responsible for the Perinatal Substance Use Project, which includes screening, telephone hot-line, information and appropriate referrals for women throughout North Carolina who are pregnant or parenting and using substances. The project provides information on bed availability for substance use services in the NC Perinatal/Maternal Substance Use and CASAWORKS for Families Residential Initiatives on a weekly basis, as well as training and technical assistance to agencies working with women who are pregnant or parenting on issues related to substance use.

- ***UNC – General Administration*** – this vendor provides fiscal oversight to nine (9) universities that receive funding for collegiate recovery programs and services. This initiative was established by then Governor McCrory in 2015 due to concerns over alcohol consumption by college students and the need to provide a college atmosphere that is not "recovery hostile." Collegiate recovery programs have been developed at the following schools: UNC-Charlotte, UNC-Chapel Hill, UNC-Greensboro, UNC-Wilmington, East Carolina University and NC A&T, Appalachian State University, North Carolina Central University and North Carolina State University.

- ***Addiction Professionals of North Carolina (APNC)*** – this contract was executed to advance policy, services, and professional development that reflect the highest standards of the prevention and treatment profession, strengthen its value to the community and promote the values of its members. This agency also employs a Director of Scholastic Recovery that works directly with the above nine campuses on collegiate recovery programming and sustainability, as well as other grass roots collegiate recovery programs in several other universities, colleges and community colleges across North Carolina. Current initiatives also include focus on the identification and potential implementation of one or more secondary school recovery programs. Other initiatives include the following: (1) Substance Use Disorders Provider Training and Technical Assistance - The goal of this program is to keep substance use disorder prevention, treatment, and recovery providers informed and provide technical assistance to ensure continuous improvement in the quality of care provided as the continuum of care evolves in the state. (2) Substance Use Disorders Policy Education - This program will assist substance use disorder prevention, treatment, and recovery stakeholders in reviewing and evaluating policy positions. Providers will be given training and technical assistance on interacting with and providing information to elected officials at the state and local level. (3) Recovery Support Services (RSS) Outreach Coordinator for Western North Carolina - This program is tasked with building collaborative partnerships across interdisciplinary teams with stakeholders focused on promoting community-based recovery supports and opportunities for people living with substance use disorder in the western region of North Carolina to achieve Enhanced Recovery. (4) Substance Abuse Prevention - This initiative will identify and provide the necessary support for knowledge and implementation of the NC Strategic Prevention Framework-Partnership for Success program (SPF-PFS). APNC will support the following goals: Prevent the onset and reduce the progression of underage alcohol use, vaping, marijuana use, and their related problems; Strengthen the prevention infrastructure capacity to use the Strategic Prevention Framework to facilitate local and state-level change in substance abuse and its consequences; and utilize evaluation results of the project to make prevention efforts effective. (5) Health Policy/Funding Technical Assistance - The goal of this program is to provide substance use disorder treatment, prevention and recovery providers operations level technical assistance in implementing emerging best practices in service delivery, business operations (including necessary changes related to Medicaid transformation), assurances of confidentiality and patient protections with transition to NC Health Connex and understanding allowable exemptions, and new funding models that would assist in the long-term sustainability of their programs.

- ***UNC-Chapel Hill Addiction Medicine Fellowship -*** It has been well established that the signs and symptoms of addiction present in every aspect of healthcare, yet they are often overlooked and under-treated due to a deficit in education and training of the workforce, minimal coordination and integration between healthcare services and community partners, and general lack of health literacy in the community. North Carolina is a predominately

rural state with 96/100 counties designated as Medically Under-Served or as a Health Professional Shortage Area (designated by the Health Resources and Services Administration (HRSA)). Reports indicate that the healthcare workforce (current and future) is not adequately educated and trained in substance use disorders, particularly in primary acute and long-term care settings, in large part due to the stigma of addiction. The Addiction Medicine Fellowship at the University of North Carolina offers a wide array of training opportunities in addiction medicine with goal of teaching fellows about systems of care and collaborating across disciplines and professions. The fellows work with physicians in Family Medicine, Anesthesia, Psychiatry, Pediatrics, OB/GYN and Preventive Medicine, while also working alongside Peer Support Specialists, Nurse Practitioners, Nurses, Psychologists and Case Managers.

- ***NC Prevention Training and Technical Assistance Center*** - this contract identifies and supports needed for the prevention workforce on an ongoing basis. They conduct a workforce study to identify areas of concern for providers and the state system. The need for increased emphasis on prevention certification and additional support around retaining and recruiting prevention workforce has been an ongoing identified need.

- ***Community Impact NC*** **-** this contract identifies and provides support to alcohol, tobacco and other drug prevention coalitions and connects with the existing training, technical assistance and evaluation contractors to provide support in starting and successfully maintaining coalitions with communities and block grant providers who are a part of substance misuse coalitions.

- ***Wake Forest University*** **-** this contract provides evaluation support to the prevention block grant providers, supports data-driven decision making and information and makes recommendations to the state for continuation/discontinuation of evidence-based prevention programming.

- ***JBS and Associates*** - Nationally recognized experts providing ongoing technical assistance and recommendations regarding Synar survey protocols, best practices, analysis and reporting for Annual Synar survey work submitted to SAMHSA to assist North Carolina prevention state staff in ensuring our retail violation rate remains under the 20% threshold.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several **other data sets** that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[16] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[16] **http://www.healthypeople.gov/2020/default.aspx**

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Footnotes:

Network Adequacy & Accessibility Analysis 2018

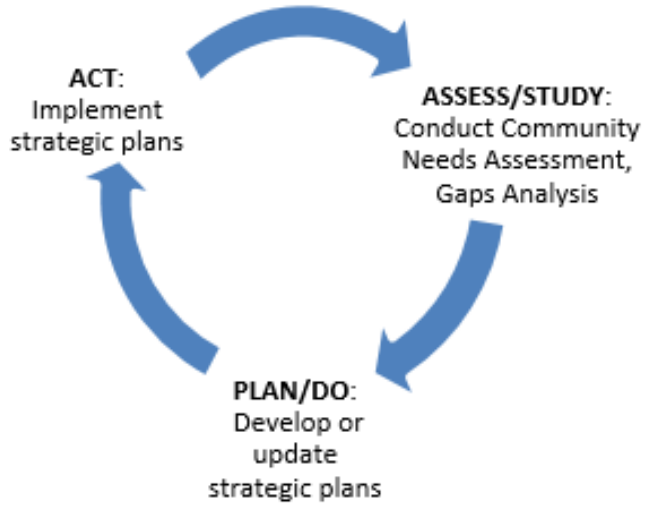
Process for SFY 2018 LME/MCO Network Adequacy & Accessibility Analysis

- Joint annual initiative between Division of Medical Assistance (DMA) and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS)
- DMA requires gaps analyses consistent with Centers for Medicare & Medicaid Services (CMS)
- LME/MCOs gathered input from consumers, family members, providers and stakeholders about community and service needs and priorities

Annual Gaps & Needs Analysis

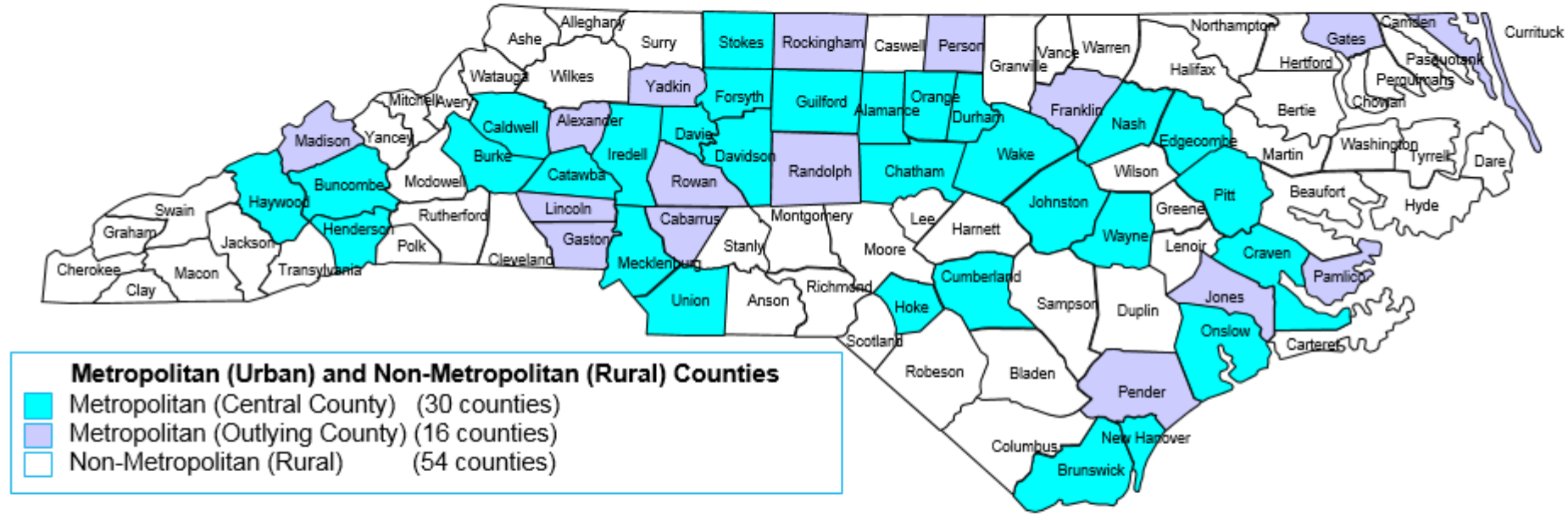
The LME/MCO Community Mental Health, Substance Use and Developmental Disabilities Services Needs and Gaps Analysis is one part of a continuous assessment and action process with each component driving the focus of the next:

- **Assess** and study the LME/MCO's community to determine needs and providers to deliver services;
- Develop or update LME/MCO strategic **plan**s, such as local business plans, network development plans and strategic initiatives, as needed, to incorporate results from the LME/MCO service needs assessment and gaps analysis;
- Implement strategic plans through local initiatives, quality improvement projects and other **act**ions;
- Review and **assess** action steps taken and determine progress and challenges in meeting needs and adjusting resources to respond to gaps in services.



North Carolina

US OMB Metropolitan (Urban) and Non-Metropolitan (Rural) Counties



Metropolitan (Urban) and Non-Metropolitan (Rural) Counties

- Metropolitan (Central County) (30 counties)
- Metropolitan (Outlying County) (16 counties)
- Non-Metropolitan (Rural) (54 counties)

Urban includes Metropolitan counties (46 counties).
Rural is anything other than Metropolitan counties (54 counties).
Central County - at least 50 percent of the population resides within urban areas of 10,000 or more population or contain at least 5,000 people residing within a single urban area of 10,000 or more population.
Outlying County - included in the Metro/Micro Statistical Area if they meet specified requirements of commuting to or from the central counties.
Data Sources: http://www.census.gov/population/metro/data/def.html (July 2015)
http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html (November 2015)

Outpatient Services

Medicaid-funded services standard

100% of eligible individuals must have a choice of two different outpatient services provider agencies within 30 miles or 30 minutes (45 miles or 45 minutes in rural counties) of their residences.

Medicaid-funded services instructions

Calculate the percent of total Medicaid enrollees who had a choice of two providers within 30/45 miles/ minutes of their residences. Consider providers inside or outside the catchment area, but within 30/45 miles/minutes of residents' homes. The denominator is the number of total Medicaid enrollees for the reporting period of 7/1/2016-6/30/2017. The numerator is the number of Medicaid enrollees during the reporting period with a choice of two outpatient services providers within 30/45 miles/ minutes of their residences.

Non-Medicaid-funded services standard

100% of eligible individuals have a choice of two different outpatient services provider agencies within 30 miles or 30 minutes (45 miles or 45 minutes in rural counties) of their residences.

Non-Medicaid-funded services instructions

Calculate the percent of consumers of non-Medicaid-funded services who had a choice of two providers within 30/45 miles/ minutes of their residences. Consider providers inside or outside the catchment area, but within 30/45 miles/minutes of residents' homes. The denominator is the total number of people who received at least one non-Medicaid-funded service (consumers) during the reporting period of 7/1/2016-6/30/2017. The numerator is the number of consumers during the reporting period with a choice of two outpatient services providers within 30/45 miles/ minutes of their residences.

Outpatient Services

Outpatient Services	# of providers accepting new Medicaid consumers	DMA_Choice 30-45	DMA_Percent Standard	# of providers accepting new Non-Medicaid consumers	DMH_One 30-45	DMH_Percent Standard
Alliance						
Outpatient-adults	339	113,380	100	67	15,332	100
Outpatient-children	339	150,360	100	67	1,304	100
Outpatient-reside in rural counties	0	0	100	0	0	100
Outpatient-reside in urban counties	339	263,740	100	67	16,636	100
Cardinal						
Outpatient-adults	1,282	250,552	100	193	23,955	100
Outpatient-children	1,282	277,879	100	193	648	100
Outpatient-reside in rural counties	1,282	58,814	100	193	1,888	100
Outpatient-reside in urban counties	1,282	469,617	100	193	22,715	100
Eastpointe						
Outpatient-adults	761	72,034	100	220	6,631	100
Outpatient-children	761	73,151	100	220	275	100
Outpatient-reside in rural counties	761	109,034	100	220	4,887	100
Outpatient-reside in urban counties	761	36,151	100	220	2,019	100
Partners						
Outpatient-adults	204	86,695	100	18	10,312	100
Outpatient-children	183	85,086	100	12	257	100
Outpatient-reside in rural counties	318	39,449	100	25	2,052	100
Outpatient-reside in urban counties	318	132,332	100	25	8,510	100
Sandhills						
Outpatient-adults	644	16,549	100	102	11,175	100
Outpatient-children	644	12,685	100	102	699	100
Outpatient-reside in rural counties	664	10,576	100	102	3,750	100
Outpatient-reside in urban counties	664	18,658	100	102	8,124	100
Trillium						
Outpatient-adults	769	19,492	100	106	13,048	100
Outpatient-children	769	15,103	100	106	837	100
Outpatient-reside in rural counties	769	9,925	100	106	3,839	100
Outpatient-reside in urban counties	769	24,670	100	106	10,046	100
Vaya						
Outpatient-adults	409	118,819	99.69	42	7,495	96.95
Outpatient-children	409	98,055	99.75	42	191	95.02
Outpatient-reside in rural counties	409	107,697	99.94	42	3,846	94.64
Outpatient-reside in urban counties	409	109,177	99.49	42	3,840	99.28

Location-Based Services

Medicaid-funded services standard

100% of eligible individuals must have a choice of two different provider agencies for each location-based service within 30 miles or 30 minutes (45 miles or 45 minutes in rural counties) of their residences.

Medicaid-funded services instructions

Calculate the percent of adult, child or total enrollees who have a choice of two providers of each Medicaid location-based service within 30/45 miles/ minutes of their residences. Consider providers inside or outside the catchment area, but within 30/45 miles/minutes of residents' homes. The denominator is the number of adult, child or total enrollees for the reporting period (7/1/2016-6/30/2017) who were age-appropriate for each location-based service. The numerator is the number of enrollees from the denominator with choice of two providers of each location-based service within 30/45 miles/ minutes of their residences. See the chart below for age-disability groups for each service.

Non-Medicaid-funded services standard

100% of eligible individuals have access to at least one provider agency for each location-based service within 30 miles or 30 minutes (45 miles or 45 minutes in rural counties) of their residences.

Non-Medicaid-funded services instructions

Calculate the percent of consumers of non-Medicaid-funded services with access to at least one provider of each location-based service within 30/45 miles/ minutes of their residences. Consider providers inside or outside the catchment area, but within 30/45 miles/minutes of residents' homes. The denominator is the total number of people in the same age-disability group(s) who received any non-Medicaid-funded service during the reporting period (7/1/2016-6/30/2017). The numerator is the number of consumers from the denominator with access to at least one provider for each location-based service within 30/45 miles/ minutes of their residences. See the chart below for age-disability groups for each service.

Location-based Services	DMA		DMHDDSAS					
	Adult ≥ 18	Child <18	Adult ≥18 MH	Child <18 MH	Adult ≥18 SUD	Child <18 SUD	Adult ≥18 I/DD	Child <18 I/DD
Psychosocial Rehabilitation	✓		✓					
Child and Adolescent Day Treatment		✓		✓		✓		
SA Comprehensive Outpatient Treatment Program	✓	✓			✓	✓		
SA Intensive Outpatient Program	✓	✓			✓	✓		
Opioid Treatment	✓				✓			
							✓	✓

Location-Based Services

Location Based Services	# of providers accepting new Medicaid consumers	DMA_Choice 30-45	DMA_Percent Standard	# of providers accepting new Non-Medicaid consumers	DMH_One 30-45	DMH_Percent Standard
Alliance						
Child and Adolescent Day Treatment	8	114,605	76.22	1	902	88.52
Day Supports-Location-Based			100.00	1	413	57.76
Opioid Treatment	7	78,446	69.19	6	4,985	100.00
Psychosocial Rehabilitation	24	113,380	100.00	8	11,499	100.00
SA Comprehensive Outpatient Treatment Program	15	263,740	100.00	4	3,660	73.01
SA Intensive Outpatient Program	20	263,740	100.00	12	5,013	100.00
Cardinal						
Child and Adolescent Day Treatment	20	242,906	87.00	4	487	79.00
Day Supports-Location-Based				8	1,075	82.00
Opioid Treatment	14	223,376	89.00	9	9,850	96.00
Psychosocial Rehabilitation	32	250,552	100.00	12	15,630	100.00
SA Comprehensive Outpatient Treatment Program	18	445,088	84.00	7	8,462	82.00
SA Intensive Outpatient Program	47	528,431	100.00	16	10,305	100.00
Eastpointe						
Child and Adolescent Day Treatment	55	73,151	100.00	28	275	100.00
Day Supports-Location-Based				26	7,519	100.00
Opioid Treatment	15	71,582	89.80	9	6,694	100.00
Psychosocial Rehabilitation	67	72,034	100.00	22	6,631	100.00
SA Comprehensive Outpatient Treatment Program	49	79,749	100.00	26	6,694	100.00
SA Intensive Outpatient Program	91	79,749	100.00	44	6,694	100.00
Partners						
Child and Adolescent Day Treatment	29	85,086	100.00	5	193	100.00
Day Supports-Location-Based				13	641	100.00
Opioid Treatment	30	86,695	100.00	6	3,834	100.00
Psychosocial Rehabilitation	25	86,695	100.00	9	6,774	100.00
SA Comprehensive Outpatient Treatment Program	10	132,598	77.00	4	3,410	88.00
SA Intensive Outpatient Program	26	171,781	100.00	8	3,855	100.00
Sandhills						
Child and Adolescent Day Treatment	41	13,662	99.80	11	551	97.87
Day Supports-Location-Based				9	914	97.75
Opioid Treatment	14	14,085	85.11	3	4,970	97.49
Psychosocial Rehabilitation	122	16,549	100.00	14	9,143	100.00
SA Comprehensive Outpatient Treatment Program	50	29,230	99.99	11	5,125	99.24
SA Intensive Outpatient Program	93	29,234	100.00	16	5,164	100.00
Trillium						
Child and Adolescent Day Treatment	62	16,301	94.83	9	754	90.08
Day Supports-Location-Based				21	1,325	98.00
Opioid Treatment	12	5,394	27.67	12	7,075	97.29
Psychosocial Rehabilitation	61	18,533	95.08	10	7,907	77.19
SA Comprehensive Outpatient Treatment Program	21	22,716	65.66	9	6,662	90.94
SA Intensive Outpatient Program	74	34,263	99.04	25	7,305	99.71
Vaya						
Child and Adolescent Day Treatment	25	71,721	71.40	0	0	0.00
Day Supports-Location-Based				0	0	0.00
Opioid Treatment	9	61,329	50.19	7	2,505	79.93
Psychosocial Rehabilitation	23	82,521	67.53	8	3,991	86.99
				4	1,813	57.74
				9	2,984	95.03

Community/Mobile Services

Medicaid-funded standard

100% of eligible individuals must have a choice of two provider agencies within the LME/MCO catchment area for each community/ mobile service.

Medicaid-funded services instructions

For the reporting period (7/1/2016-6/30/2017), the denominator is the number of adult, child or total enrollees who were age-appropriate for each specific service according to the chart below for community/mobile services. The numerator is the number of enrollees from the denominator with choice of two providers within the LME/MCO catchment area for each specific service. See the chart below for age-disability groups for each service.

Non-Medicaid-funded services standard

100% of eligible individuals have access within the LME/MCO catchment area to at least one provider agency for each community/ mobile service.

Non-Medicaid-funded services instructions

The denominator is the total number of people in the same age-disability group(s) who received any non-Medicaid-funded service during the reporting period (7/1/2016-6/30/2017). The numerator is the number of consumers from the denominator with access to at least one provider within the LME/MCO catchment area. See the chart below for age-disability groups for each service.

Community/ Mobile Services

Community /Mobile Services	# of providers accepting new Medicaid consumers	DMA_Choice Catchment	DMA_Percent Standard	# of providers accepting new Non-Medicaid consumers	DMH_OneIn Catchment	DMH_Percent Standard
Alliance						
Intensive In-Home	29	150,360	100			
Long-term Vocational Supports(non-Medicaid-funded)				11	415	100
MH/SA Supported Employment Services (IPSSE) (non-Medicaid-funded)				5	16,484	100
Cardinal						
Assertive Community Treatment Team	27	250,552	100	19		100
Community Support Team	60	250,552	100	27		100
Intensive In-Home	74	277,879	100	37		100
Long-term Vocational Supports(non-Medicaid-funded)				39	1,254	100
MH/SA Supported Employment Services (IPSSE) (non-Medicaid-funded)				11	24,603	100
Mobile Crisis	17	528,431	100	10		100
Multi-systemic Therapy	8	277,879	100	6		100
Eastpointe						
Assertive Community Treatment Team	10	79,749	100	4	6,694	100
Community Support Team	30	72,034	100	12	6,631	100
Intensive In-Home	47	73,151	100	17	275	100
Long-term Vocational Supports(non-Medicaid-funded)				10	6,694	100
MH/SA Supported Employment Services (IPSSE) (non-Medicaid-funded)				7	6,694	100
Mobile Crisis	10	145,185	100	5	6,906	100
Multi-systemic Therapy	6	73,151	100	4	275	100
Partners						
Assertive Community Treatment Team	14	86,695	100	7	6,774	100
Community Support Team	15	86,695	100	4	9,727	100
Intensive In-Home	35	85,086	100	8	193	100
Long-term Vocational Supports(non-Medicaid-funded)				7	577	100
MH/SA Supported Employment Services (IPSSE) (non-Medicaid-funded)				16	9,727	100
Mobile Crisis	12	171,781	100	3	10,569	100
Multi-systemic Therapy	4	85,086	100	2	193	100
Sandhills						
Assertive Community Treatment Team	51	16,549	100	11	9,143	
Community Support Team	94	16,549	100	3	10,805	
Intensive In-Home	131	13,690	100	19	563	
Long-term Vocational Supports(non-Medicaid-funded)				22	730	100
MH/SA Supported Employment Services (IPSSE) (non-Medicaid-funded)				9	10,805	100
Mobile Crisis	49	29,234	100	14	11,874	
Multi-systemic Therapy	11	13,690	100	4	563	
Trillium						
Assertive Community Treatment Team	26	19,492	100	4	10,243	100
Community Support Team	53	19,492	100	5	12,738	100
Intensive In-Home	102	17,189	100	20	837	100
Long-term Vocational Supports(non-Medicaid-funded)				21	937	100
MH/SA Supported Employment Services (IPSSE) (non-Medicaid-funded)				13	1,352	100
Mobile Crisis	223	34,595	100	13	13,885	100
Multi-systemic Therapy	10	17,189	100	6	837	100
Vaya						
Assertive Community Treatment Team	9	122,193	100	8	4,588	100
Community Support Team	10	122,193	100	7	7,722	100
Intensive In-Home	11	100,444	100	0	0	0
Long-term Vocational Supports(non-Medicaid-funded)				28	62	100
MH/SA Supported Employment Services (IPSSE) (non-Medicaid-funded)				3	7,722	100
	35	222,640	100	3	7,999	100
	1	0	0	0	0	0

Crisis Services

Medicaid-funded services standard

100% of eligible individuals must have access within the LME/MCO catchment area to at least one provider agency for each crisis service.

Medicaid-funded services instructions

For the reporting period (7/1/2016-6/30/2017), the denominator is the number of adult, child or total enrollees who were age-appropriate for each specific service according to the chart below for crisis services. The numerator is the number of enrollees from the denominator with access to at least one provider within the LME/MCO catchment area for each specific service. See the chart below for age-disability groups for each service.

Non-Medicaid-funded services standard

100% of eligible individuals must have access within the LME/MCO catchment area to at least one provider agency for each crisis service.

Non-Medicaid-funded services instructions

Calculate the percent of consumers of non-Medicaid-funded services with access within the LME/MCO catchment area to at least one provider of each crisis service. The denominator is the total number of people in the same age-disability group(s) who received any non-Medicaid-funded service during the reporting period (7/1/2016-6/30/2017). The numerator is the number of consumers from the denominator with access within the LME/MCO catchment area to at least one provider for each crisis service. See the chart below for age-disability groups for each service.

Crisis Services	DMA		DMHDDSAS					
	Adult ≥18	Child <18	Adult ≥18 MH	Child <18 MH	Adult ≥18 SUD	Child <18 SUD	Adult ≥18 I/DD	Child <18 I/DD
Facility-Based Crisis - adults	✓		✓		✓		✓	
Facility-Based Respite	✓	✓	✓	✓	✓	✓	✓	✓
Detoxification (non-hospital)	✓	✓			✓	✓		
Facility-Based Crisis - children		✓		✓		✓		✓

Crisis Services

Crisis Services	# of providers accepting new Medicaid consumers	DMA_Choice Catchment	DMA_Percent Standard	# of providers accepting new Non-Medicaid consumers	DMH_OneIn Catchment	DMH_Percent Standard
Alliance						
Detoxification (non-hospital)	2	263,740	100	2	5,013	100
Facility Based Crisis-adults	3	113,380	100	3	16,899	100
Facility-Based Crisis - children	0	0	0	2	18,218	100
Cardinal						
Detoxification (non-hospital)	3	528,431	100	7	10,305	100
Facility Based Crisis-adults	6	250,552	100	5	23,955	100
Facility-Based Crisis - children	12	528,431	100	2	24,603	100
Eastpointe						
Detoxification (non-hospital)	8	79,749	100	3	6,694	100
Facility Based Crisis-adults	6	72,034	100	4	6,631	100
Facility-Based Crisis - children	30	145,185	100	16	6,906	100
Partners						
Detoxification (non-hospital)	3	171,781	100	2	3,855	100
Facility Based Crisis-adults	6	86,695	100	3	10,312	100
Facility-Based Crisis - children	0	0	0	3	10,569	100
Sandhills						
Detoxification (non-hospital)	21	29,234	100	1	5,164	100
Facility Based Crisis-adults	18	16,549	100	3	11,175	100
Facility-Based Crisis - children	0	0	0	0	0	0
Trillium						
Detoxification (non-hospital)	3	34,595	100	1	7,326	100
Facility Based Crisis-adults	99	19,492	100	7	13,048	100
Facility-Based Crisis - children	0	0	0	7	13,885	100
Vaya						
Detoxification (non-hospital)	2	222,640	100	1	3,140	100
Facility Based Crisis-adults	3	122,193	100	3	7,788	100
Facility-Based Crisis - children	0	0	0	0	0	0

Inpatient Services

Medicaid-funded services standard

100% of eligible individuals must have access within the LME/MCO catchment area to at least one provider agency for each inpatient service.

Medicaid-funded services instructions

For the reporting period (7/1/2016-6/30/2017), the denominator is the number of adult, child or total enrollees who were age-appropriate for each specific service for inpatient services. The numerator is the number of enrollees from the denominator with access to at least one provider within the LME/MCO catchment area for each specific service. See the chart below for age-disability groups for each service.

Non-Medicaid-funded services standard

100% of eligible individuals must have access within the LME/MCO catchment area to at least one provider agency for each inpatient service.

Non-Medicaid-funded services instructions

Calculate the percent of consumers of non-Medicaid-funded services with access within the LME/MCO catchment area to at least one provider of each inpatient service. The denominator is the total number of people in the same age-disability group(s) who received any non-Medicaid-funded service during the reporting period (7/1/2016-6/30/2017). The numerator is the number of consumers from the denominator with access within the LME/MCO catchment area to at least one provider for each inpatient service. See the chart below for age-disability groups for each service.

Inpatient Services	DMA		DMHDDSAS					
	Adult ≥18	Child <18	Adult ≥18 MH	Child <18 MH	Adult ≥18 SUD	Child <18 SUD	Adult ≥18 I/DD	Child <18 I/DD
Inpatient Hospital – Adult	✓		✓		✓			
Inpatient Hospital – Adolescent /Child		✓		✓		✓		

Inpatient Services

Inpatient Services	# of providers accepting new Medicaid consumers	DMA_Choice Catchment	DMA_Percent Standard	# of providers accepting new Non-Medicaid consumers	DMH_OneIn Catchment	DMH_Percent Standard
Alliance						
Inpatient Hospital – Adolescent/Child	1	150,360	100	1	1,019	100
Inpatient Hospital – Adult	6	113,380	100	4	16,484	100
Cardinal						
Inpatient Hospital – Adolescent/Child	20	277,879	100	3	648	100
Inpatient Hospital – Adult	19	250,552	100	3	23,955	100
Eastpointe						
Inpatient Hospital – Adolescent/Child	15	73,151	100	1	297	100
Inpatient Hospital – Adult	31	72,034	100	3	6,631	100
Partners						
Inpatient Hospital – Adolescent/Child	9	85,086	100	6	193	100
Inpatient Hospital – Adult	8	86,695	100	3	9,727	100
Sandhills						
Inpatient Hospital – Adolescent/Child	145	13,690	100	8	563	100
Inpatient Hospital – Adult	145	16,549	100	8	10,805	100
Trillium						
Inpatient Hospital – Adolescent/Child	34	17,189	100	8	837	100
Inpatient Hospital – Adult	273	19,492	100	11	12,738	100
Vaya						
Inpatient Hospital – Adolescent/Child	1	100,444	100	0	0	0
Inpatient Hospital – Adult	7	122,193	100	5	7,722	100

Specialized Services

Medicaid-funded services standard

100% of eligible individuals must have access to at least one provider agency for each specialized service.

Medicaid-funded services instructions

Count only parent agencies with current contracts with the LME/MCO as of 1/1/18, to provide the Medicaid-funded services listed below.

Non-Medicaid-funded services standard

100% of eligible individuals must have access to at least one provider agency for each specialized service.

Non-Medicaid-funded services instructions

Count only parent agencies with current contracts with the LME/MCO as of 1/1/18, to provide the non-Medicaid-funded services listed below.

Specialized Services

Specialized Services	DMA_Facilities With Contract	DMH_Facilities With Contract
Alliance		
Child MH Out-of-home respite		3
Partial Hospitalization	1	1
Psychiatric Residential Treatment Facility	11	1
Residential Treatment Level 1	6	
Residential Treatment Level 2: other than Therapeutic Foster Care	21	1
Residential Treatment Level 2: Therapeutic Foster Care	7	0
Residential Treatment Level 3	22	
Residential Treatment Level 4	1	
SA Halfway Houses (non-Medicaid-funded)		2
SA Medically Monitored Community Residential Treatment	1	1
SA Non-Medical Community Residential Treatment	0	0
Cardinal		
Partial Hospitalization	4	1
Psychiatric Residential Treatment Facility	20	2
Residential Treatment Level 1	23	
Residential Treatment Level 2: other than Therapeutic Foster Care	23	0
Residential Treatment Level 2: Therapeutic Foster Care	15	0
Residential Treatment Level 3	44	
Residential Treatment Level 4	0	
SA Halfway Houses (non-Medicaid-funded)		1
SA Medically Monitored Community Residential Treatment	4	4
SA Non-Medical Community Residential Treatment	0	0
Eastpointe		
Partial Hospitalization	8	6
Psychiatric Residential Treatment Facility	12	12
Residential Treatment Level 1	9	4
Residential Treatment Level 2: other than Therapeutic Foster Care	22	22
Residential Treatment Level 2: Therapeutic Foster Care	4	4
Residential Treatment Level 3	11	11
Residential Treatment Level 4	2	1
SA Halfway Houses (non-Medicaid-funded)		2
SA Medically Monitored Community Residential Treatment	4	2
SA Non-Medical Community Residential Treatment	6	3
Partners		
Partial Hospitalization	9	2
Psychiatric Residential Treatment Facility	19	0
Residential Treatment Level 1	8	0
Residential Treatment Level 2: other than Therapeutic Foster Care	30	4
Residential Treatment Level 2: Therapeutic Foster Care	7	1
Residential Treatment Level 3	22	0
Residential Treatment Level 4	0	0
SA Halfway Houses (non-Medicaid-funded)		0
SA Medically Monitored Community Residential Treatment	1	1
SA Non-Medical Community Residential Treatment	0	1

Specialized Services	DMA_Facilities With Contract	DMH_Facilities With Contract
Sandhills		
Partial Hospitalization	7	
Psychiatric Residential Treatment Facility	22	
Residential Treatment Level 1	3	
Residential Treatment Level 2: other than Therapeutic Foster Care	37	
Residential Treatment Level 2: Therapeutic Foster Care	12	
Residential Treatment Level 3	43	0
Residential Treatment Level 4	1	0
SA Halfway Houses (non-Medicaid-funded)		0
SA Medically Monitored Community Residential Treatment	0	0
SA Non-Medical Community Residential Treatment	4	0
Trillium		
Partial Hospitalization	9	0
Psychiatric Residential Treatment Facility	21	0
Residential Treatment Level 1	6	0
Residential Treatment Level 2: other than Therapeutic Foster Care	36	1
Residential Treatment Level 2: Therapeutic Foster Care	4	0
Residential Treatment Level 3	22	0
Residential Treatment Level 4	1	0
SA Halfway Houses (non-Medicaid-funded)		1
SA Medically Monitored Community Residential Treatment	0	0
SA Non-Medical Community Residential Treatment	0	0
Vaya		
Partial Hospitalization	9	0
Psychiatric Residential Treatment Facility	24	0
Residential Treatment Level 1	16	0
Residential Treatment Level 2: other than Therapeutic Foster Care	35	3
Residential Treatment Level 2: Therapeutic Foster Care	12	1
Residential Treatment Level 3	30	
Residential Treatment Level 4	0	
SA Halfway Houses (non-Medicaid-funded)		0
SA Medically Monitored Community Residential Treatment	1	0
SA Non-Medical Community Residential Treatment	0	0

Exception Requests

- Any time you have less than 100% Access and Choice an exception request should be completed.
- An exception request can be completed at any point during the year.
- Exception requests should be submitted by email to the LME/MCO's DMA Contract Manager and DMH/DD/SAS LME/MCO Liaison.
- Exception requests that are approved are good for one year, unless otherwise indicated.

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Exception Requests: Required Information

- Number of providers of the service under contract
- Number of individuals receiving the service
- Number of individuals in need of the service
- Reasons why the access and choice standard can not be met
- New request or have you previously requested exception
- Plan for how the LME/MCO will meet an individual's need for access or choice to the service
- Expected ending date of this exception

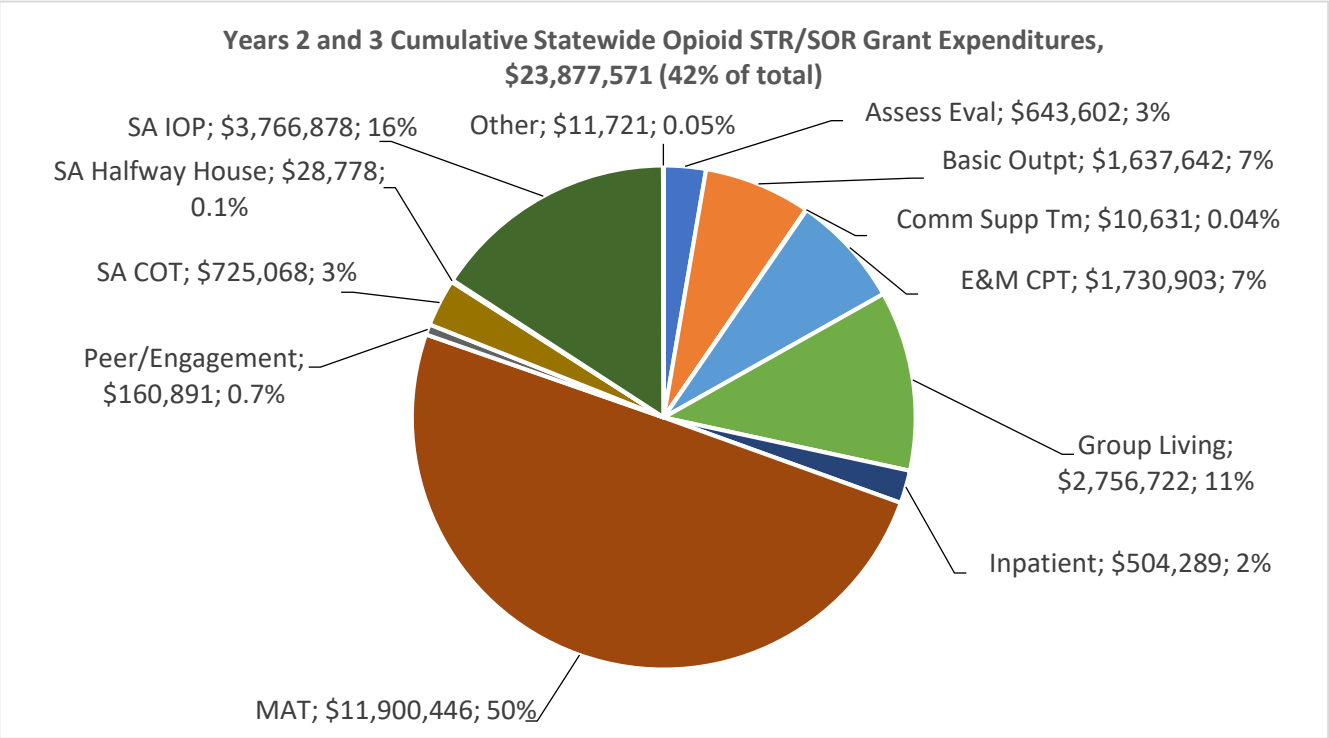
Follow-up is done on a quarterly basis through the Interdepartmental Monitoring Team.

DMH/DD/SAS Opioid and STR/SOR Grant Service Level Report

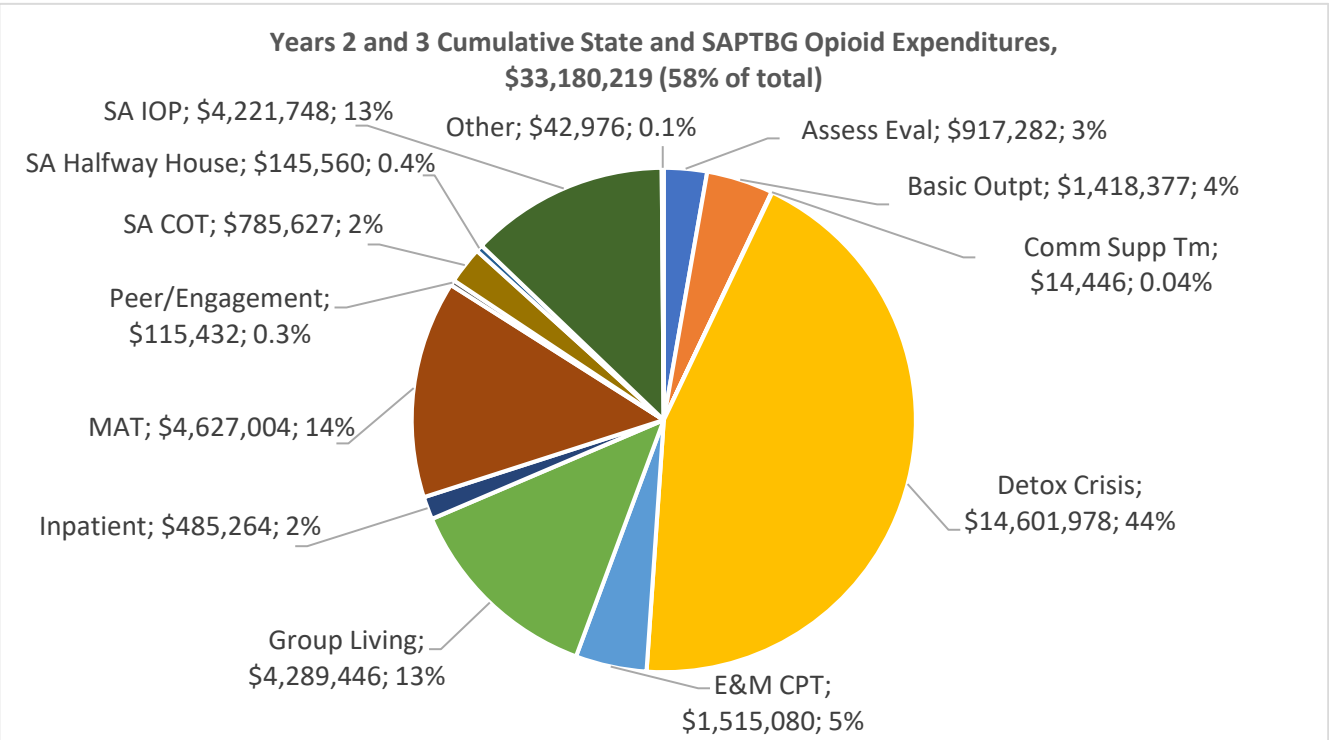
Period Ending July 31, 2019 *(Dates of service paid through September 10, 2019 checkwrite)*

Prepared by NC DHHS DMH/DD/SAS Quality Management

9/23/2019

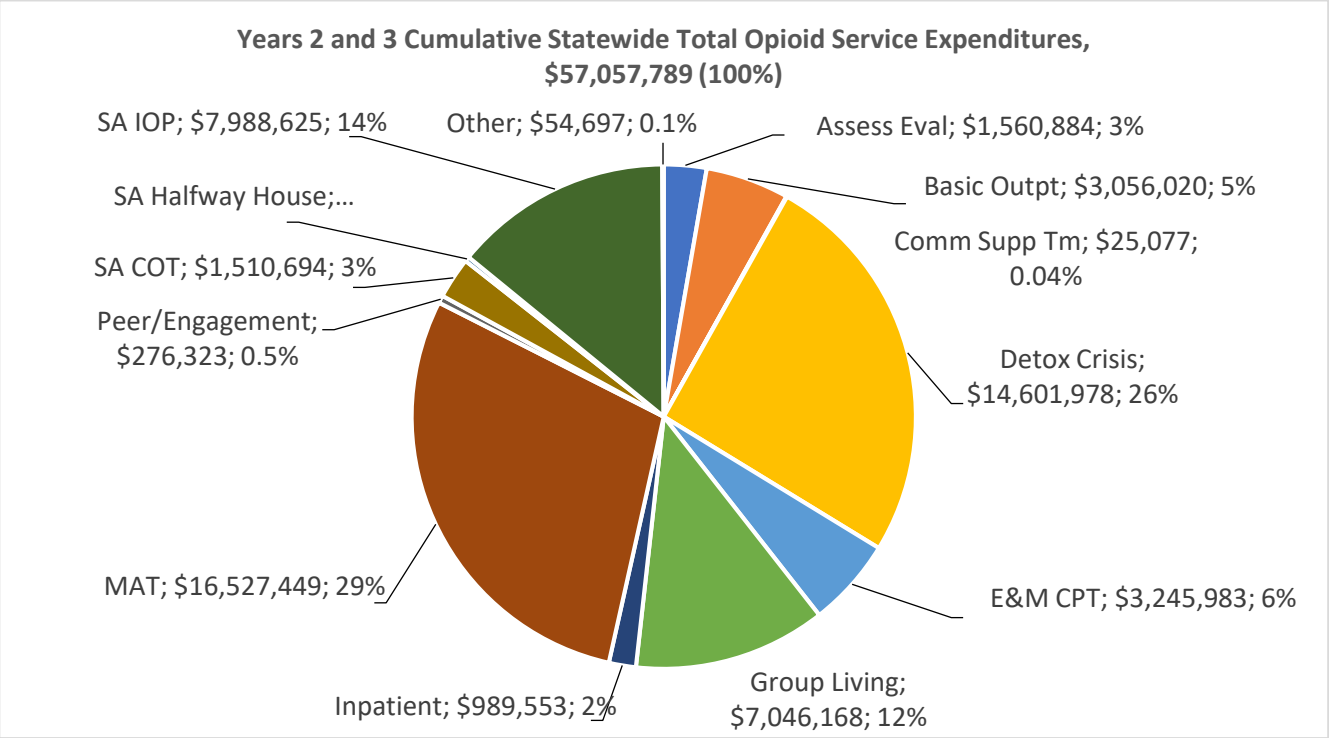


Note: Chart percentages are computed from total Opioid STR/SOR Grant expenditures.



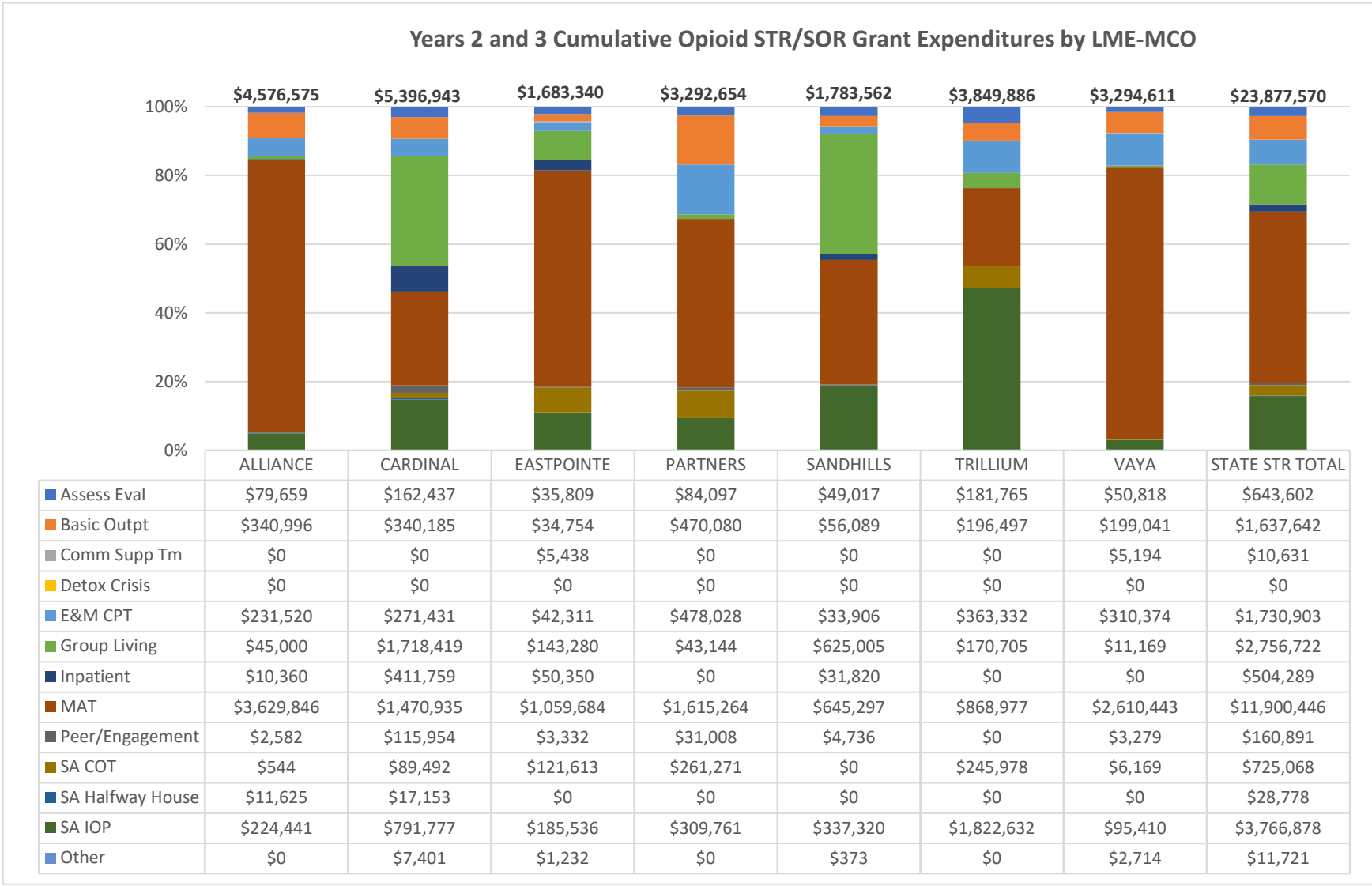
Note: Chart percentages are computed from total of State-funded and SAPTBG expenditures.

Source: DMHDDSAS Paid Claims in NCTracks



Note: Chart percentages are computed from total Opioid STR/SOR Grant, State-funded and SAPTBG expenditures.

Source: DMHDDSAS Paid Claims in NCTracks

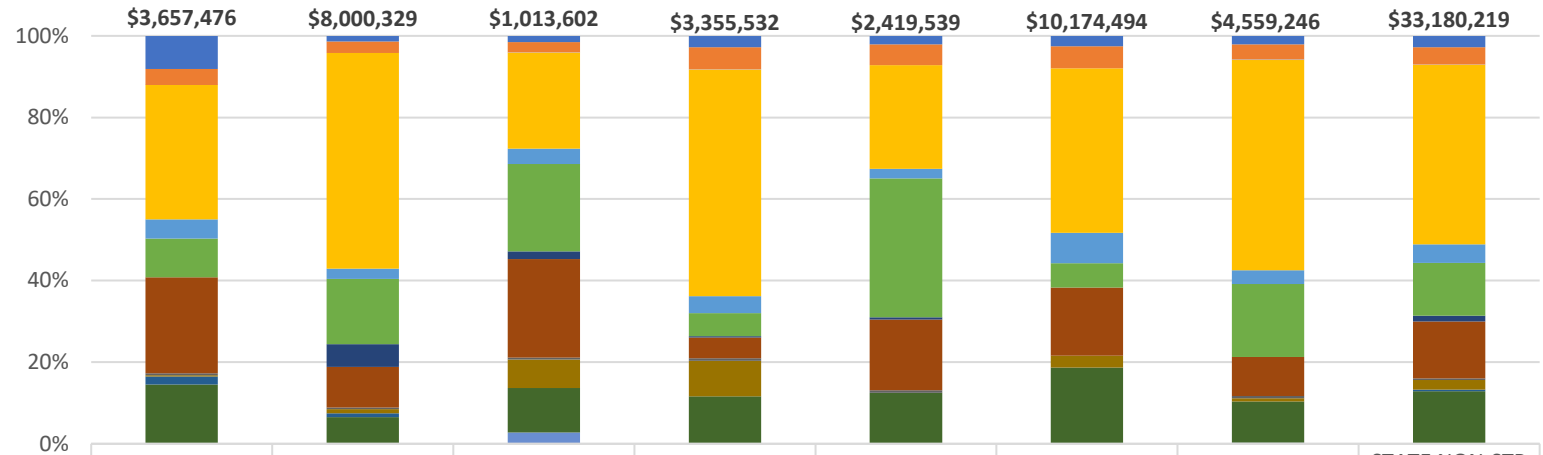


	ALLIANCE	CARDINAL	EASTPOINTE	PARTNERS	SANDHILLS	TRILLIUM	VAYA	STATE STR TOTAL
Assess Eval	$79,659	$162,437	$35,809	$84,097	$49,017	$181,765	$50,818	$643,602
Basic Outpt	$340,996	$340,185	$34,754	$470,080	$56,089	$196,497	$199,041	$1,637,642
Comm Supp Tm	$0	$0	$5,438	$0	$0	$0	$5,194	$10,631
Detox Crisis	$0	$0	$0	$0	$0	$0	$0	$0
E&M CPT	$231,520	$271,431	$42,311	$478,028	$33,906	$363,332	$310,374	$1,730,903
Group Living	$45,000	$1,718,419	$143,280	$43,144	$625,005	$170,705	$11,169	$2,756,722
Inpatient	$10,360	$411,759	$50,350	$0	$31,820	$0	$0	$504,289
MAT	$3,629,846	$1,470,935	$1,059,684	$1,615,264	$645,297	$868,977	$2,610,443	$11,900,446
Peer/Engagement	$2,582	$115,954	$3,332	$31,008	$4,736	$0	$3,279	$160,891
SA COT	$544	$89,492	$121,613	$261,271	$0	$245,978	$6,169	$725,068
SA Halfway House	$11,625	$17,153	$0	$0	$0	$0	$0	$28,778
SA IOP	$224,441	$791,777	$185,536	$309,761	$337,320	$1,822,632	$95,410	$3,766,878
Other	$0	$7,401	$1,232	$0	$373	$0	$2,714	$11,721

Note: Dollar values above each bar are column totals.

Source: DMHDDSAS Paid Claims in NCTracks

Years 2 and 3 Cumulative State-Funded and SAPTBG Opioid Service Expenditures by LME-MCO

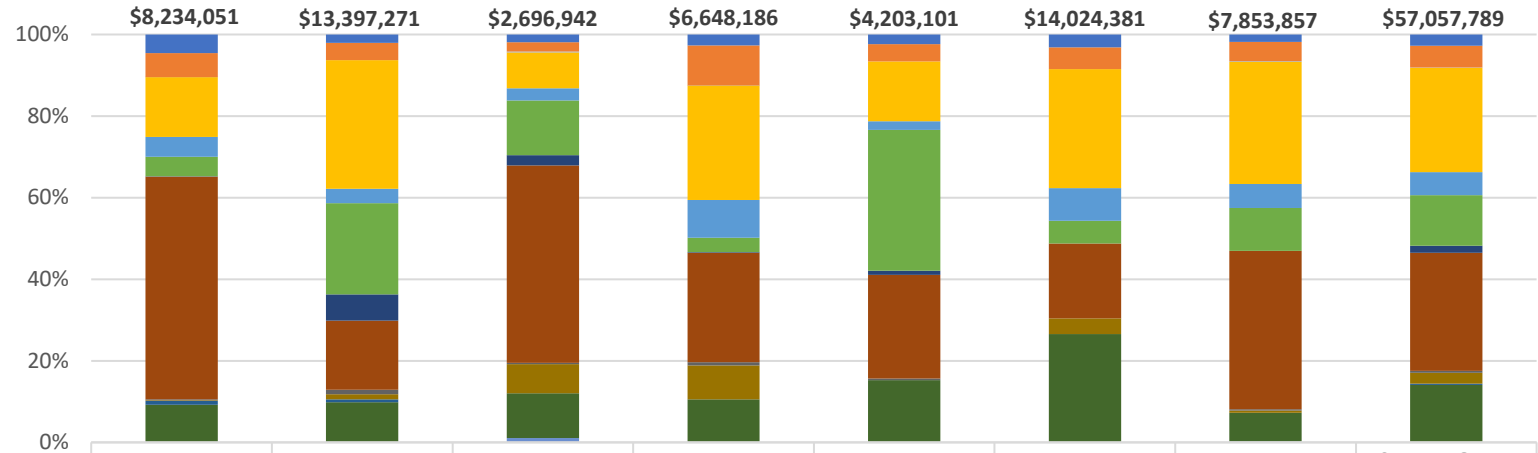


	ALLIANCE	CARDINAL	EASTPOINTE	PARTNERS	SANDHILLS	TRILLIUM	VAYA	STATE NON-STR TOTAL
Assess Eval	$295,795	$108,115	$15,188	$94,060	$49,171	$260,831	$94,123	$917,282
Basic Outpt	$144,122	$230,009	$25,907	$180,372	$124,158	$546,846	$166,966	$1,418,377
Comm Supp Tm	$1,160	$0	$870	$3,486	$0	$0	$8,930	$14,446
Detox Crisis	$1,204,075	$4,226,491	$238,618	$1,863,601	$615,900	$4,102,116	$2,351,176	$14,601,978
E&M CPT	$172,130	$199,652	$38,085	$140,259	$55,667	$757,894	$151,393	$1,515,080
Group Living	$346,978	$1,283,660	$216,919	$189,496	$824,291	$610,510	$817,593	$4,289,446
Inpatient	$0	$443,324	$19,000	$9,620	$13,320	$0	$0	$485,264
MAT	$861,622	$797,442	$245,282	$170,173	$420,202	$1,695,887	$436,395	$4,627,004
Peer/Engagement	$17,684	$33,785	$4,284	$21,771	$13,559	$0	$24,350	$115,432
SA COT	$11,610	$78,935	$71,016	$293,011	$0	$297,133	$33,922	$785,627
SA Halfway House	$69,613	$75,947	$0	$0	$0	$0	$0	$145,560
SA IOP	$532,686	$519,678	$110,387	$389,151	$302,851	$1,903,279	$463,716	$4,221,748
Other	$0	$3,292	$28,047	$533	$420	$0	$10,683	$42,976

Note: Dollar values above each bar are column totals.

Source: DMHDDSAS Paid Claims in NCTracks

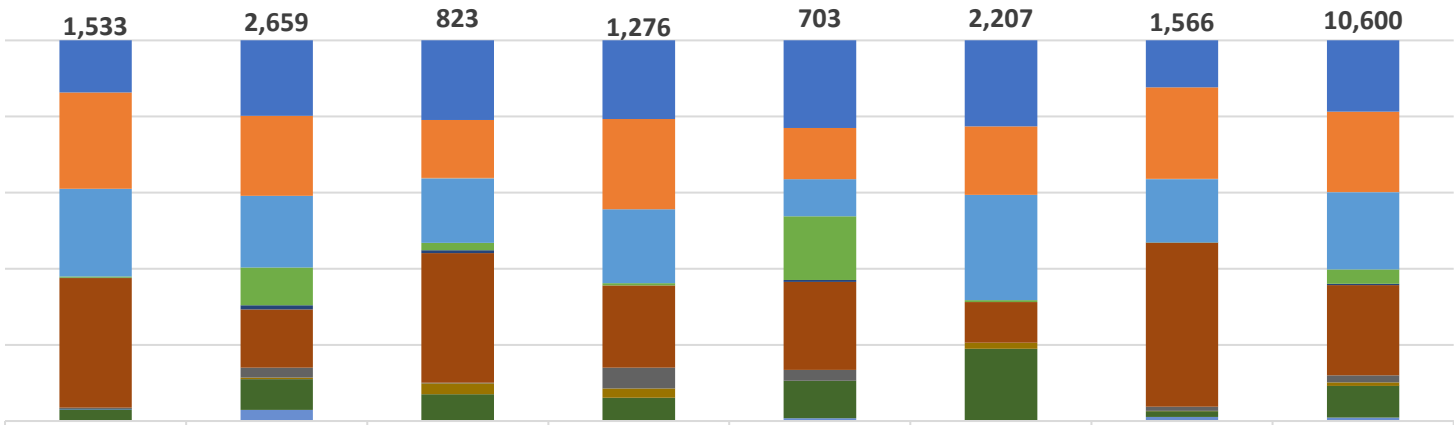
Years 2 and 3 Cumulative Opioid Service Expenditures by LME-MCO, All Funding Sources



	ALLIANCE	CARDINAL	EASTPOINTE	PARTNERS	SANDHILLS	TRILLIUM	VAYA	STATE TOTAL, ALL OPIOID
Assess Eval	$375,455	$270,551	$50,997	$178,157	$98,188	$442,596	$144,941	$1,560,884
Basic Outpt	$485,118	$570,193	$60,661	$650,452	$180,246	$743,342	$366,007	$3,056,020
Comm Supp Tm	$1,160	$0	$6,308	$3,486	$0	$0	$14,124	$25,077
Detox Crisis	$1,204,075	$4,226,491	$238,618	$1,863,601	$615,900	$4,102,116	$2,351,176	$14,601,978
E&M CPT	$403,650	$471,083	$80,396	$618,287	$89,573	$1,121,226	$461,768	$3,245,983
Group Living	$391,978	$3,002,079	$360,199	$232,640	$1,449,295	$781,215	$828,762	$7,046,168
Inpatient	$10,360	$855,083	$69,350	$9,620	$45,140	$0	$0	$989,553
MAT	$4,491,468	$2,268,378	$1,304,966	$1,785,437	$1,065,499	$2,564,864	$3,046,838	$16,527,449
Peer/Engagement	$20,266	$149,738	$7,616	$52,779	$18,295	$0	$27,629	$276,323
SA COT	$12,154	$168,426	$192,630	$554,282	$0	$543,112	$40,091	$1,510,694
SA Halfway House	$81,239	$93,099	$0	$0	$0	$0	$0	$174,338
SA IOP	$757,128	$1,311,455	$295,922	$698,912	$640,171	$3,725,911	$559,127	$7,988,625
Other	$0	$10,693	$29,280	$533	$794	$0	$13,397	$54,697

Note: Dollar values above each bar are column totals. Totals include Opioid STR Grant, State-funded, and SAPTBG expenditures.

Source: DMHDDSAS Paid Claims in NCTracks

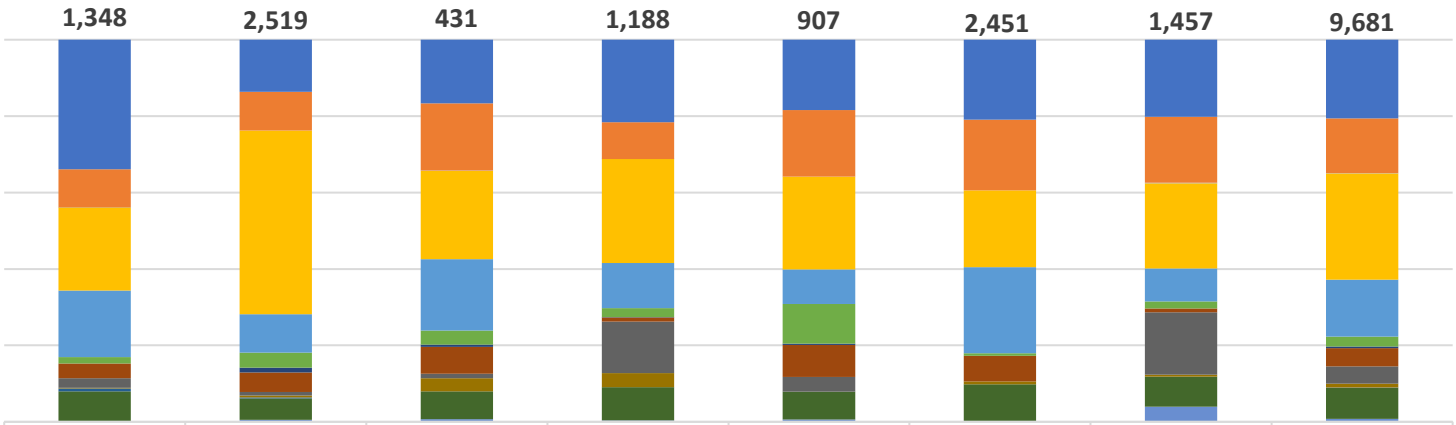


	ALLIANCE	CARDINAL	EASTPOINTE	PARTNERS	SANDHILLS	TRILLIUM	VAYA	STATEWIDE CLIENT COUNT (UNDUP)
Assess Eval	517	1123	311	698	327	1050	390	4385
Basic Outpt	954	1192	227	802	191	834	764	4941
Comm Supp Tm	0	0	4	0	0	0	3	7
Detox Crisis	0	0	0	0	0	0	0	0
E&M CPT	868	1063	250	656	139	1287	526	4752
Group Living	14	563	29	19	238	23	1	877
Inpatient	2	62	11	0	7	0	0	82
MAT	1285	866	507	730	329	495	1368	5543
Peer/Engagement	13	148	3	185	41	0	35	425
SA COT	1	23	42	81	0	74	2	220
SA Halfway House	7	4	0	0	0	0	0	11
SA IOP	112	456	103	208	139	882	47	1940
Other	0	165	2	0	11	0	35	213

Note: Client counts above each bar and statewide counts are unduplicated; other table values include duplication across services and LMEs-MCOs.

Source: DMHDDSAS Paid Claims in NCTracks

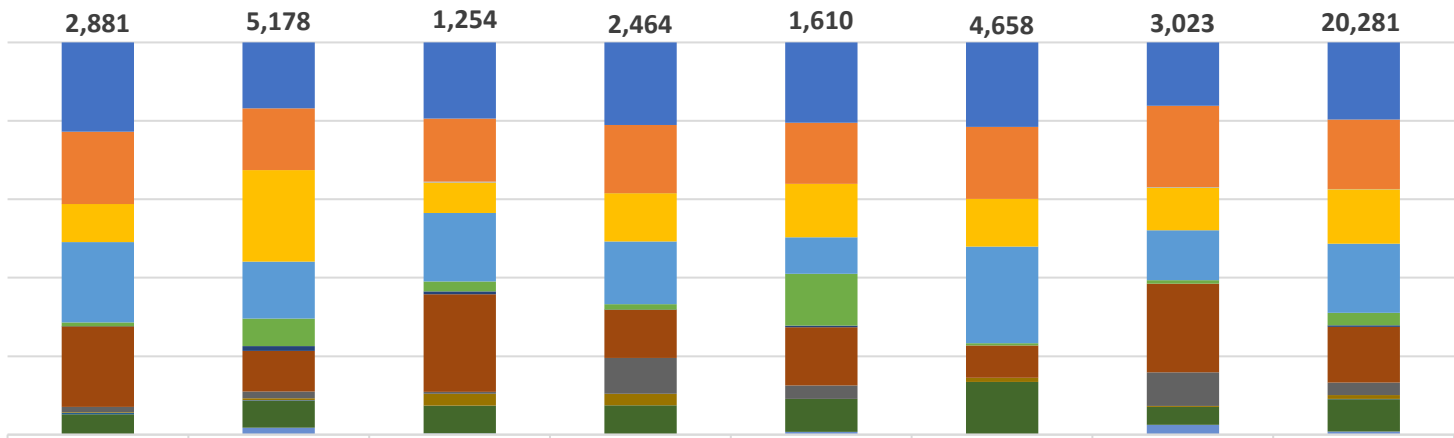
Years 2 and 3 Cumulative Non-STR/SOR (Only) Opioid Service Unduplicated Client Counts



	ALLIANCE	CARDINAL	EASTPOINTE	PARTNERS	SANDHILLS	TRILLIUM	VAYA	STATEWIDE CLIENT COUNT (UNDUP)
Assess Eval	1035	725	127	607	330	1499	610	4826
Basic Outpt	303	541	134	271	311	1329	522	3356
Comm Supp Tm	1	0	1	1	0	0	5	7
Detox Crisis	664	2563	176	765	436	1440	675	6521
E&M CPT	530	533	143	333	161	1621	261	3489
Group Living	52	209	28	66	187	45	54	622
Inpatient	0	69	4	3	5	0	0	81
MAT	118	272	54	30	150	479	32	1118
Peer/Engagement	76	47	9	380	69	0	494	1066
SA COT	6	27	26	103	0	58	13	231
SA Halfway House	23	13	0	0	0	0	0	36
SA IOP	243	301	56	245	131	703	239	1902
Other	0	27	5	10	11	0	120	173

Note: Client counts above each bar and statewide counts are unduplicated; other table values include duplication across services and LMEs-MCOs.

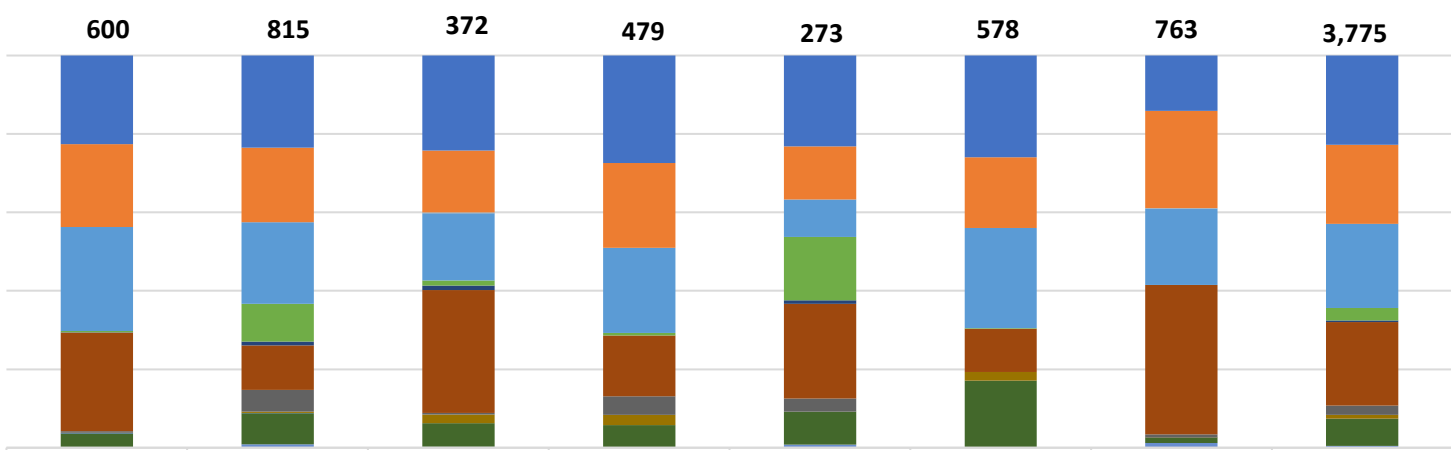
Source: DMHDDSAS Paid Claims in NCTracks



	ALLIANCE	CARDINAL	EASTPOINTE	PARTNERS	SANDHILLS	TRILLIUM	VAYA	STATEWIDE CLIENT COUNT (UNDUP)
Assess Eval	1552	1848	438	1305	657	2549	1000	9211
Basic Outpt	1257	1733	361	1073	502	2163	1286	8297
Comm Supp Tm	1	0	5	1	0	0	8	14
Detox Crisis	664	2563	176	765	436	1440	675	6521
E&M CPT	1398	1596	393	989	300	2908	787	8241
Group Living	66	772	57	85	425	68	55	1499
Inpatient	2	131	15	3	12	0	0	163
MAT	1403	1138	561	760	479	974	1400	6661
Peer/Engagement	89	195	12	565	110	0	529	1491
SA COT	7	50	68	184	0	132	15	451
SA Halfway House	30	17	0	0	0	0	0	47
SA IOP	355	757	159	453	270	1585	286	3842
Other	0	192	7	10	22	0	155	386

Note: Client counts above each bar and statewide counts are unduplicated; other table values include duplication across services and LMEs-MCOs.

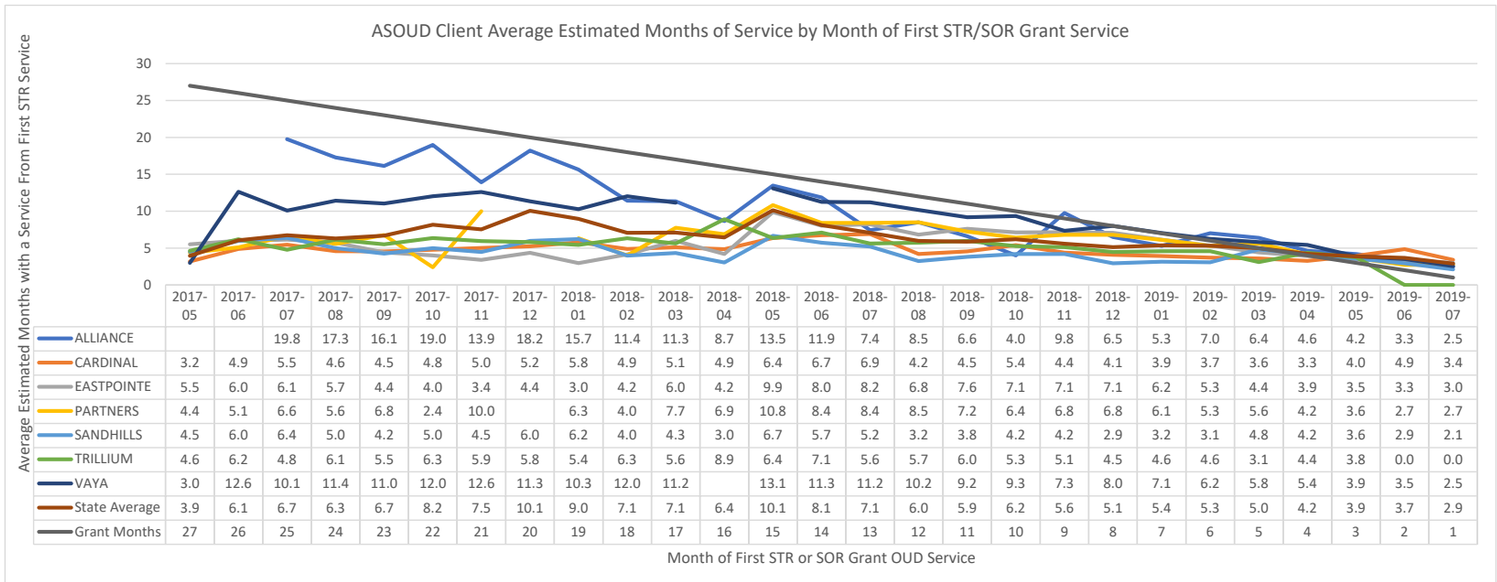
Source: DMHDDSAS Paid Claims in NCTracks



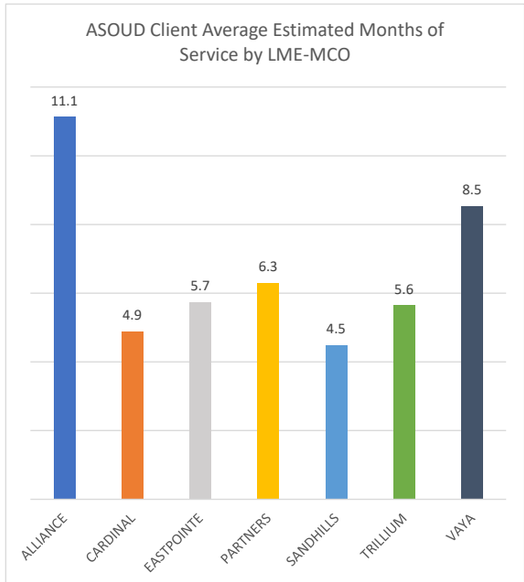
	ALLIANCE	CARDINAL	EASTPOINTE	PARTNERS	SANDHILLS	TRILLIUM	VAYA	STATEWIDE CLIENT COUNT (UNDUP)
Assess Eval	426	490	189	448	139	378	247	2297
Basic Outpt	398	396	123	353	81	262	434	2027
Comm Supp Tm	0	0	2	0	0	0	1	3
Detox Crisis	0	0	0	0	0	0	0	0
E&M CPT	500	433	134	355	57	371	342	2165
Group Living	6	201	10	11	97	3	0	321
Inpatient	2	21	9	0	5	0	0	37
MAT	473	236	245	253	145	160	667	2147
Peer/Engagement	8	115	3	78	20	0	13	237
SA COT	1	7	17	43	0	32	1	101
SA Halfway House	3	2	0	0	0	0	0	5
SA IOP	68	164	47	94	50	249	24	693
Other	0	19	2	0	5	0	21	47

Note: Client counts above each bar and statewide counts are unduplicated; other table values include duplication across services and LMEs-MCOs.

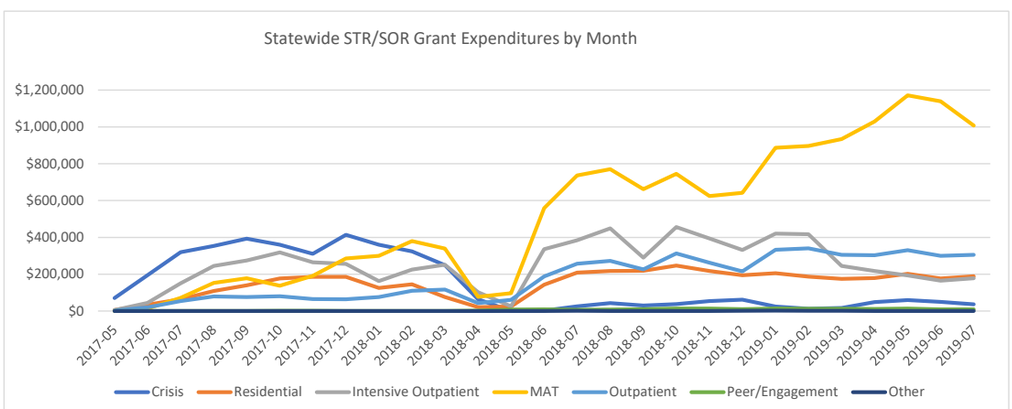
Source: DMHDDSAS Paid Claims in NCTracks

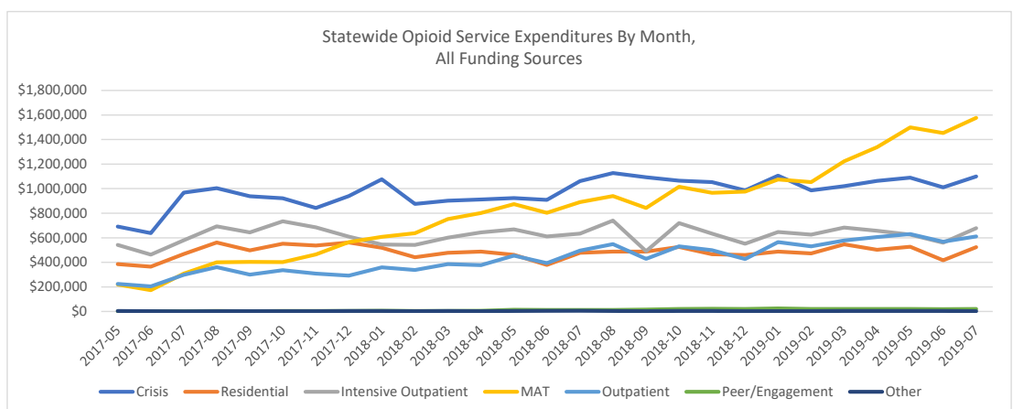


	2017-05	2017-06	2017-07	2017-08	2017-09	2017-10	2017-11	2017-12	2018-01	2018-02	2018-03	2018-04	2018-05	2018-06	2018-07	2018-08	2018-09	2018-10	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07
ALLIANCE			19.8	17.3	16.1	19.0	13.9	18.2	15.7	11.4	11.3	8.7	13.5	11.9	7.4	8.5	6.6	4.0	9.8	6.5	5.3	7.0	6.4	4.6	4.2	3.3	2.5
CARDINAL	3.2	4.9	5.5	4.6	4.5	4.8	5.0	5.2	5.8	4.9	5.1	4.9	6.4	6.7	6.9	4.2	4.5	5.4	4.4	4.1	3.9	3.7	3.6	3.3	4.0	4.9	3.4
EASTPOINTE	5.5	6.0	6.1	5.7	4.4	4.0	3.4	4.4	3.0	4.2	6.0	4.2	9.9	8.0	8.2	6.8	7.6	7.1	7.1	7.1	6.2	5.3	4.4	3.9	3.5	3.3	3.0
PARTNERS	4.4	5.1	6.6	5.6	6.8	2.4	10.0		6.3	4.0	7.7	6.9	10.8	8.4	8.4	8.5	7.2	6.4	6.8	6.8	6.1	5.3	5.6	4.2	3.6	2.7	2.7
SANDHILLS	4.5	6.0	6.4	5.0	4.2	5.0	4.5	6.0	6.2	4.0	4.3	3.0	6.7	5.7	5.2	3.2	3.8	4.2	4.2	2.9	3.2	3.1	4.8	4.2	3.6	2.9	2.1
TRILLIUM	4.6	6.2	4.8	6.1	5.5	6.3	5.9	5.8	5.4	6.3	5.6	8.9	6.4	7.1	5.6	5.7	6.0	5.3	5.1	4.5	4.6	4.6	3.1	4.4	3.8	0.0	0.0
VAYA	3.0	12.6	10.1	11.4	11.0	12.0	12.6	11.3	10.3	12.0	11.2		13.1	11.3	11.2	10.2	9.2	9.3	7.3	8.0	7.1	6.2	5.8	5.4	3.9	3.5	2.5
State Average	3.9	6.1	6.7	6.3	6.7	8.2	7.5	10.1	9.0	7.1	7.1	6.4	10.1	8.1	7.1	6.0	5.9	6.2	5.6	5.1	5.4	5.3	5.0	4.2	3.9	3.7	2.9
Grant Months	27	26	25	24	23	22	21	20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1



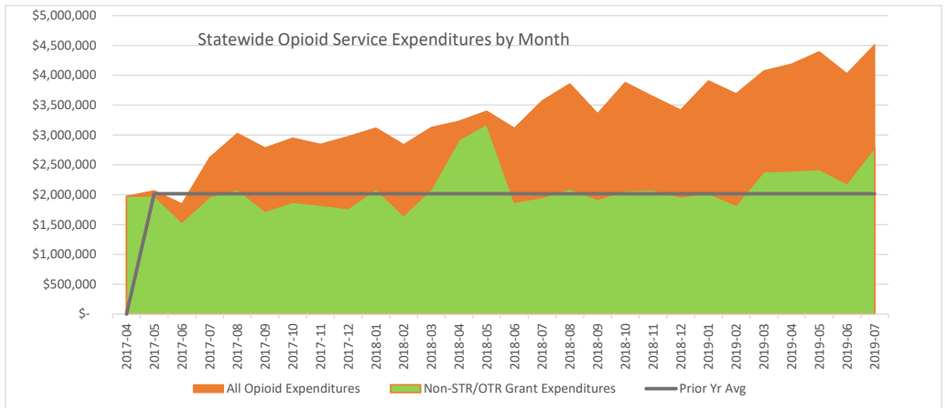
Client months of service is estimated as the number of months from and including an initial grant-funded service through and including the most recent month with an OUD service paid by any funding source.
Grant Months is the number of months from the May 2017 STR Grant implementation date through the current report month.
The calculated months of service estimate is based on month of current report final checkwrite date and therefore may be greater than Grant Months.

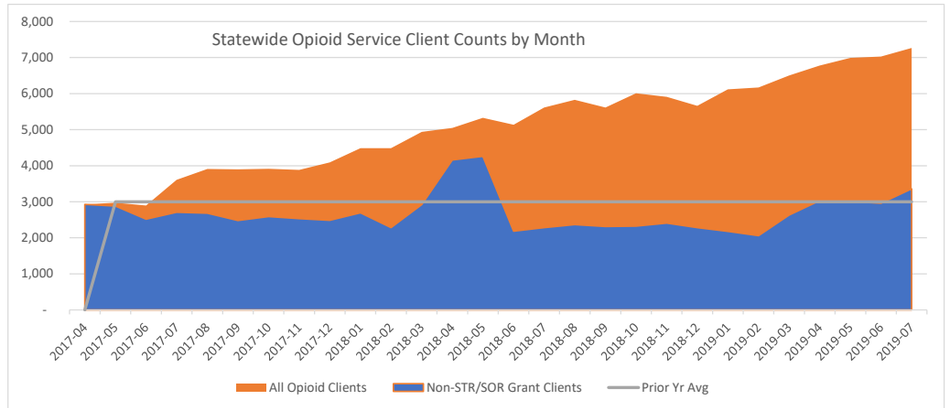




Crisis = Detox Crisis, Inpatient; Residential = SA Halfway House, Group Living; Intensive Outpatient = CST, SA COT, SA IOP; Outpatient = Assess/Eval, Basic Outpaient, E&M CPT
Source: DMHDDSAS Paid Claims in NCTracks
Note: Claims lag and denials impact recent months and vary by LME/MCO. Report expenditure amounts are based on Dates of Service; expenditures based on Dates of Payment will differ.

DMH/DD/SAS Opioid and STR/SOR Grant Service Level Report **Period Ending July 31, 2019** **Statewide Total** **9/23/2019**



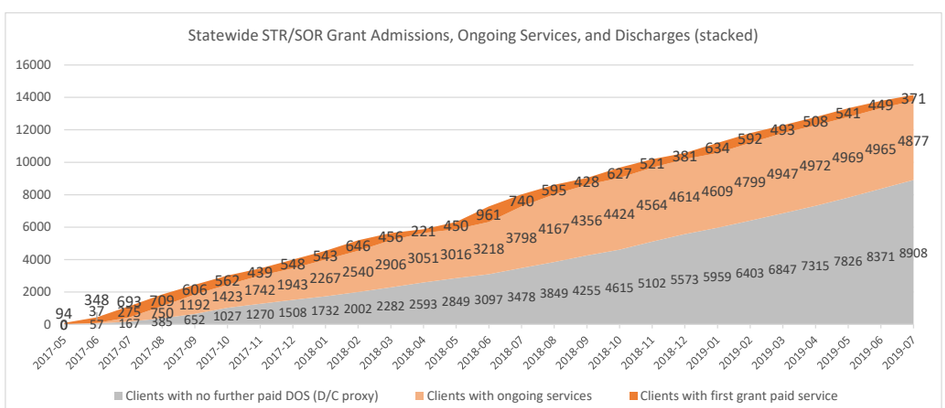


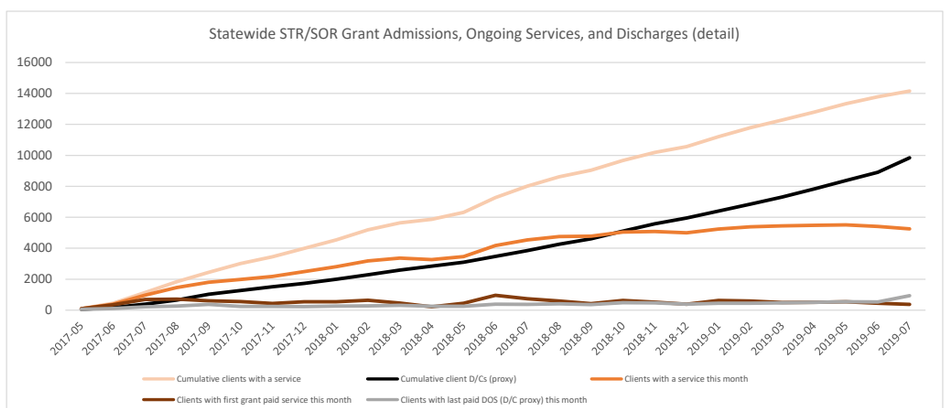
STR/SOR Grant/ASOUD Benefit Plan member expenditures and client counts are shown in orange in graphs above. Individuals must be new to or not currently in treatment for OUD to be enrolled in ASOUD.

Unduplicated OUD Clients, All Funding Sources May 2016- April 2017 11,519 May 2017-April 2018 14,653 May 2018-April 2019 17,273

OUD Service Expenditures and Client Counts

	DOS YYYYMM																	
Values	**2018-02**	**2018-03**	**2018-04**	**2018-05**	**2018-06**	**2018-07**	**2018-08**	**2018-09**	**2018-10**	**2018-11**	**2018-12**	**2019-01**	**2019-02**	**2019-03**	**2019-04**	**2019-05**	**2019-06**	**2019-07**
Value	$2,838,442	$3,128,528	$3,230,136	$3,400,280	$3,113,938	$3,574,685	$3,858,432	$3,359,247	$3,879,578	$3,646,633	$3,420,787	$3,908,351	$3,691,667	$4,076,668	$4,188,459	$4,396,659	$4,029,913	$4,512,493
Client Count	4487	4941	5049	5330	5134	5613	5829	5613	6010	5911	5663	6118	6171	6504	6780	6990	7030	7266
Avg Per Client	$633	$633	$640	$638	$607	$637	$662	$598	$646	$617	$604	$639	$598	$627	$618	$629	$573	$621

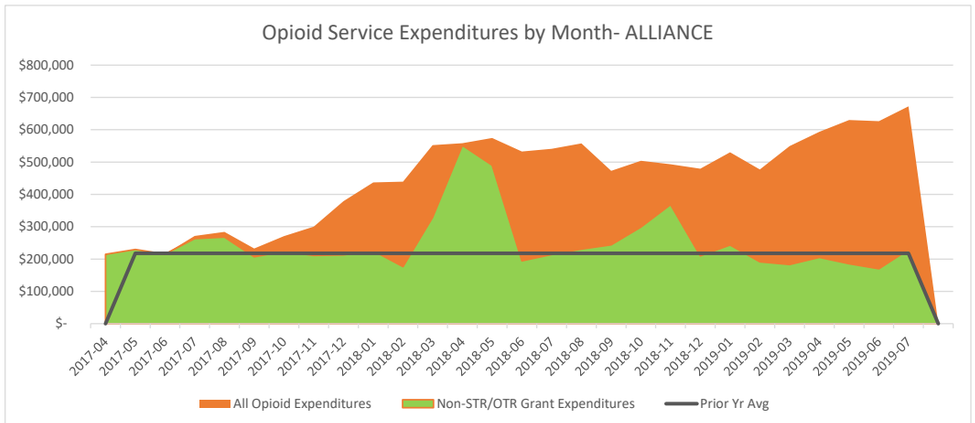


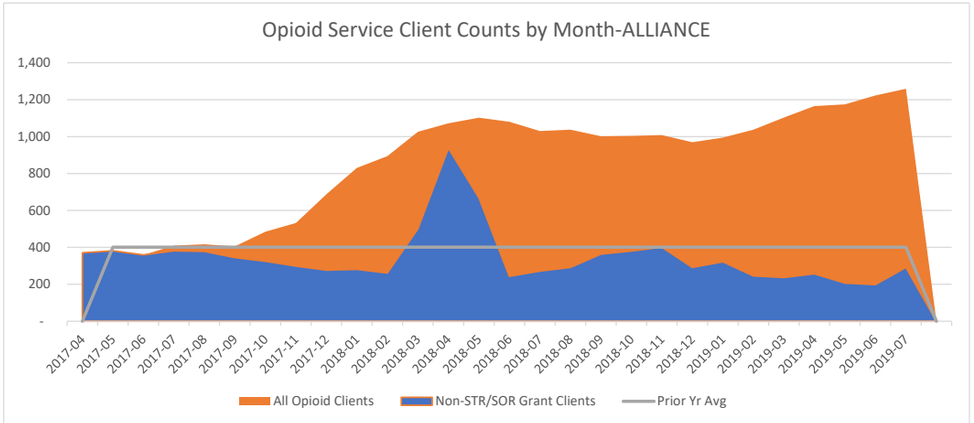


Ongoing services include all funding sources, provided client previously received a grant-funded service; discharge is inferred (D/C proxy) if most recent service occurred in a previous month.

Source: DMHDDSAS Paid Claims in NCTracks

Note: Claims lag and denials impact recent months and vary by LME/MCO. Report expenditure amounts are based on Dates of Service; expenditures based on Dates of Payment will differ.



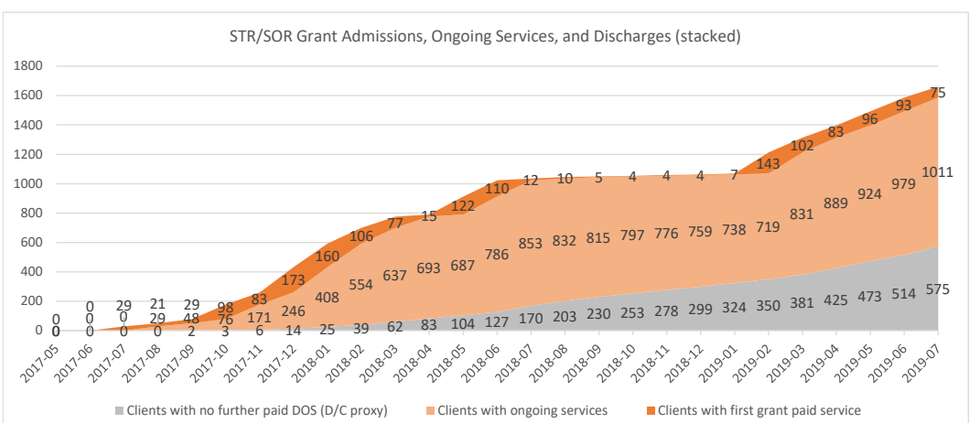


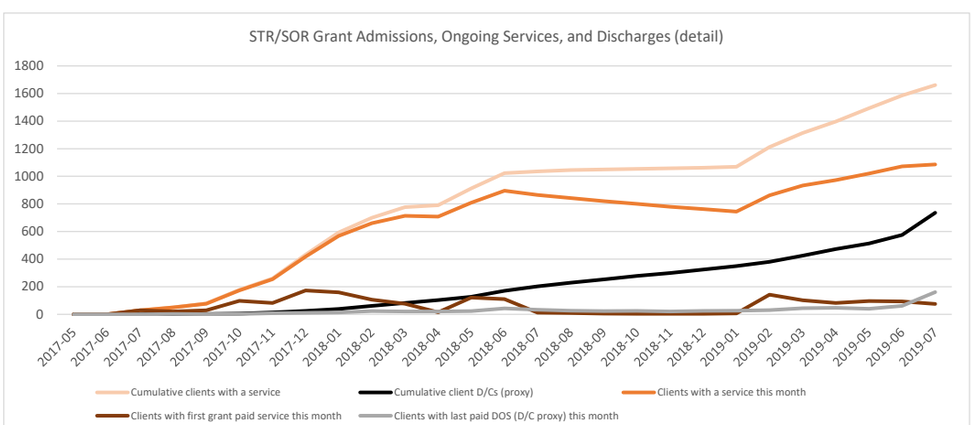
STR/SOR Grant/ASOUD Benefit Plan member expenditures and client counts are shown in orange in graphs above. Individuals must be new to or not currently in treatment for OUD to be enrolled in ASOUD.

Unduplicated OUD Clients, All Funding Sources May 2016- April 2017 1,467 May 2017-April 2018 2,182 May 2018-April 2019 2,502

OUD Service Expenditures and Client Counts

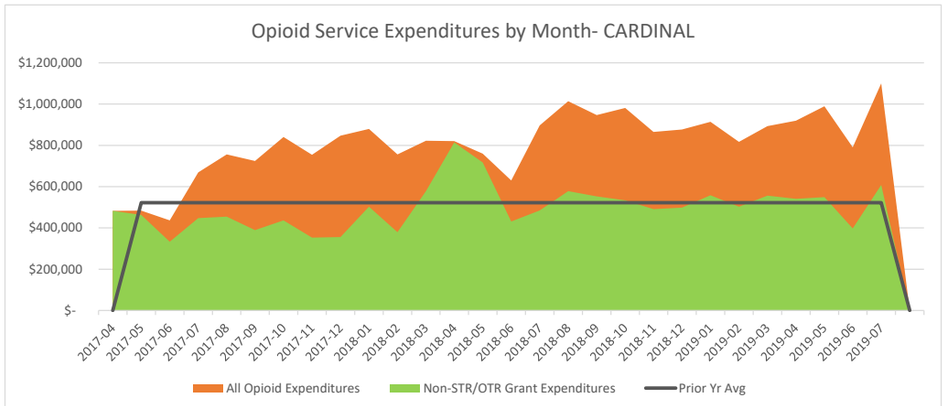
	DOS YYYYMM																	
Values	**2018-02**	**2018-03**	**2018-04**	**2018-05**	**2018-06**	**2018-07**	**2018-08**	**2018-09**	**2018-10**	**2018-11**	**2018-12**	**2019-01**	**2019-02**	**2019-03**	**2019-04**	**2019-05**	**2019-06**	**2019-07**
Value	$439,526	$552,467	$558,480	$574,354	$532,666	$541,038	$557,704	$472,874	$503,778	$493,071	$479,537	$530,019	$477,120	$549,285	$593,710	$629,902	$626,580	$672,415
Client Count	894	1026	1072	1102	1080	1030	1037	1002	1004	1008	969	995	1037	1103	1165	1174	1223	1259
Avg Per Client	$492	$538	$521	$521	$493	$525	$538	$472	$502	$489	$495	$533	$460	$498	$510	$537	$512	$534

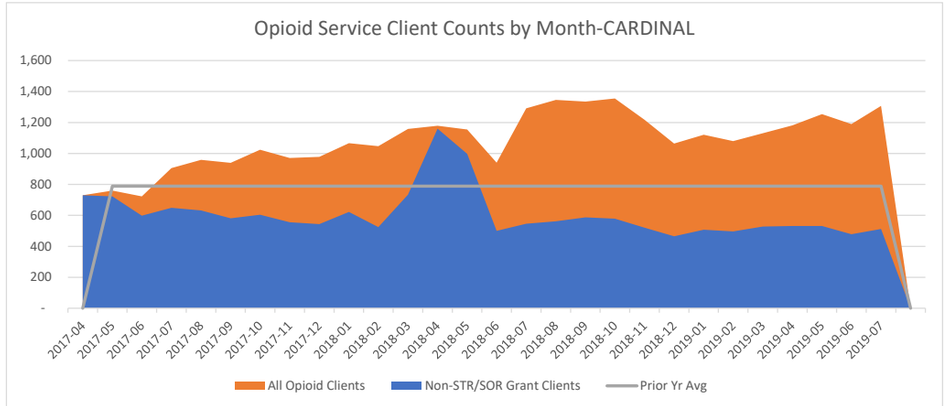




Ongoing services include all funding sources, provided client previously received a grant-funded service; discharge is inferred (D/C proxy) if most recent service occurred in a previous month.
Source: DMHDDSAS Paid Claims in NCTracks
Note: Claims lag and denials impact recent months and vary by LME/MCO. Report expenditure amounts are based on Dates of Service; expenditures based on Dates of Payment will differ.

DMH/DD/SAS Opioid and STR/SOR Grant Service Level Report **Period Ending July 31, 2019** **CARDINAL** **9/23/2019**



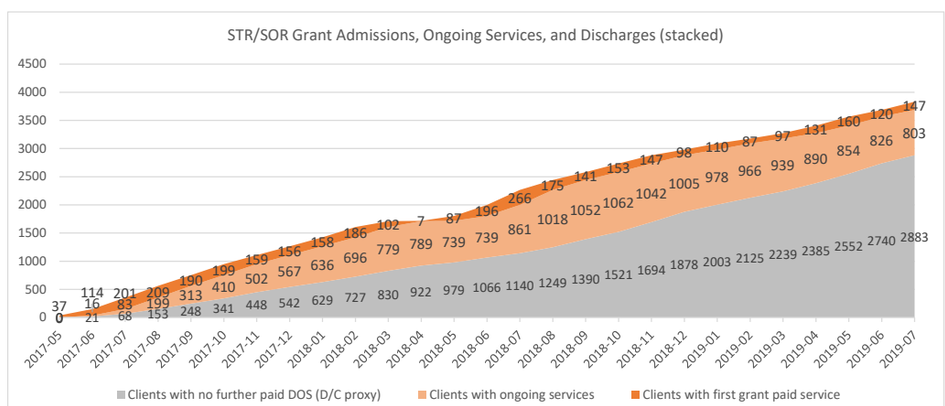


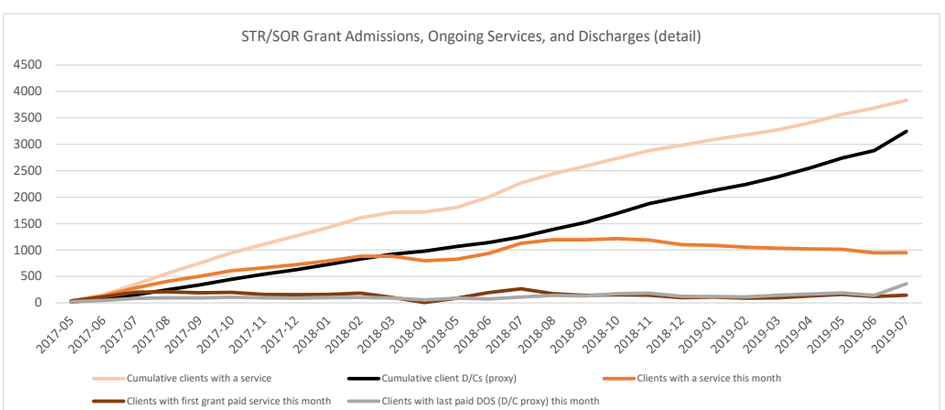
STR/SOR Grant/ASOUD Benefit Plan member expenditures and client counts are shown in orange in graphs above. Individuals must be new to or not currently in treatment for OUD to be enrolled in ASOUD.

Unduplicated OUD Clients, All Funding Sources May 2016- April 2017 3,383 May 2017-April 2018 4,055 May 2018-April 2019 4,374

OUD Service Expenditures and Client Counts

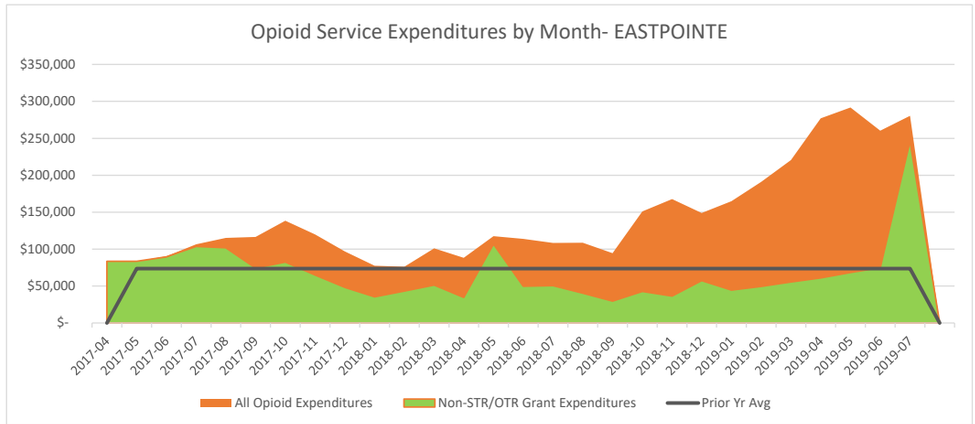
	DOS YYYYMM																	
Values	**2018-02**	**2018-03**	**2018-04**	**2018-05**	**2018-06**	**2018-07**	**2018-08**	**2018-09**	**2018-10**	**2018-11**	**2018-12**	**2019-01**	**2019-02**	**2019-03**	**2019-04**	**2019-05**	**2019-06**	**2019-07**
Value	$756,242	$822,038	$820,532	$759,824	$630,361	$897,271	$1,014,014	$946,686	$981,702	$865,260	$877,313	$914,233	$816,815	$893,603	$919,951	$989,149	$790,809	$1,100,281
Client Count	1047	1158	1179	1155	940	1291	1346	1335	1355	1218	1064	1121	1079	1131	1181	1254	1190	1307
Avg Per Client	$722	$710	$696	$658	$671	$695	$753	$709	$725	$710	$825	$816	$757	$790	$779	$789	$665	$842

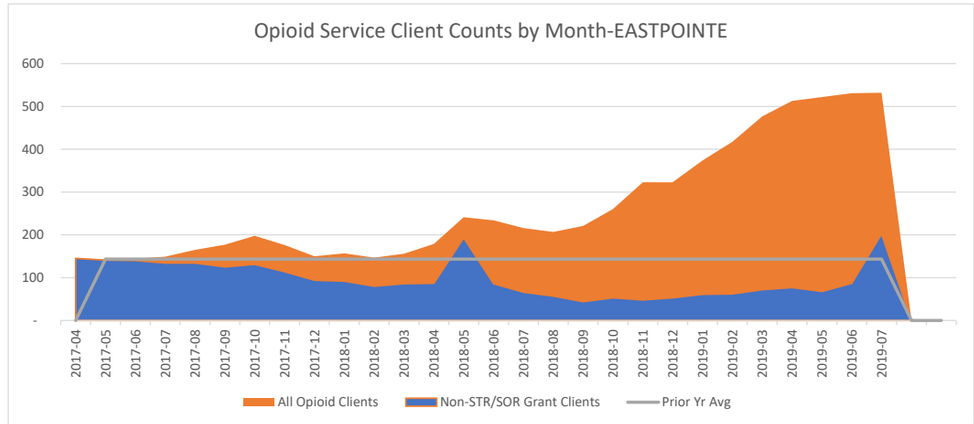




Ongoing services include all funding sources, provided client previously received a grant-funded service; discharge is inferred (D/C proxy) if most recent service occurred in a previous month.
Source: DMHDDSAS Paid Claims in NCTracks
Note: Claims lag and denials impact recent months, which varies by LME/MCO. This report is based on Dates of Service, and thus does not reflect Cures payments based date of payment.
Centerpoint expenditures and clients through 2016-06 are included in the top graphs, for the time prior to the merger with Cardinal.

DMH/DD/SAS Opioid and STR/SOR Grant Service Level Report **Period Ending July 31, 2019** **EASTPOINTE** **9/23/2019**



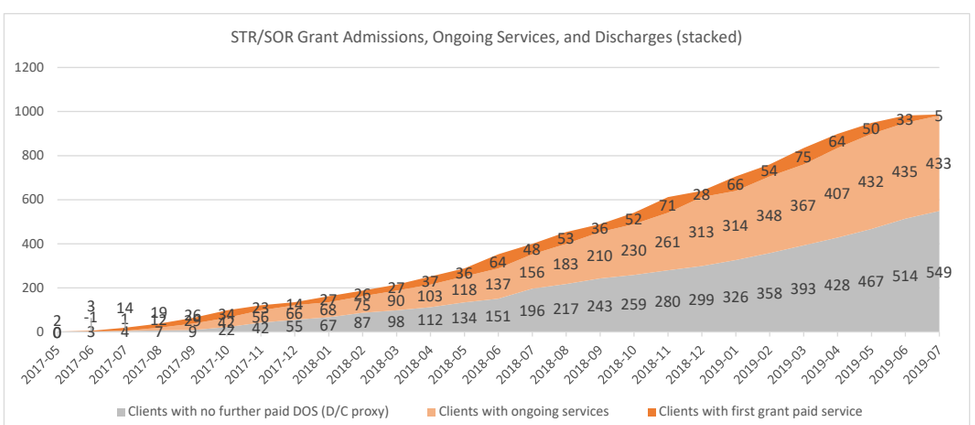


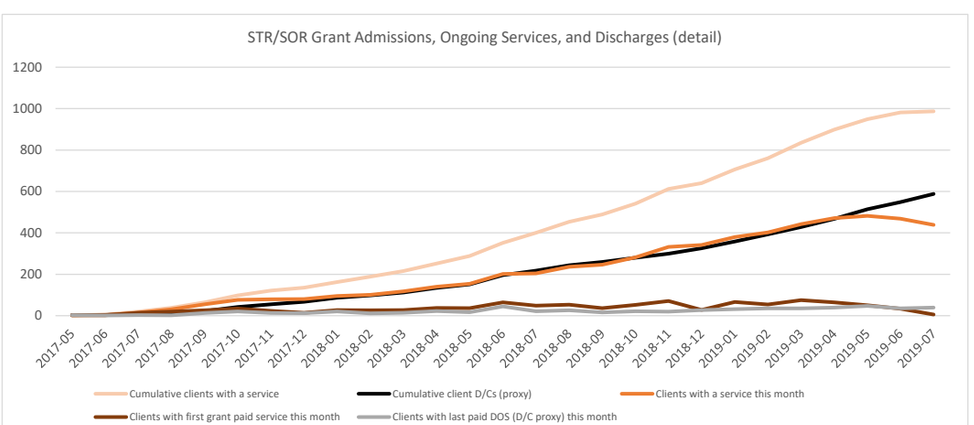
STR/SOR Grant/ASOUD Benefit Plan member expenditures and client counts are shown in orange in graphs above. Individuals must be new to or not currently in treatment for OUD to be enrolled in ASOUD.

Unduplicated OUD Clients, All Funding Sources May 2016- April 2017 626 May 2017-April 2018 656 May 2018-April 2019 1,061

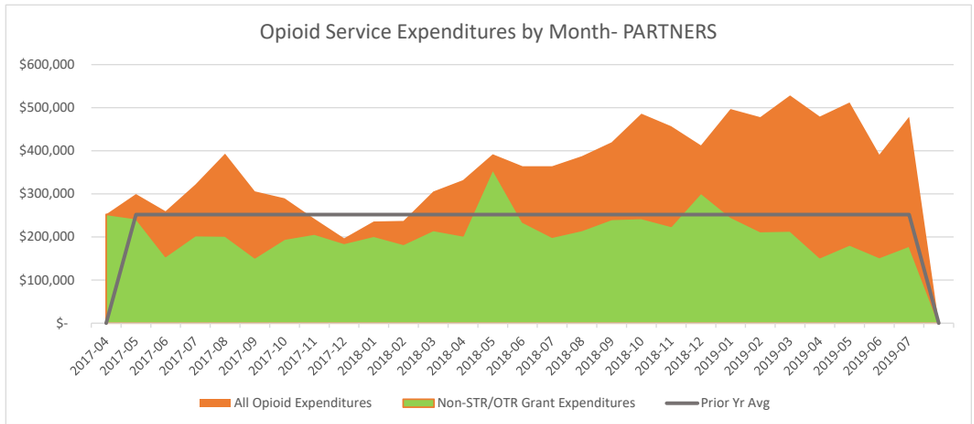
OUD Service Expenditures and Client Counts

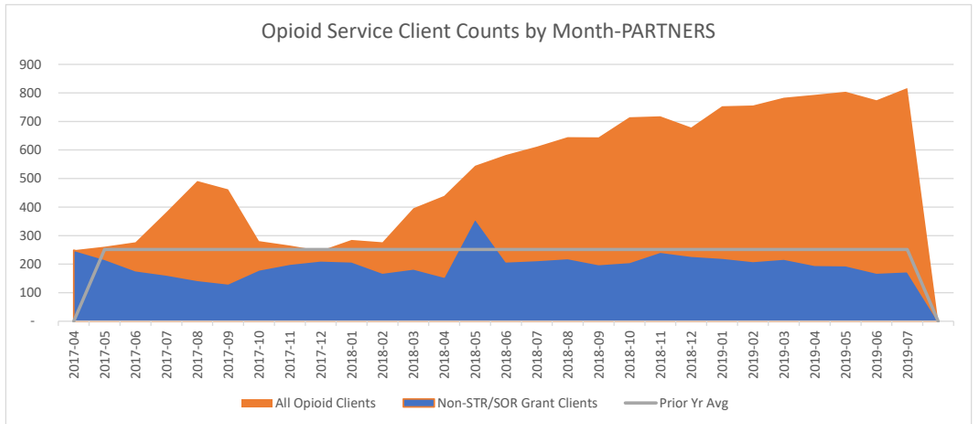
	DOS YYYYMM																	
Values	**2018-02**	**2018-03**	**2018-04**	**2018-05**	**2018-06**	**2018-07**	**2018-08**	**2018-09**	**2018-10**	**2018-11**	**2018-12**	**2019-01**	**2019-02**	**2019-03**	**2019-04**	**2019-05**	**2019-06**	**2019-07**
Value	$76,176	$101,096	$88,116	$117,538	$113,783	$108,486	$108,645	$94,533	$151,035	$167,867	$149,006	$164,984	$191,002	$220,646	$277,077	$291,714	$260,241	$280,386
Client Count	147	156	179	241	234	216	207	221	260	323	323	374	417	477	513	522	531	532
Avg Per Client	$518	$648	$492	$488	$486	$502	$525	$428	$581	$520	$461	$441	$458	$463	$540	$559	$490	$527





Ongoing services include all funding sources, provided client previously received a grant-funded service; discharge is inferred (D/C proxy) if most recent service occurred in a previous month.
Source: DMHDDSAS Paid Claims in NCTracks
Note: Claims lag and denials impact recent months and vary by LME/MCO. Report expenditure amounts are based on Dates of Service; expenditures based on Dates of Payment will differ.



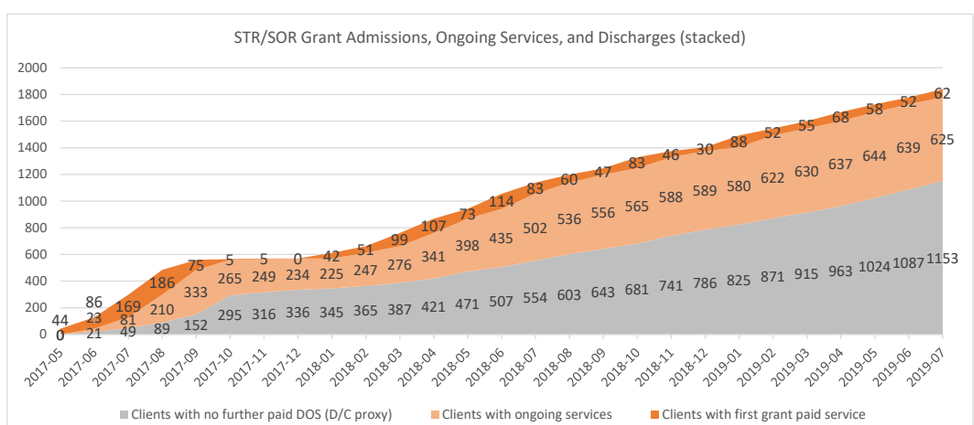


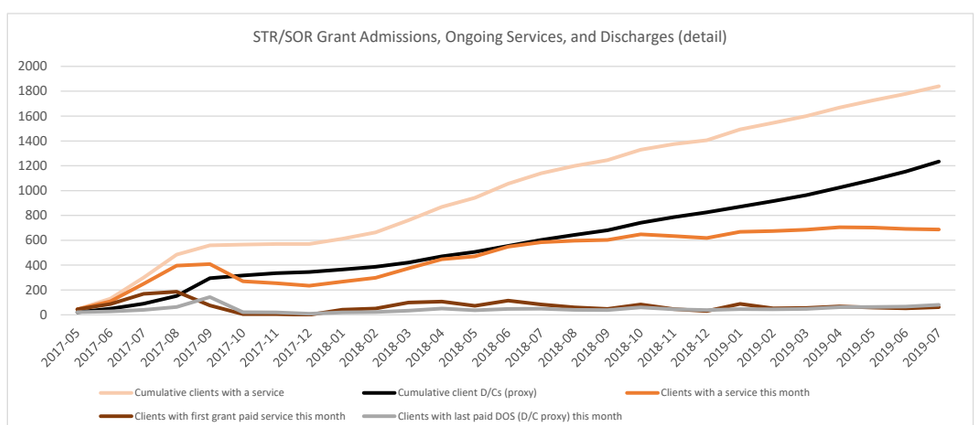
STR/SOR Grant/ASOUD Benefit Plan member expenditures and client counts are shown in orange in graphs above. Individuals must be new to or not currently in treatment for OUD to be enrolled in ASOUD.

Unduplicated OUD Clients, All Funding Sources May 2016- April 2017 1,446 May 2017-April 2018 1,807 May 2018-April 2019 2,125

OUD Service Expenditures and Client Counts

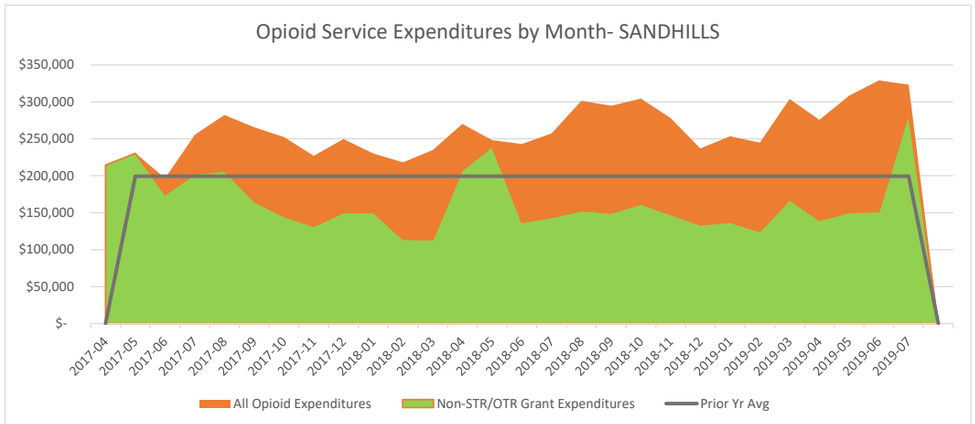
	DOS YYYYMM																	
Values	**2018-02**	**2018-03**	**2018-04**	**2018-05**	**2018-06**	**2018-07**	**2018-08**	**2018-09**	**2018-10**	**2018-11**	**2018-12**	**2019-01**	**2019-02**	**2019-03**	**2019-04**	**2019-05**	**2019-06**	**2019-07**
Value	$237,278	$305,645	$331,904	$391,958	$364,076	$364,363	$387,484	$419,650	$486,173	$456,959	$412,461	$497,019	$478,080	$528,544	$479,264	$512,163	$391,047	$478,946
Client Count	277	396	439	545	583	612	645	644	715	718	679	753	756	783	793	804	774	817
Avg Per Client	$857	$772	$756	$719	$624	$595	$601	$652	$680	$636	$607	$660	$632	$675	$604	$637	$505	$586

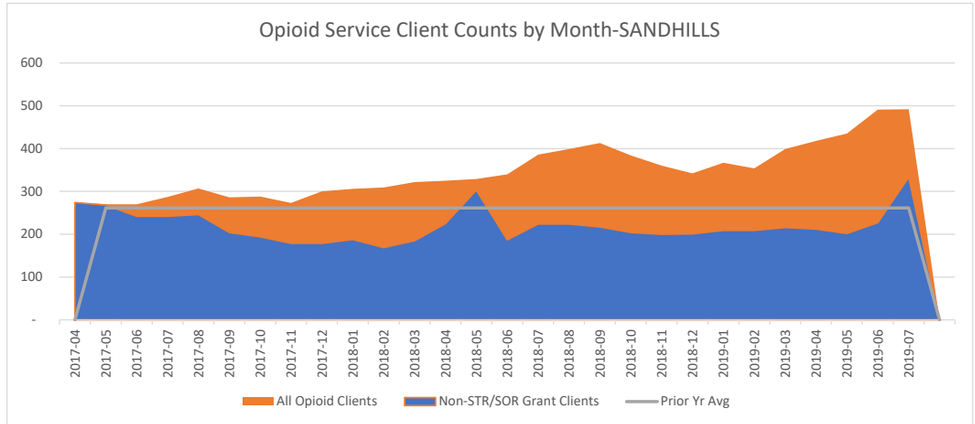




Ongoing services include all funding sources, provided client previously received a grant-funded service; discharge is inferred (D/C proxy) if most recent service occurred in a previous month.
Source: DMHDDSAS Paid Claims in NCTracks
Note: Claims lag and denials impact recent months and vary by LME/MCO. Report expenditure amounts are based on Dates of Service; expenditures based on Dates of Payment will differ.

DMH/DD/SAS Opioid and STR/SOR Grant Service Level Report **Period Ending July 31, 2019** **SANDHILLS** **9/23/2019**



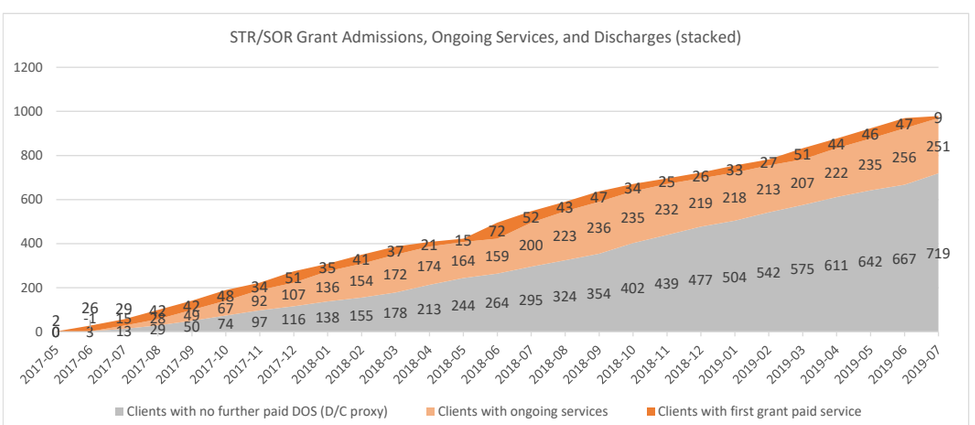


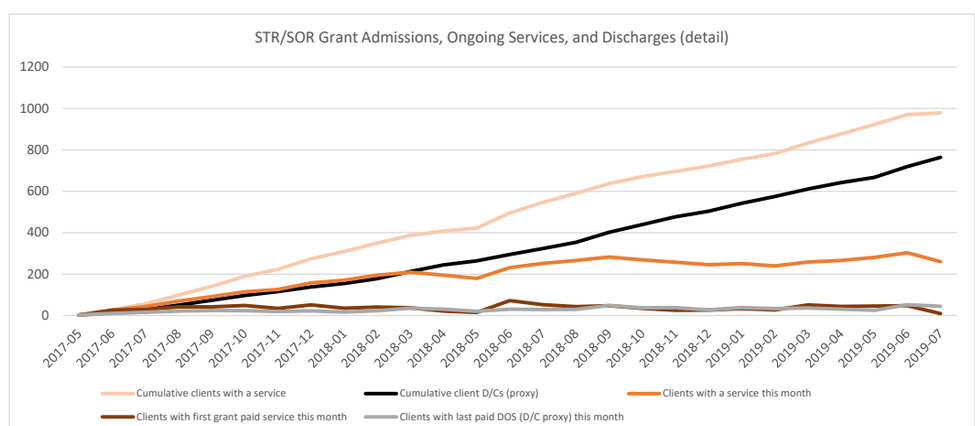
STR/SOR Grant/ASOUD Benefit Plan member expenditures and client counts are shown in orange in graphs above. Individuals must be new to or not currently in treatment for OUD to be enrolled in ASOUD.

Unduplicated OUD Clients, All Funding Sources May 2016- April 2017 1,016 May 2017-April 2018 1,110 May 2018-April 2019 1,339

OUD Service Expenditures and Client Counts

	DOS YYYYMM																	
Values	**2018-02**	**2018-03**	**2018-04**	**2018-05**	**2018-06**	**2018-07**	**2018-08**	**2018-09**	**2018-10**	**2018-11**	**2018-12**	**2019-01**	**2019-02**	**2019-03**	**2019-04**	**2019-05**	**2019-06**	**2019-07**
Value	$218,131	$234,965	$270,281	$248,301	$243,012	$257,356	$301,488	$294,818	$304,489	$278,136	$236,950	$253,389	$244,743	$303,963	$275,575	$308,489	$329,118	$323,273
Client Count	309	322	325	329	340	386	399	413	384	360	342	367	354	399	418	435	491	492
Avg Per Client	$706	$730	$832	$755	$715	$667	$756	$714	$793	$773	$693	$690	$691	$762	$659	$709	$670	$657

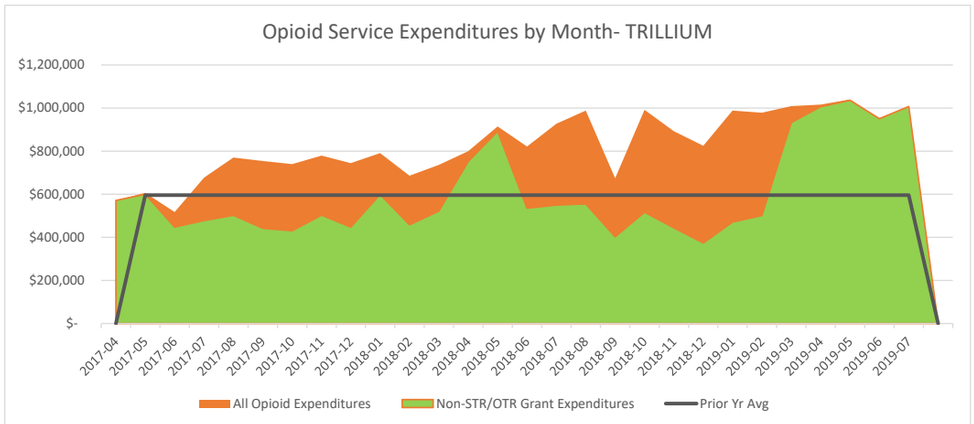


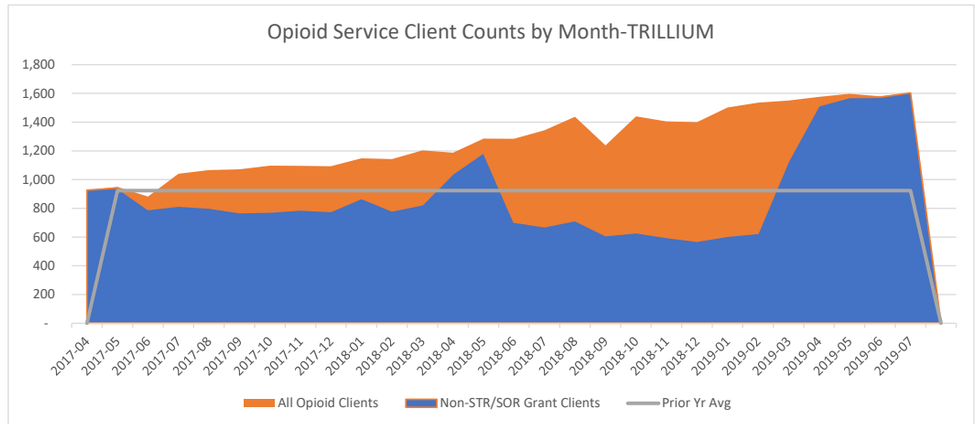


Ongoing services include all funding sources, provided client previously received a grant-funded service; discharge is inferred (D/C proxy) if most recent service occurred in a previous month.

Source: DMHDDSAS Paid Claims in NCTracks

Note: Claims lag and denials impact recent months and vary by LME/MCO. Report expenditure amounts are based on Dates of Service; expenditures based on Dates of Payment will differ.



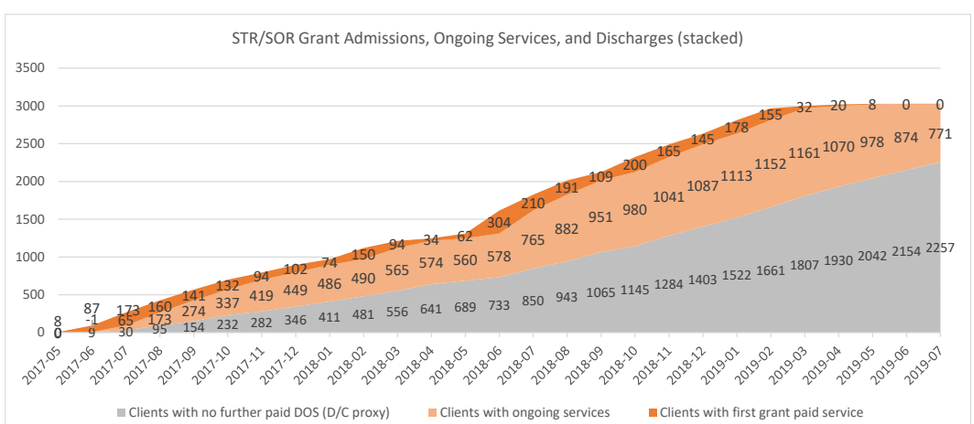


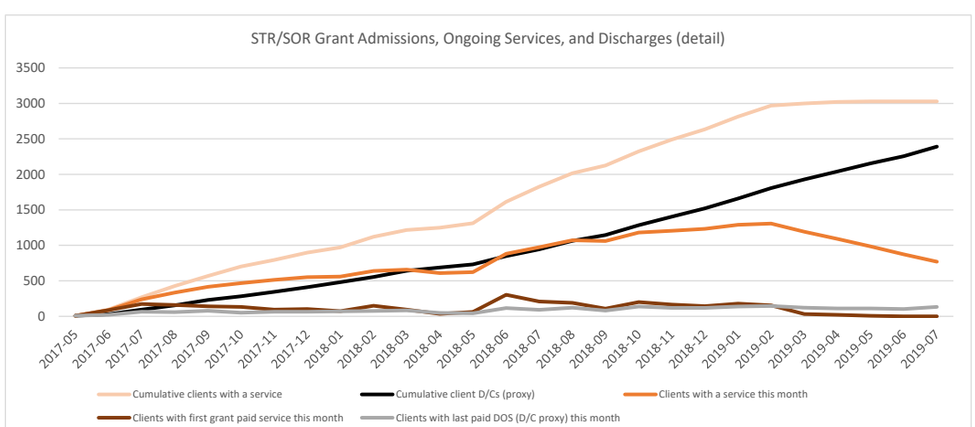
STR/SOR Grant/ASOUD Benefit Plan member expenditures and client counts are shown in orange in graphs above. Individuals must be new to or not currently in treatment for OUD to be enrolled in ASOUD.

Unduplicated OUD Clients, All Funding Sources May 2016- April 2017 2,764 May 2017-April 2018 3,315 May 2018-April 2019 3,984

OUD Service Expenditures and Client Counts

	DOS YYYYMM																		
Values	**2018-02**	**2018-03**	**2018-04**	**2018-05**	**2018-06**	**2018-07**	**2018-08**	**2018-09**	**2018-10**	**2018-11**	**2018-12**	**2019-01**	**2019-02**	**2019-03**	**2019-04**	**2019-05**	**2019-06**	**2019-07**
Value	$686,427	$736,137	$800,403	$914,299	$821,116	$926,881	$988,222	$674,773	$991,892	$891,923	$825,284	$987,932	$978,610	$1,008,499	$1,016,107	$1,039,844	$952,231	$1,006,769
Client Count	1143	1204	1187	1286	1285	1344	1438	1238	1440	1406	1400	1502	1536	1551	1576	1598	1580	1604
Avg Per Client	$601	$611	$674	$711	$639	$690	$687	$545	$689	$634	$589	$658	$637	$650	$645	$651	$603	$628

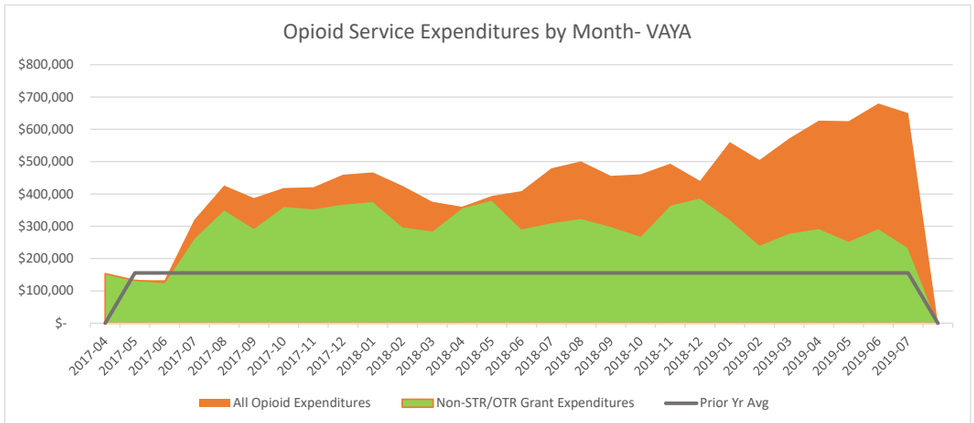


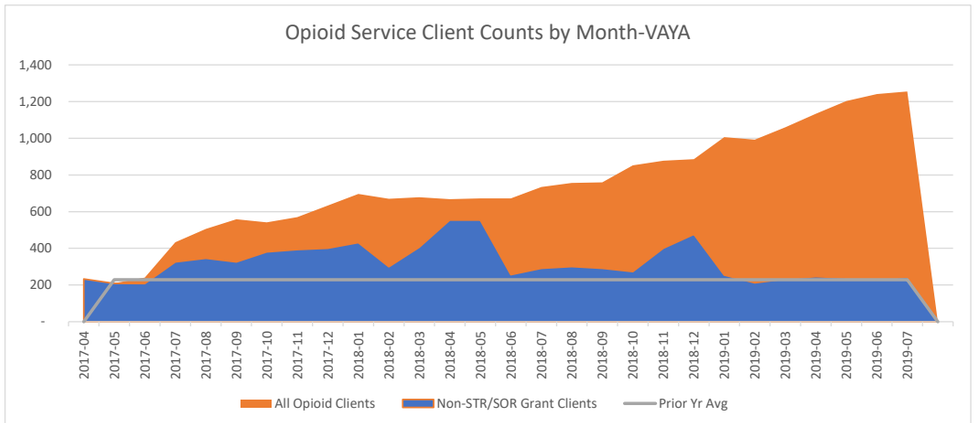


Ongoing services include all funding sources, provided client previously received a grant-funded service; discharge is inferred (D/C proxy) if most recent service occurred in a previous month.

Source: DMHDDSAS Paid Claims in NCTracks

Note: Claims lag and denials impact recent months and vary by LME/MCO. Report expenditure amounts are based on Dates of Service; expenditures based on Dates of Payment will differ.



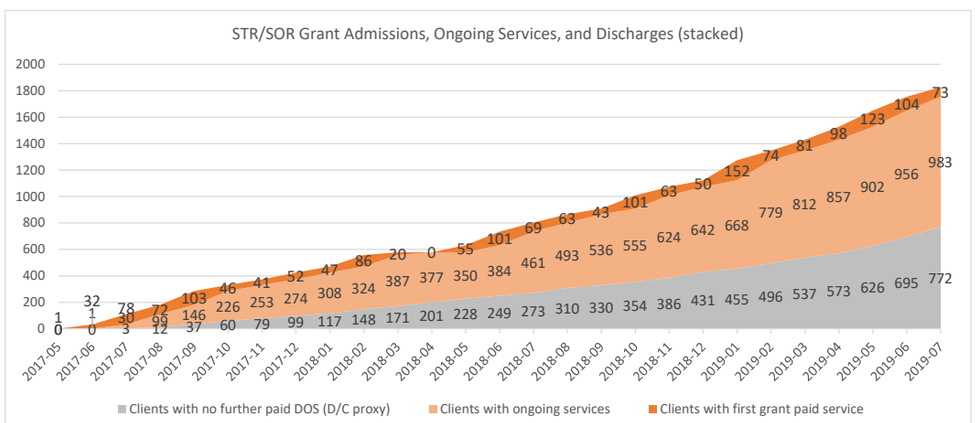


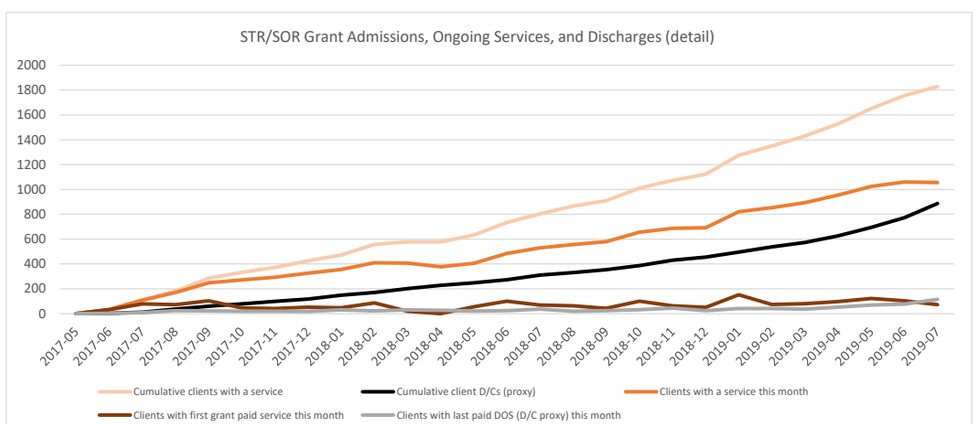
STR/SOR Grant/ASOUD Benefit Plan member expenditures and client counts are shown in orange in graphs above. Individuals must be new to or not currently in treatment for OUD to be enrolled in ASOUD.

Unduplicated OUD Clients, All Funding Sources May 2016- April 2017 1,170 May 2017-April 2018 2,010 May 2018-April 2019 2,486

OUD Service Expenditures and Client Counts

	DOS YYYYMM																	
Values	**2018-02**	**2018-03**	**2018-04**	**2018-05**	**2018-06**	**2018-07**	**2018-08**	**2018-09**	**2018-10**	**2018-11**	**2018-12**	**2019-01**	**2019-02**	**2019-03**	**2019-04**	**2019-05**	**2019-06**	**2019-07**
Value	$424,662	$376,180	$360,419	$394,006	$408,925	$479,289	$500,877	$455,914	$460,510	$493,418	$440,236	$560,776	$505,297	$572,128	$626,774	$625,398	$679,886	$650,423
Client Count	670	679	668	672	672	734	757	760	852	878	886	1006	992	1060	1134	1203	1241	1255
Avg Per Client	$634	$554	$540	$586	$609	$653	$662	$600	$541	$562	$497	$557	$509	$540	$553	$520	$548	$518





Ongoing services include all funding sources, provided client previously received a grant-funded service; discharge is inferred (D/C proxy) if most recent service occurred in a previous month.
Source: DMHDDSAS Paid Claims in NCTracks
Note: Claims lag and denials impact recent months and vary by LME/MCO. Report expenditure amounts are based on Dates of Service; expenditures based on Dates of Payment will differ.

Step 2: Identify the unmet service needs and critical gaps within the current system

Populations and Prevalence

With a population estimate of 10,524,548 residents for 2019, North Carolina has the ninth largest population among 50 states, ranking 13th in population change between 2010-2018 (https://www.census.gov/data/tables/time-series/popest/2010s-national-total.html). Adults make up about 80 percent (8,203,778) of the total population, of which approximately 540,654 are in need of services for a substance use disorder based on the prevalence estimate of 6.59 percent. Youth aged 12 to 17 make up almost ten percent of the population. Based on the prevalence estimate of 3.63% for the state, North Carolina had a total of nearly 30,000 youth with substance use needs in 2019. (population: NC Office of State Budget and Management (NC OSBM), State Demographer's Office, https://www.osbm.nc.gov/demog/county-projections.)

The table below illustrates the number of North Carolina residents in need of SUD services by age range, with prevalence percentages derived from the National Surveys on Drug Use and Health, 2016 and 2017, published 11/28/18.

July 2019 Population Estimates				**Persons in Need of SUD Services**				
Ages 12-17	Ages 18-25	Ages +26	Total (Ages 12+)	Ages 12-17 Prevalence = 3.63%	Ages 18-25 Prevalence = 12.25%	Ages 26+ Prevalence = 5.64%	Total Estimated Adults (18+) with SUD	Total Estimated Persons (12+) with SUD
818,028	1,179,445	7,024,333	9,021,806	29,694	144,482	396,172	540,654	570,349

NC Substance Abuse Prevalence Rates Source: *SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2016 and 2017, published 11/28/18, Downloaded 1/18/19. Table 23, Substance Use Disorder in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUHs. Prevalence rate in NC for adolescents (ages 12-17) is 3.63%. Prevalence for adults (ages 18-25) is 12.25% and for adults (ages 26+) is 5.64%. Total (age 12+) = 6.27%, Total (age 18+) = 6.54%. Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse in the 4th edition of DSM-IV.*

(https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaePercentsExcelCSVs2017/NSDUHsaePercents2017.pdf).

US Substance Use Disorder Prevalence Rates Source: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2017, published 11/28/18, Downloaded 1/18/19. Table 5.9B, SUD in Past Year among Persons Aged 12 or Older, by Age Group and Geographic and Socioeconomic Characteristics: Percentages 2016 and 2017. Prevalence rate in the US for adolescents (ages 12-17) is 4.0%, 4.2% for those with Medicaid/CHIP, and 3.4% for those with no health insurance. Prevalence rates for adults (ages 18-25)

is 14.8%, 13.2% for those with Medicaid/CHIP, and 13.5% for those with no health insurance. Prevalence rates for adults (ages 26+) is 6.4%, 9.4% for those with Medicaid, and 10.4% for those with no health insurance. Prevalence rates for all adults (ages 18+) is 7.6%, 10.2% for those with Medicaid/CHIP, and 11.1% for those with no health insurance.

Population Data: NC Office of State Budget and Management (OSBM). Last updated: 12/5/18 Downloaded: 1/9/19 (https://www.osbm.nc.gov/demog/county-projections)

According to the National Survey on Drug Use and Health (NSDUH), 2015-2016, for those with a family income less than 139% of the federal poverty level and uninsured, prevalence of a substance use disorder for individuals between the ages of 18 to 64 was 12.5%. The prevalence estimate for those uninsured with annual incomes between 133 and 399% of federal poverty level and a substance use disorder was 13.4%. North Carolina is not a Medicaid expansion state, and based on a civilian noninstitutionalized population of 9,845,238, there are approximately 1,186,403 uninsured individuals in our state (Data Source: American Community Survey, 2017.). The same survey also reported that 16.1% of North Carolina residents had an income in the past 12 months that was below the poverty level. Given the number of people living in poverty (estimated at 1.1 million) in North Carolina and the above prevalence, it can be estimated that over 200,000 individuals between the ages of 18 and 64 are in need of treatment for a substance use disorder and have no insurance coverage. According to data from the Division's Client Data Warehouse (CDW), in state fiscal year 2018, 97,527 individuals received at least one service for a substance use disorder. Based on the estimate that slightly over 200,000 individuals are uninsured, this is a penetration rate of 48%.

Older populations. The NC Office of State Budget and Management estimates that nearly 26 percent of North Carolina's population will be over age 60 by the year 2030, an increase of almost 61 percent from 2012. Of the state's residents, 35.7 percent are now 50 or older, 22.6 percent are 60 or older, 11.1 percent are 70 or older, and 3.7 percent are 80 or older (https://www.osbm.nc.gov/demog/county-projections). The proportion of North Carolina's population that is 60 and older is growing more rapidly than other components of the population. By 2035 NC OSBM projects there will be more older adults (ages 65 and older) than there will be children (under age 18).

North Carolina has fully transitioned to a multi-payer Medicaid Management Information System for the NC Department of Health and Human Services, called NCTracks. NCTracks was the largest, most complex IT project in state history and was the first public multi-payer system in the United States. NCTracks is used by the Division of Health Benefits (NC Medicaid), the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the Division of Public Health (DPH). Providers enrolled in NC Medicaid, DMH/DD/SAS and DPH health plans submit claims for payment of covered health care services through the NCTracks Provider Portal. NCTracks coordinates processing among the payers to ensure the proper assignment of the payer, benefit plan and pricing methodology for each service on a claim. NCTracks processes health care claims for about 70,000 enrolled DHHS providers who serve over 1 million North Carolina citizens. Providers

who are contracted by LME/MCOs to enroll and perform state funded DMH/DD/SAS services submit their claims to the LME/MCO.

Over the last several years, North Carolina has implemented a 1915(b)/(c) waiver that is statewide. Of note, North Carolina was approved for an 1115 SUD Demonstration waiver in 2019, that authorizes the state to receive federal financial participation (FFP) for the continuum of services to treat addiction to opioids and other substances, including services provided to Medicaid enrollees with a SUD who are short-term residents in residential and inpatient treatment facilities that meet the definition of an Institution for Mental Diseases (IMD).

All 100 counties are part of a catchment or service area covered by one of seven local management entities/managed care organizations (LME/MCOs) that assure the delivery of services that are of the appropriate intensity and duration for consumers with intellectual/developmental disabilities or mental health/substance use issues. Each LME/MCO contracts with providers, the majority of whom are nationally accredited, for specific services for specific populations; i.e., adults with a substance use disorder, children with a serious emotional disturbance, etc. In order for LME/MCOs to be eligible to receive categorical substance abuse block grant funds, the LME/MCO must assert and assure that the federally mandated priority populations be served; i.e., pregnant women with a substance use disorder, individuals injecting drugs, etc.

The table below illustrates number of individuals in need of SUD services based on prevalence percentages for each LME/MCO. It should be noted that these are total numbers in need and therefore an over-representation of the number of uninsured individuals in need of SUD care.

	July 2019 Population Estimates				**Persons in Need of SUD Services**				
LME/MCO	Ages 12-17	Ages 18-25	Ages 26+	Total	Ages 12-17 Prevalence = 3.63%	Ages 18-25 Prevalence = 12.25%	Ages 26+ Prevalence = 5.64%	Total Estimated Adults (18+) with SUD	Total Estimated Persons (12+) with SUD
Alliance Health	**161,719**	**222,427**	**1,255,731**	**1,639,877**	**5,870**	**27,247**	**70,823**	**98,071**	**103,941**
Cardinal Innovations	**257,237**	**339,136**	**2,151,283**	**2,747,656**	**9,338**	**41,544**	**121,332**	**162,877**	**172,214**
Eastpointe	**54,105**	**73,196**	**436,404**	**563,705**	**1,964**	**8,967**	**24,613**	**33,580**	**35,544**
Partners Behavioral Health	**80,735**	**106,666**	**700,032**	**887,433**	**2,931**	**13,067**	**39,482**	**52,548**	**61,605**
Sandhills Center	**90,255**	**133,548**	**744,137**	**967,940**	**3,276**	**16,360**	**41,969**	**58,329**	**61,605**

Trillium Health Resources	**103,529**	**189,779**	**980,466**	**1,273,774**	**3,758**	**23,248**	**55,298**	**78,546**	**82,304**
Vaya Health	**70,448**	**114,693**	**756,280**	**941,421**	**2,557**	**14,050**	**42,654**	**56,704**	**59,261**
State Total	**818,028**	**1,179,445**	**7,024,333**	**9,021,806**	**29,694**	**144,482**	**396,172**	**540,654**	**570,349**

The Division of MH/DD/SA Services and NC Medicaid require the LME/MCOs to annually complete a Needs and Gaps Analysis. DMH/DD/SAS and NC Medicaid each have performance agreements/contracts with LME/MCOs containing requirements for assessments of community need, provider capacity, gaps in services and strategic plans to address gaps. LME/MCOs gather information from consumers, family members, providers and other stakeholders about community and service needs and priorities. This Needs and Gaps Analysis is one part of a continuous assessment and action process with each component driving the focus of the next. Components include:

- Assess and study the LME/MCO's community to determine needs and providers to deliver services;
- Develop or update LME/MCO strategic plans to incorporate results from the service needs assessment and gaps analysis;
- Implement these strategic plans through local initiatives, quality improvement projects and other actions; and,
- Review and assess action steps taken and determine progress and challenges in meeting needs and adjusting resources to respond to gaps in services.

LME/MCOs complete and submit an Exception Request to DMH/DD/SAS if any service has less than 100% access and choice. These exception requests are reviewed by DMH/DD/SAS staff who will either approve or work with the LME/MCO to formulate strategies for meeting the needs. For example, although North Carolina has 74 opioid treatment programs, being a primarily rural state, there are areas that do not have the population density and prevalence of opioid use disorder to support an opioid treatment program. However, in order to better assure access to a site-based service that requires regular attendance and participation, Addictions staff have worked with several LME/MCOs to extend contracts to office-based opioid treatment practices (OBOTs). We are also in the process of determining the feasibility and legal authority to implement medication units. Medication units are brick and mortar programs that provide dosing of methadone and buprenorphine products under the license of the opioid treatment program. Other required clinical services are provided at the main site, but having the capability to dose in additional sites can reduce drive time for patients and improve consistent participation and retention.

For a complete report on all Medicaid and non-Medicaid services availability by service and LME/MCO, **please see the document titled Network Adequacy and Accessibility Analysis in the Attachments section.**

Services

Community integration/recovery support is an area that has been and will continue to be a focus of the state. The ability to obtain and sustain safe, affordable housing is one of the most significant challenges facing persons in the early stages of recovery. In addition, having meaningful work is integral to many individuals' recovery. The state has an ongoing contract with Oxford House, Inc. to provide housing for people in recovery and has set aside $100,000 for the support of statewide consumer housing through the Cross Area Service Program (CASP) Substance Abuse Services initiative. A substantial portion of block grant funds were utilized last fiscal year to support recovery housing (in addition to Oxford Houses). In that safe, affordable housing continues to be an area of need, the Division will work with LME/MCOs and providers to identify barriers that impede an individual's access to housing and employment.

Because of the strong association between substance use and trauma, the state will continue to emphasize trauma-informed care as well as the use of evidence-based practices in the treatment of substance use disorders. North Carolina supports a full continuum of substance abuse services including prevention, intervention, treatment and recovery for pregnant and parenting women and their families and women seeking custody of their child(ren). The Perinatal and Maternal Substance Use Initiative is composed of specialized programs for pregnant and parenting women with a substance related disorder and their children. These programs provide comprehensive, gender-responsive, substance abuse services that include, but are not limited to the following: screening, assessment, case management, outpatient substance abuse and mental health services, parenting skills, residential services, referrals for primary and preventative health care and referrals for appropriate interventions for their children. The children in these families benefit from various services, including those provided by the local health departments (pediatric care), early intervention programs, etc. The NC CASAWORKS for Families Residential Initiative is a collaborative project between the Division of MH/DD/SAS and the Division of Social Services. This Initiative supports eight comprehensive residential substance abuse programs for women receiving Work First cash assistance and their children. Emphasis will be placed on identifying and removing any barriers to accessing these services, increasing referrals and improving outcomes. Due to the increased use of prescription pain medications, the Division will emphasize improved access to and retention in opioid treatment programs for pregnant women.

Over the past several years, North Carolina, like many states, has experienced an increase in opioid and heroin use, misuse and overdose. In response, the state has developed strategies and implemented several initiatives to address the problem. The Opioid STR and SOR grants provided the opportunity to consolidate those efforts, as well as enhance and expand services and supports to meet the needs of the citizens of North Carolina. Given the impact on our state, the Governor and the Secretary of the Department of Health and Human Services have made this a top priority for

administration. Several sister agencies under DHHS that have current focus, initiatives or activities related to addressing the opioid crisis, in addition to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the SSA), include the Division of Public Health (DPH), the Division of Health benefits (NC Medicaid), the Office of Rural Health (ORH) and the Office of Emergency Medical Services (OEMS). The Attorney General's office is also highly involved. Epidemiologic data available from the Injury and Violence Prevention Branch, Injury Epidemiology and Surveillance Unit (NC DPH) show that prescription opioid poisoning deaths increased by 256 percent between 2000 and 2015 while deaths from heroin overdoses increased by 800 percent, indicating that the state, like the rest of the country, is facing a problem of epidemic proportions.

To combat the opioid crisis, the North Carolina Department of Health and Human Services worked with community partners to develop North Carolina's Opioid Action Plan (NC OAP). The NC OAP launched in June of 2017 and established thirteen data metrics to track and monitor the opioid epidemic. The opioid data dashboard is meant to provide integration and visualization of state and county-level metrics for stakeholders across NC to track progress towards reaching the goals outlined in NC OAP. For more information on the NC OAP visit: https://www.ncdhhs.gov/opioids. The table below is a replication of the data dashboard that can be found on the DHHS website.

Metric Summary Table: NC (Population: 10,383,620)

Metrics	Most Current Provisional Data		
	Time	Quarter	Year-To-Date
Reduce Deaths/ED Outcomes			
Number of unintentional opioid-related deaths to NC Residents (ICD-10)	2018 - Q4	387	1619
Number of ED visits that received an opioid overdose diagnosis (all intents)	2019 – Q2	1835	3405
Reduce Oversupply of Prescription Opioids			
Average rate of multiple provider episodes for prescription opioids, per 100,000 residents	2018 – Q4	22	
Number of opioid pills dispensed	2019 – Q1	107,666,000	107,666,000
Percent of patients with an opioid prescription receiving more than an average daily dose of 90+ MME of opioid analgesics	2019 – Q1	5	5
Percent of prescription days any patient had at least one opioid AND at least one benzodiazepine prescription on the same day	2019 – Q1	33	33
Reduce Diversion/Flow of Illicit Drugs			
Percent of opioid deaths involving heroin or fentanyl/fentanyl analogues	2018 – Q4	78	79
Number of acute hepatitis C cases	2019 – Q1	48	48
Increase Access to Naloxone			
Number of EMS naloxone administrations	2019 – Q2	3282	6214
Number of community naloxone reversals	2019 – Q2	1287	1837
Treatment and Recovery			
Number of buprenorphine prescriptions dispensed	2019 – Q1	181,440	181,440
Number of uninsured individuals and Medicaid beneficiaries with an opioid use disorder served by treatment programs	2019 – Q1	20,385	20,385
Number of certified peer support specialists (CPSS)	2019 – Q2	3637	3637

For detailed technical notes on these metrics and the Summary Table visit the 'How to Use / Tech Notes' area on the following website: https://injuryfreenc.shinyapps.io/OpioidActionPlan/. ED data may be suppressed in some counties when there are < 5 cases.

There are currently 74 opioid treatment programs in the state, of which approximately two-thirds are eligible to provide services to publicly-funded consumers. The Division will focus efforts on improving access, retention and outcomes specific to these programs. Please see in the Attachments section the ***North Carolina Opioid STR Needs Assessment*** for additional information specific to the opioid epidemic in North Carolina, as well as the ***Opioid STR Strategic Plan*** which identifies areas of focus and strategies for meeting identified needs.

Veterans and Military Families

North Carolina is home to a large number of active military, National Guard and Reserves, veterans, and military families, ranking fourth in the country on this criterion. In a recent study, the NC Institute of Medicine noted that 35% of North Carolinians have some relationship to the military. The number of reserve component members in the state sum up to 22,000. In 2018 in NC, there was a total of over 1112,000 individuals in the active military, with a total of over 728,000 Veterans and 190,896 dependents of service members living in this state. DMH/DD/SAS serves the needs of the military through the Governor's Working Group on Veterans, Service Members and Their Families, a project that it supports and funds through the SABG. The Governor's Working Group promotes evidence-based and best practices in the screening, assessment, and treatment of active duty, National Guard, reservists and veterans who served in the military and their families. Areas of focus include Veterans suicide, homelessness and resource and care coordination services through four regional network programs (NCServes).

State Epidemiological Outcomes Workgroup

The State Epidemiological Outcomes Workgroup (SEOW) was formed in 2005 with funding from the NC Strategic Prevention Framework/State Incentive Grant (SPF/SIG) and continues today. The SEOW is comprised of representatives from NC Department of Public Health, Injury and Violence Prevention Branch, NC Department of Public Instruction, Addiction Professionals of North Carolina and are awaiting the addition of a new lead evaluator. The SEOW meets regularly to identify needs and to develop data resources to assist with planning. The SEOW will also assist with the expansion of the bi-annual Youth Prevention Survey that was launched in 2017; provide enhancement of the data dashboard (NC-SUPPORT) or other data dashboards linking public data from various agencies with improved access to updated data; conduct continuous quality improvement checks on the state-wide prevention infrastructure; provide guidance on data-driven interventions to substance use prevention both within the PFS grant and the prevention Block Grant. The state will coordinate and collaborate with is partners to address tobacco and ENDs priorities, as well as their associated needs and gaps in substance abuse prevention services. In accordance with SABG guidelines outlined by SAMHSA for the 20% Primary Prevention Set-Aside, the substance abuse prevention system will continue to provide universal, selective and indicated prevention activities in school and community

settings. Providers are in the process of completing a mid-point needs assessment to reevaluate and determine substance use consumption, consequences, and intervening variables for every county in the state. As a part of this mid-point "check-in", populations at greatest risk are reassessed and new and emerging needs are identified, and strategies prioritized to reach those populations.

Additionally, with state funds, North Carolina supports a behavioral health disparities initiative, for which 11 communities are receiving in depth training in identifying and addressing behavioral health disparities. North Carolina views this project as a way to develop and test strategies for effectively addressing the needs of disparate populations across the state, with the intention of developing the capacity and involvement of prevention providers to address behavioral health disparities statewide.

In addition, the SABG will also continue to provide treatment through activities outlined outside of the 20% Primary Prevention Activities. These will be provided to the priority groups identified by data, emphasizing the use of trauma-informed care and evidence-based practices. Division staff will continue to work with LME/MCOs, providers, individuals in recovery and their family members and other stakeholders to further identify and prioritize areas of greatest need and strategize ways to reduce these gaps with the resources available.

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North Carolina will continue to utilize available funds including the SABG, state dollars and federal discretionary grants, to better address the needs of individuals with substance use disorders. Program and fiscal staff now conduct quarterly "budget variance" calls with all seven LME/MCOs to discuss utilization of funds, particularly when it appears an LME/MCO is under-spending in certain areas. Although funds are limited, LME/MCOs are asked to address gaps – either in specific geographic locations or specifically identified services or types of services – by expanding their provider network and credentialing additional providers. For example, with the influx of funds targeted towards individuals with an opioid use disorder, the number of opioid treatment programs with a contract for public funds has increased substantially.

As mentioned earlier, North Carolina has been approved for an 1115 SUD Demonstration Waiver that will allow for reimbursement of SUD services in facilities with more than 16 beds. Additionally, Medicaid expansion is one of the three top priorities for the department. LME/MCOs are able to credential and contract with more Medicaid providers than state-funded providers because of funding; increasing the number of individuals eligible for Medicaid benefits would better assure the availability of more resources, as well as access to care. Although it is unknown at this point if Medicaid expansion will become a reality in NC in the next year or so, Medicaid transformation is underway. Much work has been done to develop standard and tailored plans that will better meet the needs of individuals with SUD.

Access to Care

The Secretary of the Department of Health and Human Services has identified three (3) "super measures" for the LME/MCOs that the DMHDDSAS will monitor for adherence. One of these super measures is access to care. The Division has long required that LME/MCOs assure that individuals who contact them through their 24/7/365 access lines who are identified as in need of SUD treatment are provided an appointment with a community provider within 48 hours of the call. In other words, no SUD-related call is considered "routine;" all are classified as urgent or emergent. However, with the highlighting of this access to care standard as a super measure with the potential for monetary sanctions if a certain threshold is not met, it is expected that LME/MCOs will take appropriate actions to expand their network if services are not available in this timely manner. Staff on the Quality Management Team within the Division are monitoring the data specific to this standard and will report such to programmatic/clinical staff, particularly for any LME/MCO that does not meet or maintain this standard.

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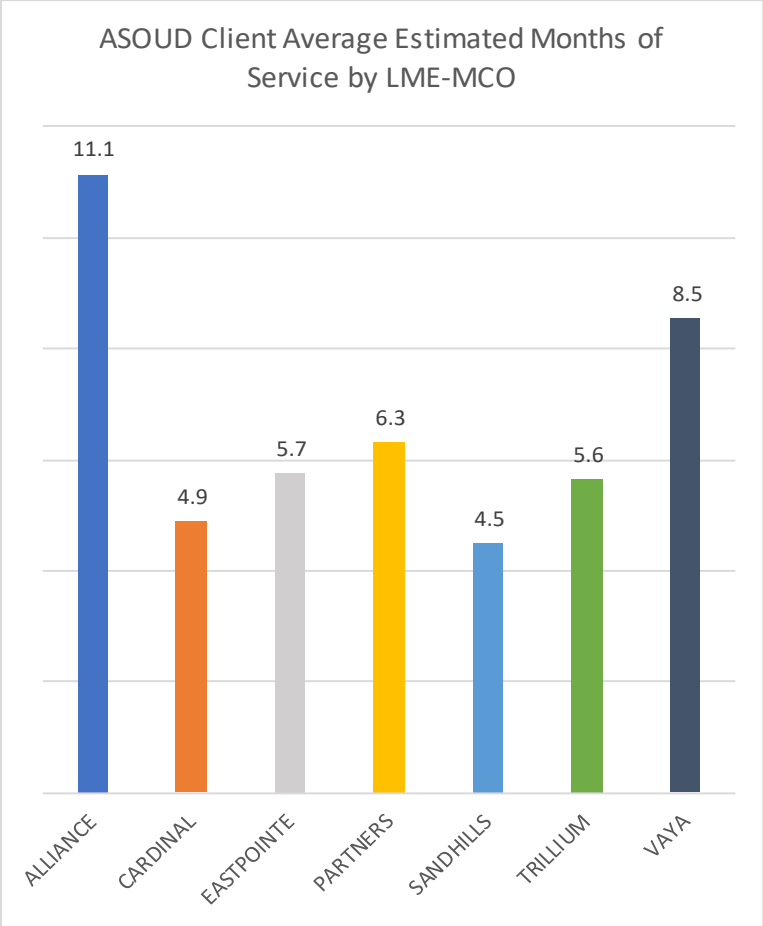
Retention in Care

Data has long supported that the longer individuals are involved in care, the better their outcomes. As part of the data collection efforts specific to the Opioid grants, we have begun tracking retention in treatment at various levels; at the LME/MCO level as aggregated and reported by service; by provider or provider type. Patient-level data is also available. The table below illustrates retention by LME/MCO specifically for those individuals being served through the SOR grant. Data utilized to create this chart show that the LME/MCOs that have more strongly promoted and supported medication assisted treatment have higher or better retention in care. **The full report, titled DMH/DD/SAS Opioid and STR/SOR Grant Service Level Report, which is produced on a monthly basis can be found in the Attachments section.**



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Quality

The Division assures quality in several ways. Monitoring is conducted annually to determine adherence to SABG standards, rules and policies, both at the LME/MCO level, as well as the provider level. During these same annual SABG monitoring visits, clinical monitoring is also conducted. Charts are reviewed to determine if comprehensive clinical assessments are conducted, that individuals are assessed for and provided the appropriate ASAM level of care and that evidence-based practices are utilized appropriately. This is in addition to clinical, programmatic and fiscal monitoring conducted by the LME/MCOs.

North Carolina also still conducts independent peer reviews annually, although the majority of SABG-funded providers are nationally accredited. Each year, specific services are identified for both adolescents and adults, and providers of those services are selected based on specific criteria, such as volume of billed services, proximity to other "like" providers, geographic location, etc. Peer reviewers undergo training and then review each other's programs. In addition to a standardized review, there is much opportunity for sharing of best practices, challenges, etc. Beginning next fiscal

year, results will be aggregated and shared with all providers and LME/MCOs to function more as a learning lab of sorts and better disseminate this information.

A portion of the SABG funds will be specifically dedicated towards training the workforce on ASAM. We chose to focus on ASAM and medication-assisted treatment, as a means to not only improve the knowledge of clinicians and other medical practitioners, but to also improve the awareness and acceptance of medication-assisted treatment as the evidence-based practice for opioid use disorders. We believe this training will improve level of care determination, but will also improve the concept of "multiple pathways to recovery" and lessen the divide between practitioners who previously espoused solely abstinence-based theory.

Awareness

In addition to the training mentioned above, North Carolina is contemplating additional ways to assure individuals are aware of the services available to them. This has, and continues to be, a function of the LME/MCOs. Some advertise through billboards, social media, radio, etc., but we do not believe this is sufficient because the numbers of calls received by the LME/MCOs has decreased over the past several years. Media campaigns have been a focus of the prevention funds through the Opioid STR grant, which has been quite successful based on the number of viewers. We believe these types of campaigns generate awareness and reduce stigma, thereby increasing the likihood individuals will seek help.

Step 2: Identify the unmet service needs and critical gaps within the current system

Populations and Prevalence

With a population estimate of 10,524,548 residents for 2019, North Carolina has the ninth largest population among 50 states, ranking 13th in population change between 2010-2018 (https://www.census.gov/data/tables/time-series/popest/2010s-national-total.html). Adults make up about 80 percent (8,203,778) of the total population, of which approximately 540,654 are in need of services for a substance use disorder based on the prevalence estimate of 6.59 percent. Youth aged 12 to 17 make up almost ten percent of the population. Based on the prevalence estimate of 3.63% for the state, North Carolina had a total of nearly 30,000 youth with substance use needs in 2019. (population: NC Office of State Budget and Management (NC OSBM), State Demographer's Office, https://www.osbm.nc.gov/demog/county-projections.)

The table below illustrates the number of North Carolina residents in need of SUD services by age range, with prevalence percentages derived from the National Surveys on Drug Use and Health, 2016 and 2017, published 11/28/18.

July 2019 Population Estimates				**Persons in Need of SUD Services**				
Ages 12-17	Ages 18-25	Ages +26	Total (Ages 12+)	Ages 12-17 Prevalence = 3.63%	Ages 18-25 Prevalence = 12.25%	Ages 26+ Prevalence = 5.64%	Total Estimated Adults (18+) with SUD	Total Estimated Persons (12+) with SUD
818,028	1,179,445	7,024,333	9,021,806	29,694	144,482	396,172	540,654	570,349

NC Substance Abuse Prevalence Rates Source: *SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2016 and 2017, published 11/28/18, Downloaded 1/18/19. Table 23, Substance Use Disorder in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUHs. Prevalence rate in NC for adolescents (ages 12-17) is 3.63%. Prevalence for adults (ages 18-25) is 12.25% and for adults (ages 26+) is 5.64%. Total (age 12+) = 6.27%, Total (age 18+) = 6.54%. Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse in the 4th edition of DSM-IV.*

(https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaePercentsExcelCSVs2017/NSDUHsaePercents2017.pdf).

US Substance Use Disorder Prevalence Rates Source: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2017, published 11/28/18, Downloaded 1/18/19. Table 5.9B, SUD in Past Year among Persons Aged 12 or Older, by Age Group and Geographic and Socioeconomic Characteristics: Percentages 2016 and 2017. Prevalence rate in the US for adolescents (ages 12-17) is 4.0%, 4.2% for those with Medicaid/CHIP, and 3.4% for those with no health insurance. Prevalence rates for adults (ages 18-25)

is 14.8%, 13.2% for those with Medicaid/CHIP, and 13.5% for those with no health insurance. Prevalence rates for adults (ages 26+) is 6.4%, 9.4% for those with Medicaid, and 10.4% for those with no health insurance. Prevalence rates for all adults (ages 18+) is 7.6%, 10.2% for those with Medicaid/CHIP, and 11.1% for those with no health insurance.

Population Data: NC Office of State Budget and Management (OSBM). Last updated: 12/5/18 Downloaded: 1/9/19 (https://www.osbm.nc.gov/demog/county-projections)

According to the National Survey on Drug Use and Health (NSDUH), 2015-2016, for those with a family income less than 139% of the federal poverty level and uninsured, prevalence of a substance use disorder for individuals between the ages of 18 to 64 was 12.5%. The prevalence estimate for those uninsured with annual incomes between 133 and 399% of federal poverty level and a substance use disorder was 13.4%. North Carolina is not a Medicaid expansion state, and based on a civilian noninstitutionalized population of 9,845,238, there are approximately 1,186,403 uninsured individuals in our state (Data Source: American Community Survey, 2017.). The same survey also reported that 16.1% of North Carolina residents had an income in the past 12 months that was below the poverty level. Given the number of people living in poverty (estimated at 1.1 million) in North Carolina and the above prevalence, it can be estimated that over 200,000 individuals between the ages of 18 and 64 are in need of treatment for a substance use disorder and have no insurance coverage. According to data from the Division's Client Data Warehouse (CDW), in state fiscal year 2018, 97,527 individuals received at least one service for a substance use disorder. Based on the estimate that slightly over 200,000 individuals are uninsured, this is a penetration rate of 48%.

Older populations. The NC Office of State Budget and Management estimates that nearly 26 percent of North Carolina's population will be over age 60 by the year 2030, an increase of almost 61 percent from 2012. Of the state's residents, 35.7 percent are now 50 or older, 22.6 percent are 60 or older, 11.1 percent are 70 or older, and 3.7 percent are 80 or older (https://www.osbm.nc.gov/demog/county-projections). The proportion of North Carolina's population that is 60 and older is growing more rapidly than other components of the population. By 2035 NC OSBM projects there will be more older adults (ages 65 and older) than there will be children (under age 18).

North Carolina has fully transitioned to a multi-payer Medicaid Management Information System for the NC Department of Health and Human Services, called NCTracks. NCTracks was the largest, most complex IT project in state history and was the first public multi-payer system in the United States. NCTracks is used by the Division of Health Benefits (NC Medicaid), the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the Division of Public Health (DPH). Providers enrolled in NC Medicaid, DMH/DD/SAS and DPH health plans submit claims for payment of covered health care services through the NCTracks Provider Portal. NCTracks coordinates processing among the payers to ensure the proper assignment of the payer, benefit plan and pricing methodology for each service on a claim. NCTracks processes health care claims for about 70,000 enrolled DHHS providers who serve over 1 million North Carolina citizens. Providers

who are contracted by LME/MCOs to enroll and perform state funded DMH/DD/SAS services submit their claims to the LME/MCO.

Over the last several years, North Carolina has implemented a 1915(b)/(c) waiver that is statewide. Of note, North Carolina was approved for an 1115 SUD Demonstration waiver in 2019, that authorizes the state to receive federal financial participation (FFP) for the continuum of services to treat addiction to opioids and other substances, including services provided to Medicaid enrollees with a SUD who are short-term residents in residential and inpatient treatment facilities that meet the definition of an Institution for Mental Diseases (IMD).

All 100 counties are part of a catchment or service area covered by one of seven local management entities/managed care organizations (LME/MCOs) that assure the delivery of services that are of the appropriate intensity and duration for consumers with intellectual/developmental disabilities or mental health/substance use issues. Each LME/MCO contracts with providers, the majority of whom are nationally accredited, for specific services for specific populations; i.e., adults with a substance use disorder, children with a serious emotional disturbance, etc. In order for LME/MCOs to be eligible to receive categorical substance abuse block grant funds, the LME/MCO must assert and assure that the federally mandated priority populations be served; i.e., pregnant women with a substance use disorder, individuals injecting drugs, etc.

The table below illustrates number of individuals in need of SUD services based on prevalence percentages for each LME/MCO. It should be noted that these are total numbers in need and therefore an over-representation of the number of uninsured individuals in need of SUD care.

	July 2019 Population Estimates				**Persons in Need of SUD Services**				
LME/MCO	Ages 12-17	Ages 18-25	Ages 26+	Total	Ages 12-17 Prevalence = 3.63%	Ages 18-25 Prevalence = 12.25%	Ages 26+ Prevalence = 5.64%	Total Estimated Adults (18+) with SUD	Total Estimated Persons (12+) with SUD
Alliance Health	**161,719**	**222,427**	**1,255,731**	**1,639,877**	**5,870**	**27,247**	**70,823**	**98,071**	**103,941**
Cardinal Innovations	**257,237**	**339,136**	**2,151,283**	**2,747,656**	**9,338**	**41,544**	**121,332**	**162,877**	**172,214**
Eastpointe	**54,105**	**73,196**	**436,404**	**563,705**	**1,964**	**8,967**	**24,613**	**33,580**	**35,544**
Partners Behavioral Health	**80,735**	**106,666**	**700,032**	**887,433**	**2,931**	**13,067**	**39,482**	**52,548**	**61,605**
Sandhills Center	**90,255**	**133,548**	**744,137**	**967,940**	**3,276**	**16,360**	**41,969**	**58,329**	**61,605**

Trillium Health Resources	**103,529**	**189,779**	**980,466**	**1,273,774**	**3,758**	**23,248**	**55,298**	**78,546**	**82,304**
Vaya Health	**70,448**	**114,693**	**756,280**	**941,421**	**2,557**	**14,050**	**42,654**	**56,704**	**59,261**
State Total	**818,028**	**1,179,445**	**7,024,333**	**9,021,806**	**29,694**	**144,482**	**396,172**	**540,654**	**570,349**

The Division of MH/DD/SA Services and NC Medicaid require the LME/MCOs to annually complete a Needs and Gaps Analysis. DMH/DD/SAS and NC Medicaid each have performance agreements/contracts with LME/MCOs containing requirements for assessments of community need, provider capacity, gaps in services and strategic plans to address gaps. LME/MCOs gather information from consumers, family members, providers and other stakeholders about community and service needs and priorities. This Needs and Gaps Analysis is one part of a continuous assessment and action process with each component driving the focus of the next. Components include:

- Assess and study the LME/MCO's community to determine needs and providers to deliver services;
- Develop or update LME/MCO strategic plans to incorporate results from the service needs assessment and gaps analysis;
- Implement these strategic plans through local initiatives, quality improvement projects and other actions; and,
- Review and assess action steps taken and determine progress and challenges in meeting needs and adjusting resources to respond to gaps in services.

LME/MCOs complete and submit an Exception Request to DMH/DD/SAS if any service has less than 100% access and choice. These exception requests are reviewed by DMH/DD/SAS staff who will either approve or work with the LME/MCO to formulate strategies for meeting the needs. For example, although North Carolina has 74 opioid treatment programs, being a primarily rural state, there are areas that do not have the population density and prevalence of opioid use disorder to support an opioid treatment program. However, in order to better assure access to a site-based service that requires regular attendance and participation, Addictions staff have worked with several LME/MCOs to extend contracts to office-based opioid treatment practices (OBOTs). We are also in the process of determining the feasibility and legal authority to implement medication units. Medication units are brick and mortar programs that provide dosing of methadone and buprenorphine products under the license of the opioid treatment program. Other required clinical services are provided at the main site, but having the capability to dose in additional sites can reduce drive time for patients and improve consistent participation and retention.

For a complete report on all Medicaid and non-Medicaid services availability by service and LME/MCO, **please see the document titled Network Adequacy and Accessibility Analysis in the Attachments section.**

Services

Community integration/recovery support is an area that has been and will continue to be a focus of the state. The ability to obtain and sustain safe, affordable housing is one of the most significant challenges facing persons in the early stages of recovery. In addition, having meaningful work is integral to many individuals' recovery. The state has an ongoing contract with Oxford House, Inc. to provide housing for people in recovery and has set aside $100,000 for the support of statewide consumer housing through the Cross Area Service Program (CASP) Substance Abuse Services initiative. A substantial portion of block grant funds were utilized last fiscal year to support recovery housing (in addition to Oxford Houses). In that safe, affordable housing continues to be an area of need, the Division will work with LME/MCOs and providers to identify barriers that impede an individual's access to housing and employment.

Because of the strong association between substance use and trauma, the state will continue to emphasize trauma-informed care as well as the use of evidence-based practices in the treatment of substance use disorders. North Carolina supports a full continuum of substance abuse services including prevention, intervention, treatment and recovery for pregnant and parenting women and their families and women seeking custody of their child(ren). The Perinatal and Maternal Substance Use Initiative is composed of specialized programs for pregnant and parenting women with a substance related disorder and their children. These programs provide comprehensive, gender-responsive, substance abuse services that include, but are not limited to the following: screening, assessment, case management, outpatient substance abuse and mental health services, parenting skills, residential services, referrals for primary and preventative health care and referrals for appropriate interventions for their children. The children in these families benefit from various services, including those provided by the local health departments (pediatric care), early intervention programs, etc. The NC CASAWORKS for Families Residential Initiative is a collaborative project between the Division of MH/DD/SAS and the Division of Social Services. This Initiative supports eight comprehensive residential substance abuse programs for women receiving Work First cash assistance and their children. Emphasis will be placed on identifying and removing any barriers to accessing these services, increasing referrals and improving outcomes. Due to the increased use of prescription pain medications, the Division will emphasize improved access to and retention in opioid treatment programs for pregnant women.

Over the past several years, North Carolina, like many states, has experienced an increase in opioid and heroin use, misuse and overdose. In response, the state has developed strategies and implemented several initiatives to address the problem. The Opioid STR and SOR grants provided the opportunity to consolidate those efforts, as well as enhance and expand services and supports to meet the needs of the citizens of North Carolina. Given the impact on our state, the Governor and the Secretary of the Department of Health and Human Services have made this a top priority for

administration. Several sister agencies under DHHS that have current focus, initiatives or activities related to addressing the opioid crisis, in addition to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the SSA), include the Division of Public Health (DPH), the Division of Health benefits (NC Medicaid), the Office of Rural Health (ORH) and the Office of Emergency Medical Services (OEMS). The Attorney General's office is also highly involved. Epidemiologic data available from the Injury and Violence Prevention Branch, Injury Epidemiology and Surveillance Unit (NC DPH) show that prescription opioid poisoning deaths increased by 256 percent between 2000 and 2015 while deaths from heroin overdoses increased by 800 percent, indicating that the state, like the rest of the country, is facing a problem of epidemic proportions.

To combat the opioid crisis, the North Carolina Department of Health and Human Services worked with community partners to develop North Carolina's Opioid Action Plan (NC OAP). The NC OAP launched in June of 2017 and established thirteen data metrics to track and monitor the opioid epidemic. The opioid data dashboard is meant to provide integration and visualization of state and county-level metrics for stakeholders across NC to track progress towards reaching the goals outlined in NC OAP. For more information on the NC OAP visit: https://www.ncdhhs.gov/opioids. The table below is a replication of the data dashboard that can be found on the DHHS website.

Metric Summary Table: NC (Population: 10,383,620)

Metrics	Most Current Provisional Data		
	Time	Quarter	Year-To-Date
Reduce Deaths/ED Outcomes			
Number of unintentional opioid-related deaths to NC Residents (ICD-10)	2018 - Q4	387	1619
Number of ED visits that received an opioid overdose diagnosis (all intents)	2019 – Q2	1835	3405
Reduce Oversupply of Prescription Opioids			
Average rate of multiple provider episodes for prescription opioids, per 100,000 residents	2018 – Q4	22	
Number of opioid pills dispensed	2019 – Q1	107,666,000	107,666,000
Percent of patients with an opioid prescription receiving more than an average daily dose of 90+ MME of opioid analgesics	2019 – Q1	5	5
Percent of prescription days any patient had at least one opioid AND at least one benzodiazepine prescription on the same day	2019 – Q1	33	33
Reduce Diversion/Flow of Illicit Drugs			
Percent of opioid deaths involving heroin or fentanyl/fentanyl analogues	2018 – Q4	78	79
Number of acute hepatitis C cases	2019 – Q1	48	48
Increase Access to Naloxone			
Number of EMS naloxone administrations	2019 – Q2	3282	6214
Number of community naloxone reversals	2019 – Q2	1287	1837
Treatment and Recovery			
Number of buprenorphine prescriptions dispensed	2019 – Q1	181,440	181,440
Number of uninsured individuals and Medicaid beneficiaries with an opioid use disorder served by treatment programs	2019 – Q1	20,385	20,385
Number of certified peer support specialists (CPSS)	2019 – Q2	3637	3637

For detailed technical notes on these metrics and the Summary Table visit the 'How to Use / Tech Notes' area on the following website: https://injuryfreenc.shinyapps.io/OpioidActionPlan/. ED data may be suppressed in some counties when there are < 5 cases.

There are currently 74 opioid treatment programs in the state, of which approximately two-thirds are eligible to provide services to publicly-funded consumers. The Division will focus efforts on improving access, retention and outcomes specific to these programs. Please see in the Attachments section the ***North Carolina Opioid STR Needs Assessment*** for additional information specific to the opioid epidemic in North Carolina, as well as the ***Opioid STR Strategic Plan*** which identifies areas of focus and strategies for meeting identified needs.

Veterans and Military Families

North Carolina is home to a large number of active military, National Guard and Reserves, veterans, and military families, ranking fourth in the country on this criterion. In a recent study, the NC Institute of Medicine noted that 35% of North Carolinians have some relationship to the military. The number of reserve component members in the state sum up to 22,000. In 2018 in NC, there was a total of over 1112,000 individuals in the active military, with a total of over 728,000 Veterans and 190,896 dependents of service members living in this state. DMH/DD/SAS serves the needs of the military through the Governor's Working Group on Veterans, Service Members and Their Families, a project that it supports and funds through the SABG. The Governor's Working Group promotes evidence-based and best practices in the screening, assessment, and treatment of active duty, National Guard, reservists and veterans who served in the military and their families. Areas of focus include Veterans suicide, homelessness and resource and care coordination services through four regional network programs (NCServes).

State Epidemiological Outcomes Workgroup

The State Epidemiological Outcomes Workgroup (SEOW) was formed in 2005 with funding from the NC Strategic Prevention Framework/State Incentive Grant (SPF/SIG) and continues today. The SEOW is comprised of representatives from NC Department of Public Health, Injury and Violence Prevention Branch, NC Department of Public Instruction, Addiction Professionals of North Carolina and are awaiting the addition of a new lead evaluator. The SEOW meets regularly to identify needs and to develop data resources to assist with planning. The SEOW will also assist with the expansion of the bi-annual Youth Prevention Survey that was launched in 2017; provide enhancement of the data dashboard (NC-SUPPORT) or other data dashboards linking public data from various agencies with improved access to updated data; conduct continuous quality improvement checks on the state-wide prevention infrastructure; provide guidance on data-driven interventions to substance use prevention both within the PFS grant and the prevention Block Grant. The state will coordinate and collaborate with its partners to address tobacco and ENDs priorities, as well as their associated needs and gaps in substance abuse prevention services. In accordance with SABG guidelines outlined by SAMHSA for the 20% Primary Prevention Set-Aside, the substance abuse prevention system will continue to provide universal, selective and indicated prevention activities in school and community

settings. Providers are in the process of completing a mid-point needs assessment to reevaluate and determine substance use consumption, consequences, and intervening variables for every county in the state. As a part of this mid-point "check-in", populations at greatest risk are reassessed and new and emerging needs are identified, and strategies prioritized to reach those populations.

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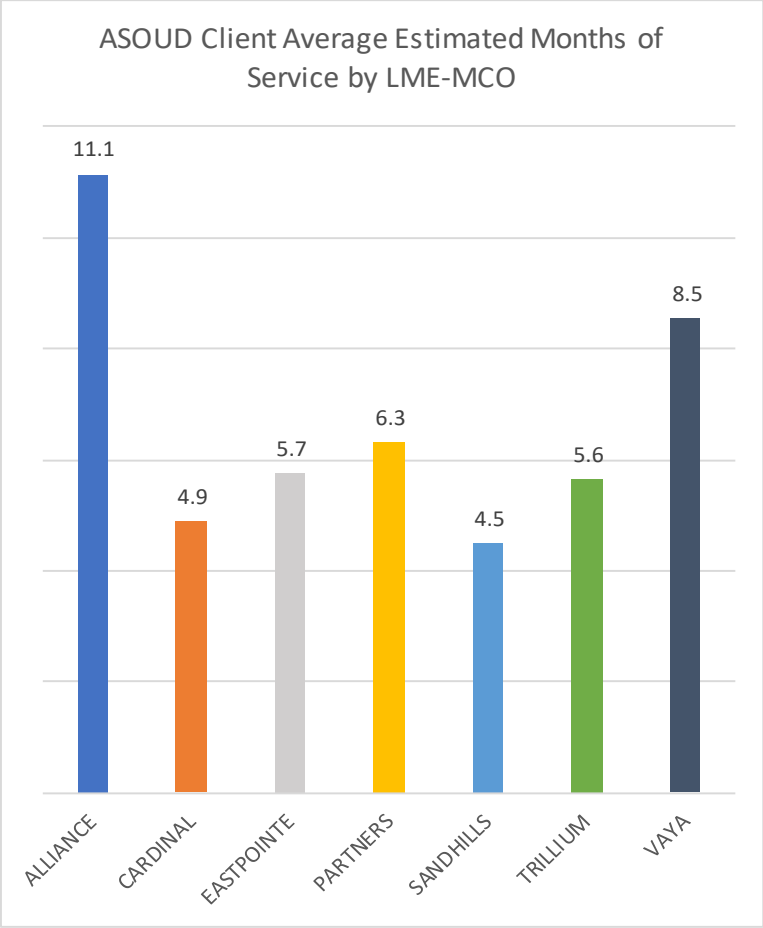
As stated above, with the influx of funds to address the opioid crisis, new providers have been credentialed to provide SUD treatment and recovery services. Additional work will continue to focus on areas of the state that are under-served. Some of these areas do not have the population to support an opioid treatment program; we are therefore attempting to better engage "non-traditional" providers such as office-based opioid treatment practices, FQHCs and other community health providers. We have implemented an "ECHO for MAT" initiative that particularly targets waivered physicians not currently prescribing or not prescribing to their limit in an effort to improve access to care in our more rural areas. Some of these practices, such as the FQHCs, serve not only individuals with an opioid use disorder, but other/all SUDs. If Medicaid expansion is successful, we expect settings such as this will be optimal locations for individuals because both behavioral health and physical health needs can be addressed at the same location.

Retention in Care

Data has long supported that the longer individuals are involved in care, the better their outcomes. As part of the data collection efforts specific to the Opioid grants, we have begun tracking retention in treatment at various levels; at the LME/MCO level as aggregated and reported by service; by provider or provider type. Patient-level data is also available. The table below illustrates retention by LME/MCO specifically for those individuals being served through the SOR grant. Data utilized to create this chart show that the LME/MCOs that have more strongly promoted and supported medication assisted treatment have higher or better retention in care. **The full report, titled DMH/DD/SAS Opioid and STR/SOR Grant Service Level Report, which is produced on a monthly basis can be found in the Attachments section.**



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Quality

The Division assures quality in several ways. Monitoring is conducted annually to determine adherence to SABG standards, rules and policies, both at the LME/MCO level, as well as the provider level. During these same annual SABG monitoring visits, clinical monitoring is also conducted. Charts are reviewed to determine if comprehensive clinical assessments are conducted, that individuals are assessed for and provided the appropriate ASAM level of care and that evidence-based practices are utilized appropriately. This is in addition to clinical, programmatic and fiscal monitoring conducted by the LME/MCOs.

North Carolina also still conducts independent peer reviews annually, although the majority of SABG-funded providers are nationally accredited. Each year, specific services are identified for both adolescents and adults, and providers of those services are selected based on specific criteria, such as volume of billed services, proximity to other "like" providers, geographic location, etc. Peer reviewers undergo training and then review each other's programs. In addition to a standardized review, there is much opportunity for sharing of best practices, challenges, etc. Beginning next fiscal

year, results will be aggregated and shared with all providers and LME/MCOs to function more as a learning lab of sorts and better disseminate this information.

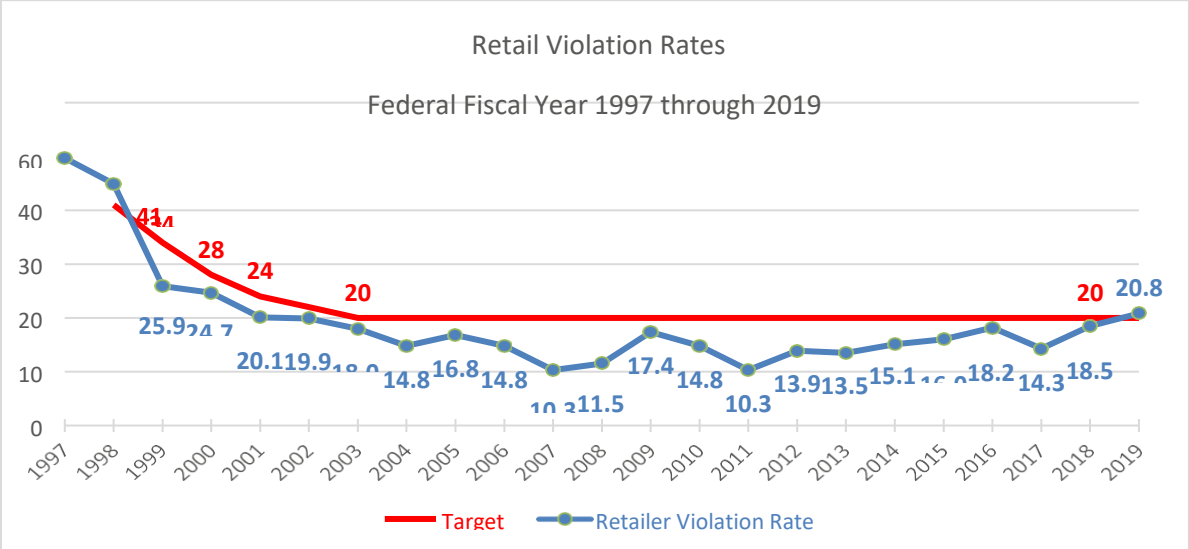
A portion of the SABG funds will be specifically dedicated towards training the workforce on ASAM. We chose to focus on ASAM and medication-assisted treatment, as a means to not only improve the knowledge of clinicians and other medical practitioners, but to also improve the awareness and acceptance of medication-assisted treatment as the evidence-based practice for opioid use disorders. We believe this training will improve level of care determination, but will also improve the concept of "multiple pathways to recovery" and lessen the divide between practitioners who previously espoused solely abstinence-based theory.

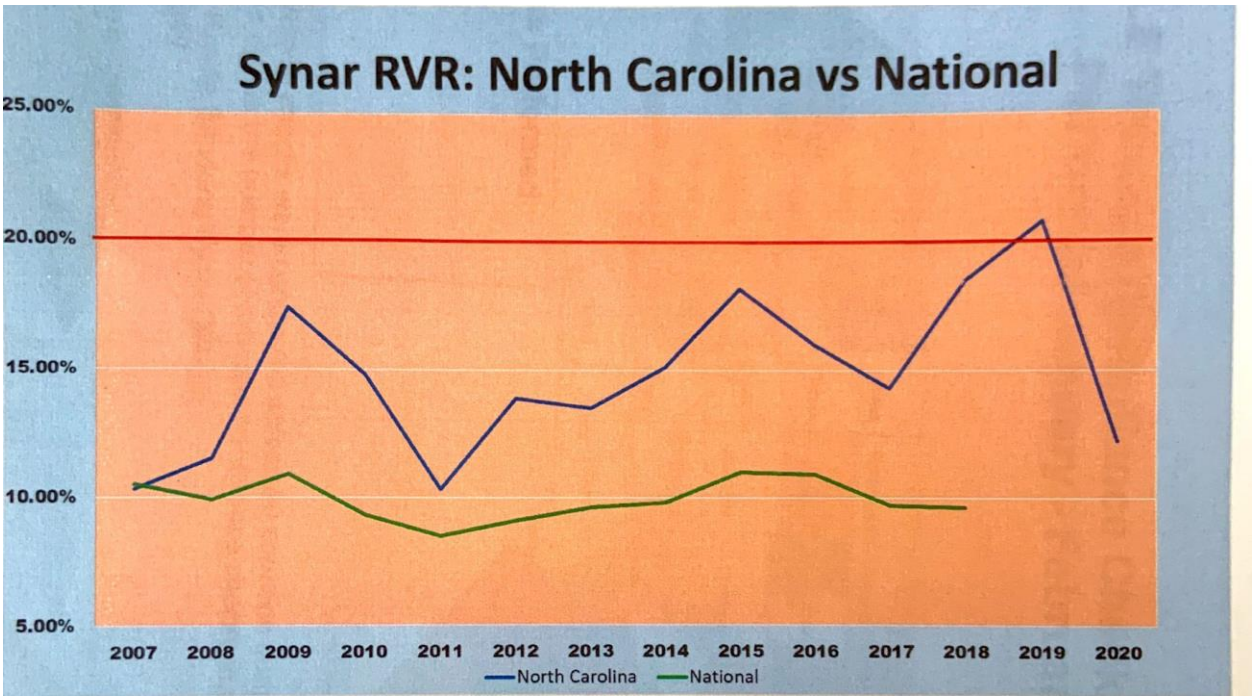
Awareness

In addition to the training mentioned above, North Carolina is contemplating additional ways to assure individuals are aware of the services available to them. This has, and continues to be, a function of the LME/MCOs. Some advertise through billboards, social media, radio, etc., but we do not believe this is sufficient because the numbers of calls received by the LME/MCOs has decreased over the past several years. Media campaigns have been a focus of the prevention funds through the Opioid STR grant, which has been quite successful based on the number of viewers. We believe these types of campaigns generate awareness and reduce stigma, thereby increasing the likihood individuals will seek help.

Primary Prevention Unmet Needs

Primary prevention identified lowering the state tobacco retail violation rate (RVR) as the priority unmet need, as North Carolina has been close to and/or over the SAMHSA threshold rate of 20% in 2016, 2018 and 2019 and higher than the national weighted average RVR since 2008. In federal fiscal year (FFY) 2019, the annual Synar Survey was conducted between February and April 2018 by two private contractors surveying a total of 803 tobacco retailers which resulted in a **20.8**% retailer violation rate (RVR).





In addition to the Synar Survey, the North Carolina-based office of the Food and Drug Administration (FDA) program also conducts tobacco compliance checks. Local law enforcement and ALE are required to chaperone these compliance checks per N.C. GS 14-313(B). FDA primarily focuses on emerging tobacco products such as e-cigarettes, vapors and cigars. According to the FDA, between July 2018-June 2019, the North Carolina FDA team conducted:

- 3,113 tobacco compliances checks resulting in 870 issued violations from the FDA.
- Out of the 3,113 compliance checks, 757 were emerging (e-cigarette, vapor) products (**24% violation rate**)
- 113 out of 3,113 were single cigarettes, smokeless tobacco and packs of cigarettes violations (**3.62% violation rate**).

Critical Gaps

From 2014 to early 2019, Alcohol Law Enforcement did not conduct any compliance checks resulting in citations to tobacco retailers in violation of selling tobacco products to minors. North Carolina also contracted the same vendor to conduct the annual Synar survey for over twenty years despite the need to update and revise protocols to include age testing and recruiting of additional minors to reflect racially and ethnically diverse areas in North Carolina. In addition, prior to April 2018, many direct service prevention providers did not conduct comprehensive tobacco merchant outreach and education. As a result, some of these factors may have contributed to the higher RVR rates in FFY 2016, 2018 and 2019.

Addressing Gaps-Compliance Checks

DMH/DD/SAS and the Division of Public Health (DPH) requested funding for tobacco compliance checks. In July 2018, the North Carolina Generally Assembly approved a reoccurring budget of $300,000 for these compliance checks. DMH/DD/SAS uses these funds to contract with the Department of Public Safety (DPS) Alcohol Law Enforcement (ALE) to enforce N.C G.S 14-313(B), the youth access to tobacco law. As a result of numerous meetings between DMH and Prevention leadership and Alcohol Law Enforcement leadership, written warnings were issued by ALE between January-February 2019 during a period of chaperoned FDA compliance checks.

- ALE completed a total of 384 compliance checks resulting in 139 written warnings.
- Between April 2019-June 2019, ALE conducted 139-90-day follow-up compliance checks resulting in 25 citations/arrests.
- ALE will follow-up with the 78 stores out of compliance during the FFY20 Synar survey and issue citations if stores continue to sell to minors.

In total during State Fiscal Year 2019, it's estimated that 31% of tobacco retailers had an ALE and/or FDA compliance check involving a minor.

Addressing Gaps- Synar Survey protocols

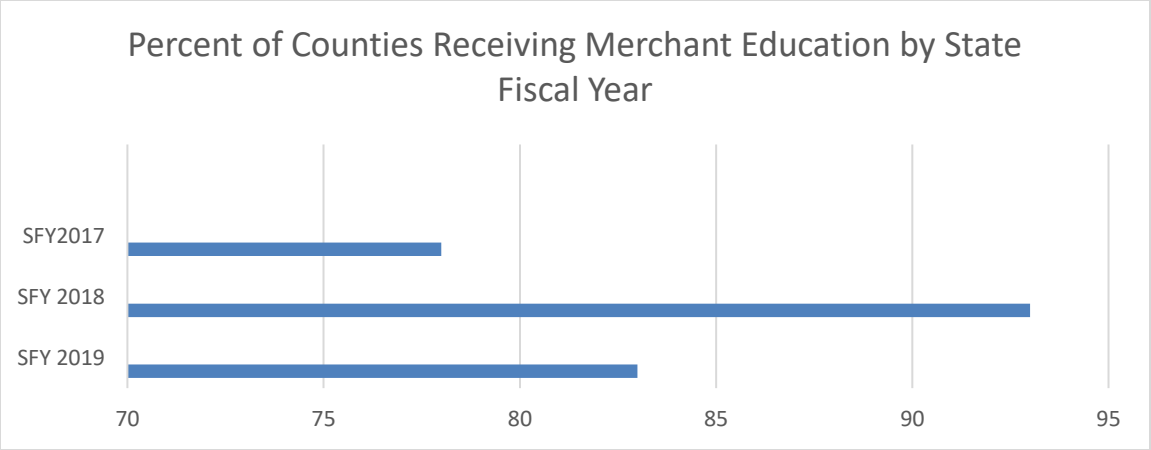
In October 2018, DMH/DD/SAS contracted with JBS International, a national Synar expert for-profit organization to improve NC Synar program and survey procedures. Between October 2018-April 2019, DMH/DD/SAS worked with JBS, Governor's Institute and ALE to make the following changes to the Synar program including, but not limited to:

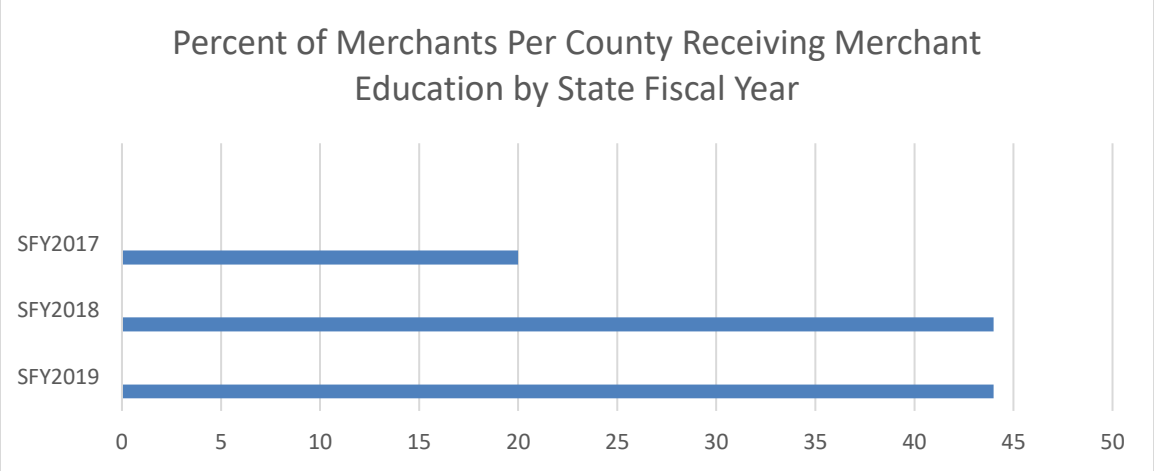
- Conducting a coverage study to ensure retail list coverage rate of NC's tobacco retailer list was at least 80% per SAMHSA requirements. (Note: The North Carolina retail list coverage rate was 87%.). This allowed ALE officers to utilize a list rather than an area (map) frame.
- ALE agreed to conduct the FFY20 annual Synar compliance checks
- Annual Synar survey protocols were adjusted to reflect the following changes:
    - Survey design went from an area to a list frame,
    - Minors were required to age test to at 16 years of age for the survey,
    - Minors were instructed not to carry their state issued ID during the survey,
    - ALE recruited at least 2 minors for every ALE district (approximately 18 total minors)
    - Tobacco products requested during the survey were limited to traditional tobacco products (cigarettes and smokeless tobacco).

Addressing Gaps-Merchant Education

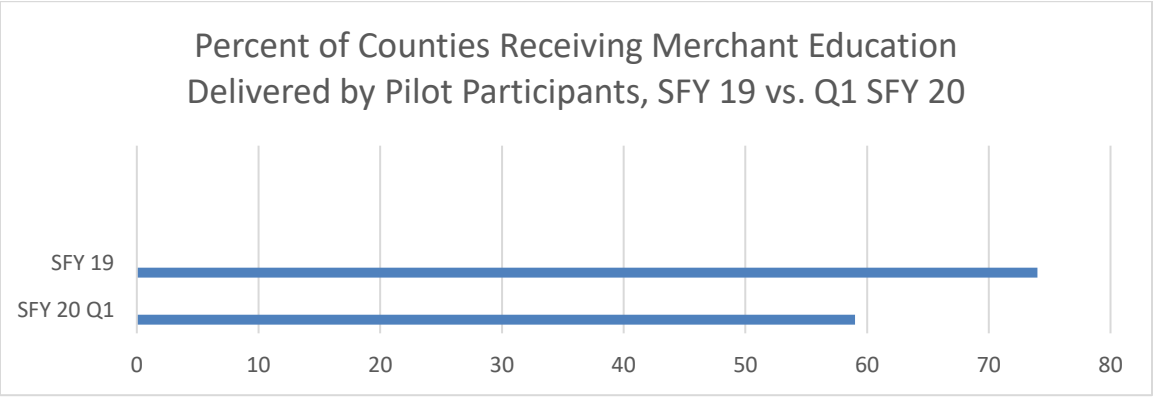
In response, the NC primary prevention office asked direct service prevention providers to expand their tobacco merchant education efforts by:

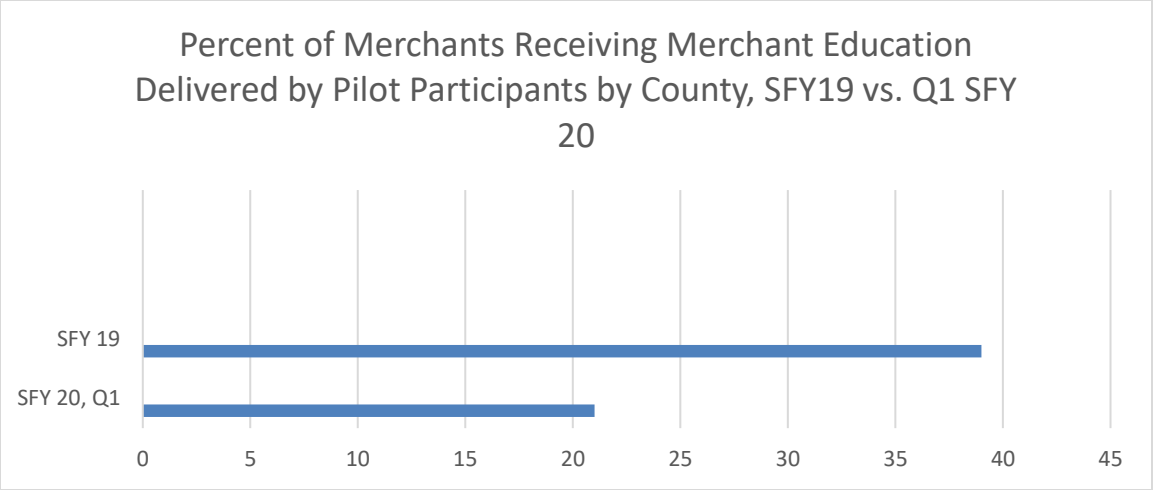
- Increasing the number of merchant education visits and coverage by county. The number of counties receiving merchant education increased from SFY 2017 to SFY 2018, but the percentage of merchants reached per county stayed the same from SFY 2018 to SFY 2019. As a result in SFY20, DMH asked direct service prevention providers to visit merchants only twice per fiscal year and to reach additional retailers (versus going to the same merchant multiple times).





- Encouraging providers (who self-selected to participate in a pilot study) to visit at least 90% of the tobacco retailers in their counties and/or census tract, neighborhood from July 1-September 30, 2019. Those receiving pilot funds reached almost as many counties and merchants in three months as they did in a full year without pilot funds.





- Encouraging providers to expand upon merchant education and to conduct tobacco purchase surveys with a younger looking 18-year-olds and to share results where retailers "sold" products with local law enforcement and ALE officers from July 1-September 30, 2019.

Initial Success

During FFY 20 Synar Survey from July to September 2019, 622 survey compliance checks were completed by DPS ALE agents. Out of the 622 survey compliance checks, 78 retailers were out of compliance, resulting in an unofficial RVR of **12.2%.** This is well below the 20% threshold set by SAMHSA and below the 20.8% retailer violation rate in the previous year's survey. Despite this initial success, there is additional work to be done to continue the positive progress made during this survey period.

Next Steps

The most recent FFY20 Synar Survey indicates that additional education and outreach needs to occur to encourage tobacco retailers to ask for an ID, appropriately check the ID and to not sell tobacco products to anyone under 18.

- Eighty-three (83%) percent (520/622) of the clerks asked for an ID, but in some cases still sold tobacco products.
- Sixteen (16%) percent (102/622) of the clerks did not ask for an ID. Of those not asking for an ID, 64.7% sold products to a minor.

The FFY20 Synar survey also demonstrated that gas stations, tobacco outlets and grocery stores are more likely to sell tobacco products to minors.

Continued collaboration and partnerships need to occur in FFY 21 to ensure continued law enforcement commitment to conducing more compliance checks resulting in citations to tobacco retailers in violation of the youth access to tobacco law. DMH would also like to see increased effort in building statewide partnerships to advocate for tobacco licensing. Merchant education efforts need to place more emphasis on encouraging retailers in gas stations, tobacco outlets and grocery stores to ask for and check IDs and not to sell tobacco products to minors. Finally, future Synar survey efforts should begin addressing the e-cigarette epidemic by testing retail compliance with ENDS products, as demonstrated by the NC FDA compliance check violation rates. North Carolina is

currently considering a pilot e-cigarette compliance check initiative with some of its discretionary prevention grant funding.

Step 2: Identify the unmet service needs and critical gaps within the current system

Populations and Prevalence

With a population estimate of 10,524,548 residents for 2019, North Carolina has the ninth largest population among 50 states, ranking 13th in population change between 2010-2018 (https://www.census.gov/data/tables/time-series/popest/2010s-national-total.html). Adults make up about 80 percent (8,203,778) of the total population, of which approximately 540,654 are in need of services for a substance use disorder based on the prevalence estimate of 6.59 percent. Youth aged 12 to 17 make up almost ten percent of the population. Based on the prevalence estimate of 3.63% for the state, North Carolina had a total of nearly 30,000 youth with substance use needs in 2019. (population: NC Office of State Budget and Management (NC OSBM), State Demographer's Office, https://www.osbm.nc.gov/demog/county-projections.)

The table below illustrates the number of North Carolina residents in need of SUD services by age range, with prevalence percentages derived from the National Surveys on Drug Use and Health, 2016 and 2017, published 11/28/18.

July 2019 Population Estimates				**Persons in Need of SUD Services**				
Ages 12-17	Ages 18-25	Ages +26	Total (Ages 12+)	Ages 12-17 Prevalence = 3.63%	Ages 18-25 Prevalence = 12.25%	Ages 26+ Prevalence = 5.64%	Total Estimated Adults (18+) with SUD	Total Estimated Persons (12+) with SUD
818,028	1,179,445	7,024,333	9,021,806	29,694	144,482	396,172	540,654	570,349

NC Substance Abuse Prevalence Rates Source: *SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2016 and 2017, published 11/28/18, Downloaded 1/18/19. Table 23, Substance Use Disorder in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUHs. Prevalence rate in NC for adolescents (ages 12-17) is 3.63%. Prevalence for adults (ages 18-25) is 12.25% and for adults (ages 26+) is 5.64%. Total (age 12+) = 6.27%, Total (age 18+) = 6.54%. Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse in the 4th edition of DSM-IV.*

(https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaePercentsExcelCSVs2017/NSDUHsaePercents2017.pdf).

US Substance Use Disorder Prevalence Rates Source: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2017, published 11/28/18, Downloaded 1/18/19. Table 5.9B, SUD in Past Year among Persons Aged 12 or Older, by Age Group and Geographic and Socioeconomic Characteristics: Percentages 2016 and 2017. Prevalence rate in the US for adolescents (ages 12-17) is 4.0%, 4.2% for those with Medicaid/CHIP, and 3.4% for those with no health insurance. Prevalence rates for adults (ages 18-25)

is 14.8%, 13.2% for those with Medicaid/CHIP, and 13.5% for those with no health insurance. Prevalence rates for adults (ages 26+) is 6.4%, 9.4% for those with Medicaid, and 10.4% for those with no health insurance. Prevalence rates for all adults (ages 18+) is 7.6%, 10.2% for those with Medicaid/CHIP, and 11.1% for those with no health insurance.

Population Data: NC Office of State Budget and Management (OSBM). Last updated: 12/5/18 Downloaded: 1/9/19 (https://www.osbm.nc.gov/demog/county-projections)

According to the National Survey on Drug Use and Health (NSDUH), 2015-2016, for those with a family income less than 139% of the federal poverty level and uninsured, prevalence of a substance use disorder for individuals between the ages of 18 to 64 was 12.5%. The prevalence estimate for those uninsured with annual incomes between 133 and 399% of federal poverty level and a substance use disorder was 13.4%. North Carolina is not a Medicaid expansion state, and based on a civilian noninstitutionalized population of 9,845,238, there are approximately 1,186,403 uninsured individuals in our state (Data Source: American Community Survey, 2017.). The same survey also reported that 16.1% of North Carolina residents had an income in the past 12 months that was below the poverty level. Given the number of people living in poverty (estimated at 1.1 million) in North Carolina and the above prevalence, it can be estimated that over 200,000 individuals between the ages of 18 and 64 are in need of treatment for a substance use disorder and have no insurance coverage. According to data from the Division's Client Data Warehouse (CDW), in state fiscal year 2018, 97,527 individuals received at least one service for a substance use disorder. Based on the estimate that slightly over 200,000 individuals are uninsured, this is a penetration rate of 48%.

Older populations. The NC Office of State Budget and Management estimates that nearly 26 percent of North Carolina's population will be over age 60 by the year 2030, an increase of almost 61 percent from 2012. Of the state's residents, 35.7 percent are now 50 or older, 22.6 percent are 60 or older, 11.1 percent are 70 or older, and 3.7 percent are 80 or older (https://www.osbm.nc.gov/demog/county-projections). The proportion of North Carolina's population that is 60 and older is growing more rapidly than other components of the population. By 2035 NC OSBM projects there will be more older adults (ages 65 and older) than there will be children (under age 18).

North Carolina has fully transitioned to a multi-payer Medicaid Management Information System for the NC Department of Health and Human Services, called NCTracks. NCTracks was the largest, most complex IT project in state history and was the first public multi-payer system in the United States. NCTracks is used by the Division of Health Benefits (NC Medicaid), the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the Division of Public Health (DPH). Providers enrolled in NC Medicaid, DMH/DD/SAS and DPH health plans submit claims for payment of covered health care services through the NCTracks Provider Portal. NCTracks coordinates processing among the payers to ensure the proper assignment of the payer, benefit plan and pricing methodology for each service on a claim. NCTracks processes health care claims for about 70,000 enrolled DHHS providers who serve over 1 million North Carolina citizens. Providers

who are contracted by LME/MCOs to enroll and perform state funded DMH/DD/SAS services submit their claims to the LME/MCO.

Over the last several years, North Carolina has implemented a 1915(b)/(c) waiver that is statewide. Of note, North Carolina was approved for an 1115 SUD Demonstration waiver in 2019, that authorizes the state to receive federal financial participation (FFP) for the continuum of services to treat addiction to opioids and other substances, including services provided to Medicaid enrollees with a SUD who are short-term residents in residential and inpatient treatment facilities that meet the definition of an Institution for Mental Diseases (IMD).

All 100 counties are part of a catchment or service area covered by one of seven local management entities/managed care organizations (LME/MCOs) that assure the delivery of services that are of the appropriate intensity and duration for consumers with intellectual/developmental disabilities or mental health/substance use issues. Each LME/MCO contracts with providers, the majority of whom are nationally accredited, for specific services for specific populations; i.e., adults with a substance use disorder, children with a serious emotional disturbance, etc. In order for LME/MCOs to be eligible to receive categorical substance abuse block grant funds, the LME/MCO must assert and assure that the federally mandated priority populations be served; i.e., pregnant women with a substance use disorder, individuals injecting drugs, etc.

The table below illustrates number of individuals in need of SUD services based on prevalence percentages for each LME/MCO. It should be noted that these are total numbers in need and therefore an over-representation of the number of uninsured individuals in need of SUD care.

	July 2019 Population Estimates				**Persons in Need of SUD Services**				
LME/MCO	Ages 12-17	Ages 18-25	Ages 26+	Total	Ages 12-17 Prevalence = 3.63%	Ages 18-25 Prevalence = 12.25%	Ages 26+ Prevalence = 5.64%	Total Estimated Adults (18+) with SUD	Total Estimated Persons (12+) with SUD
Alliance Health	**161,719**	**222,427**	**1,255,731**	**1,639,877**	**5,870**	**27,247**	**70,823**	**98,071**	**103,941**
Cardinal Innovations	**257,237**	**339,136**	**2,151,283**	**2,747,656**	**9,338**	**41,544**	**121,332**	**162,877**	**172,214**
Eastpointe	**54,105**	**73,196**	**436,404**	**563,705**	**1,964**	**8,967**	**24,613**	**33,580**	**35,544**
Partners Behavioral Health	**80,735**	**106,666**	**700,032**	**887,433**	**2,931**	**13,067**	**39,482**	**52,548**	**61,605**
Sandhills Center	**90,255**	**133,548**	**744,137**	**967,940**	**3,276**	**16,360**	**41,969**	**58,329**	**61,605**

Trillium Health Resources	**103,529**	**189,779**	**980,466**	**1,273,774**	**3,758**	**23,248**	**55,298**	**78,546**	**82,304**
Vaya Health	**70,448**	**114,693**	**756,280**	**941,421**	**2,557**	**14,050**	**42,654**	**56,704**	**59,261**
State Total	**818,028**	**1,179,445**	**7,024,333**	**9,021,806**	**29,694**	**144,482**	**396,172**	**540,654**	**570,349**

The Division of MH/DD/SA Services and NC Medicaid require the LME/MCOs to annually complete a Needs and Gaps Analysis. DMH/DD/SAS and NC Medicaid each have performance agreements/contracts with LME/MCOs containing requirements for assessments of community need, provider capacity, gaps in services and strategic plans to address gaps. LME/MCOs gather information from consumers, family members, providers and other stakeholders about community and service needs and priorities. This Needs and Gaps Analysis is one part of a continuous assessment and action process with each component driving the focus of the next. Components include:

- Assess and study the LME/MCO's community to determine needs and providers to deliver services;
- Develop or update LME/MCO strategic plans to incorporate results from the service needs assessment and gaps analysis;
- Implement these strategic plans through local initiatives, quality improvement projects and other actions; and,
- Review and assess action steps taken and determine progress and challenges in meeting needs and adjusting resources to respond to gaps in services.

LME/MCOs complete and submit an Exception Request to DMH/DD/SAS if any service has less than 100% access and choice. These exception requests are reviewed by DMH/DD/SAS staff who will either approve or work with the LME/MCO to formulate strategies for meeting the needs. For example, although North Carolina has 74 opioid treatment programs, being a primarily rural state, there are areas that do not have the population density and prevalence of opioid use disorder to support an opioid treatment program. However, in order to better assure access to a site-based service that requires regular attendance and participation, Addictions staff have worked with several LME/MCOs to extend contracts to office-based opioid treatment practices (OBOTs). We are also in the process of determining the feasibility and legal authority to implement medication units. Medication units are brick and mortar programs that provide dosing of methadone and buprenorphine products under the license of the opioid treatment program. Other required clinical services are provided at the main site, but having the capability to dose in additional sites can reduce drive time for patients and improve consistent participation and retention.

For a complete report on all Medicaid and non-Medicaid services availability by service and LME/MCO, **please see the document titled Network Adequacy and Accessibility Analysis in the Attachments section.**

Services

Community integration/recovery support is an area that has been and will continue to be a focus of the state. The ability to obtain and sustain safe, affordable housing is one of the most significant challenges facing persons in the early stages of recovery. In addition, having meaningful work is integral to many individuals' recovery. The state has an ongoing contract with Oxford House, Inc. to provide housing for people in recovery and has set aside $100,000 for the support of statewide consumer housing through the Cross Area Service Program (CASP) Substance Abuse Services initiative. A substantial portion of block grant funds were utilized last fiscal year to support recovery housing (in addition to Oxford Houses). In that safe, affordable housing continues to be an area of need, the Division will work with LME/MCOs and providers to identify barriers that impede an individual's access to housing and employment.

Because of the strong association between substance use and trauma, the state will continue to emphasize trauma-informed care as well as the use of evidence-based practices in the treatment of substance use disorders. North Carolina supports a full continuum of substance abuse services including prevention, intervention, treatment and recovery for pregnant and parenting women and their families and women seeking custody of their child(ren). The Perinatal and Maternal Substance Use Initiative is composed of specialized programs for pregnant and parenting women with a substance related disorder and their children. These programs provide comprehensive, gender-responsive, substance abuse services that include, but are not limited to the following: screening, assessment, case management, outpatient substance abuse and mental health services, parenting skills, residential services, referrals for primary and preventative health care and referrals for appropriate interventions for their children. The children in these families benefit from various services, including those provided by the local health departments (pediatric care), early intervention programs, etc. The NC CASAWORKS for Families Residential Initiative is a collaborative project between the Division of MH/DD/SAS and the Division of Social Services. This Initiative supports eight comprehensive residential substance abuse programs for women receiving Work First cash assistance and their children. Emphasis will be placed on identifying and removing any barriers to accessing these services, increasing referrals and improving outcomes. Due to the increased use of prescription pain medications, the Division will emphasize improved access to and retention in opioid treatment programs for pregnant women.

Over the past several years, North Carolina, like many states, has experienced an increase in opioid and heroin use, misuse and overdose. In response, the state has developed strategies and implemented several initiatives to address the problem. The Opioid STR and SOR grants provided the opportunity to consolidate those efforts, as well as enhance and expand services and supports to meet the needs of the citizens of North Carolina. Given the impact on our state, the Governor and the Secretary of the Department of Health and Human Services have made this a top priority for

administration. Several sister agencies under DHHS that have current focus, initiatives or activities related to addressing the opioid crisis, in addition to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the SSA), include the Division of Public Health (DPH), the Division of Health Benefits (NC Medicaid), the Office of Rural Health (ORH) and the Office of Emergency Medical Services (OEMS). The Attorney General's office is also highly involved. Epidemiologic data available from the Injury and Violence Prevention Branch, Injury Epidemiology and Surveillance Unit (NC DPH) show that prescription opioid poisoning deaths increased by 256 percent between 2000 and 2015 while deaths from heroin overdoses increased by 800 percent, indicating that the state, like the rest of the country, is facing a problem of epidemic proportions.

To combat the opioid crisis, the North Carolina Department of Health and Human Services worked with community partners to develop North Carolina's Opioid Action Plan (NC OAP). The NC OAP launched in June of 2017 and established thirteen data metrics to track and monitor the opioid epidemic. The opioid data dashboard is meant to provide integration and visualization of state and county-level metrics for stakeholders across NC to track progress towards reaching the goals outlined in NC OAP. For more information on the NC OAP visit: https://www.ncdhhs.gov/opioids. The table below is a replication of the data dashboard that can be found on the DHHS website.

Metric Summary Table: NC (Population: 10,383,620)

Metrics	Most Current Provisional Data		
	Time	Quarter	Year-To-Date
Reduce Deaths/ED Outcomes			
Number of unintentional opioid-related deaths to NC Residents (ICD-10)	2018 - Q4	387	1619
Number of ED visits that received an opioid overdose diagnosis (all intents)	2019 – Q2	1835	3405
Reduce Oversupply of Prescription Opioids			
Average rate of multiple provider episodes for prescription opioids, per 100,000 residents	2018 – Q4	22	
Number of opioid pills dispensed	2019 – Q1	107,666,000	107,666,000
Percent of patients with an opioid prescription receiving more than an average daily dose of 90+ MME of opioid analgesics	2019 – Q1	5	5
Percent of prescription days any patient had at least one opioid AND at least one benzodiazepine prescription on the same day	2019 – Q1	33	33
Reduce Diversion/Flow of Illicit Drugs			
Percent of opioid deaths involving heroin or fentanyl/fentanyl analogues	2018 – Q4	78	79
Number of acute hepatitis C cases	2019 – Q1	48	48
Increase Access to Naloxone			
Number of EMS naloxone administrations	2019 – Q2	3282	6214
Number of community naloxone reversals	2019 – Q2	1287	1837
Treatment and Recovery			
Number of buprenorphine prescriptions dispensed	2019 – Q1	181,440	181,440
Number of uninsured individuals and Medicaid beneficiaries with an opioid use disorder served by treatment programs	2019 – Q1	20,385	20,385
Number of certified peer support specialists (CPSS)	2019 – Q2	3637	3637

For detailed technical notes on these metrics and the Summary Table visit the 'How to Use / Tech Notes' area on the following website: https://injuryfreenc.shinyapps.io/OpioidActionPlan/. ED data may be suppressed in some counties when there are < 5 cases.

There are currently 74 opioid treatment programs in the state, of which approximately two-thirds are eligible to provide services to publicly-funded consumers. The Division will focus efforts on improving access, retention and outcomes specific to these programs. Please see in the Attachments section the ***North Carolina Opioid STR Needs Assessment*** for additional information specific to the opioid epidemic in North Carolina, as well as the ***Opioid STR Strategic Plan*** which identifies areas of focus and strategies for meeting identified needs.

Persons Who Inject Drugs (PWID)

The increased incidence of injection drug use, driven by the overdose crisis, can lead to sharing and reuse of syringes and injection supplies and the associated spread of bloodborne infections in communities with limited syringe access. Syringe exchange is an evidence-based public health strategy to reduce the spread of infections like HIV and hepatitis C and address health needs of people who inject drugs.

North Carolina legalized syringe exchange programs (SEPs) in July 2016 with the enactment of GS 90-113.27. The law gives broad guidance for establishing an SEP and outlines core health services SEPs must provide to participants, including: access to syringes and injection supplies at no cost and in quantities sufficient to prevent sharing and reuse (needs-based distribution); secure disposal of syringes and injection supplies; education on overdose prevention, communicable diseases, safer use and treatment for substance use disorder and mental health conditions; naloxone access (through the SEP or other local source); and referrals to substance use disorder and mental health treatment. The law requires SEPs to register with the Division of Public Health (DPH) and submit an annual report that includes data on provided services and impact.

The *STOP* (Strengthen Opioid Misuse Prevention) *Act* of 2017 changed the SEP law's funding language from a prohibition on the use of *all public funds* to a prohibition on the use of *state funds* for the purchase of syringes and injection supplies. SEP leaders report the law change has helped some local communities support SEP services, but regularly express interest in seeing remaining funding barriers lifted to allow partners greater flexibility in supporting and sustaining this important work.

In North Carolina, the rates of acute hepatitis B (HBV) and acute hepatitis C (HCV) have increased in the past five years. Newly diagnosed human immunodeficiency virus (HIV) increased between 2015 and 2016 in North Carolina as well. As transmission of these diseases can occur through injection drug use (IDU) practices, it is important to understand the epidemiology of these diseases in the state.

The number of acute HBV cases diagnosed in North Carolina in 2017 was 185, a rate of 1.8 cases per 100,000 population, compared to 94 cases in 2013 (1.4 per 100,000). The highest rates of newly diagnosed acute HBV occurred among the 35 to 44-year-old age group. This age group comprised 35% of the total acute HBV cases. In 2017, acute HBV diagnoses among White/Caucasian men and women comprised 70% of the total acute HBV, at rates of 2.4 and 1.6 per 100,000, respectively. The

highest rates of acute HBV in 2016 were among American Indian/Alaska Native women, a rate of 1.6 per 100,000. **In 2017, the use of injecting drugs was reported by 33% of people with acute HBV, which is likely underreported.** Acute HBV exposure through injection drug use has also been increasing since 2014 (14% in 2013 to 33% in 2017). The highest rates of acute HBV were among residents living in the western part of NC.

The number of acute HCV cases diagnosed in North Carolina in 2017 was 186 at a rate of 1.8 cases per 100,000 population, compared to 87 cases in 2013 (0.9 per 100,000). The highest rates of newly diagnosed acute HCV occurred among the 20 to 39-year-old age group. This age group comprised 52% of the total acute HCV cases. In 2017, acute HCV diagnoses among White/Caucasian men and women comprised 79% of the total acute HCV, at rates of 2.3 and 2.2 per 100,000, respectively. The highest rates of acute HCV in 2017 were among American Indian/Alaska Native men and women, a rate of 7.3 per 100,000. **In 2017, the use of injecting drugs was reported by 47% of people with acute HCV, which again is likely underreported. Acute HCV exposure through IDU has also been increasing since 2013 (34% in 2014 to 47% in 2017).** The highest rates of acute HCV were among residents living in the western part of NC.

There were 1,310 new diagnoses of HIV reported among the adult and adolescent (over 13 years old) population, at a rate of 15.9 cases per 100,000 population in 2017. This rate is a slight decrease from 2016, where 1,399 persons were newly diagnosed with HIV at a rate of 16.4 per 100,000 population. Men made up the highest proportion of newly diagnosed HIV (N=1,057; 81%) compared to women (N=253;19%). People between 20 and 29 years old had the highest rates of newly diagnosed HIV in 2017, comprising 41% (N=537) of the newly diagnosed population. Black/African Americans represented 65% (N=849) of new diagnoses, with a rate of 45.5 per 100,000. For adults and adolescents newly diagnosed with HIV in 2017, men who report sex with men (MSM), indicated in 64.5% of all cases; heterosexual transmission risk in 29.8%; **injection drug use (IDU) in 3.4%,** and MSM/IDU in 2.4%. The highest rates of HIV were among residents living in the central part of the state.[1]

Hepatitis A outbreaks are expanding nationwide. The Centers for Disease Control and Prevention (CDC) has received reports from multiple states of more than 3,700 cases of hepatitis A infections associated with person-to-person transmission during January 2017 through July 2018. Cases have occurred primarily among three risk groups**: (1) persons who use injection or non-injection drugs**; (2) persons experiencing homelessness; and (3) men who have sex with men (MSM). High hospitalization and death rates have been observed, highlighting the severe effect on patients and the need for strong coordination to prevent infections and connect people to care. North Carolina is also experiencing an outbreak of hepatitis A, though not of the same magnitude as some other states. A majority of cases reported in this outbreak are among MSM, and numerous cases have also been associated with drug use and/or homelessness. (https://www.drugabuse.gov/opioid-summaries-by-state/north-carolina-opioid-summary.)

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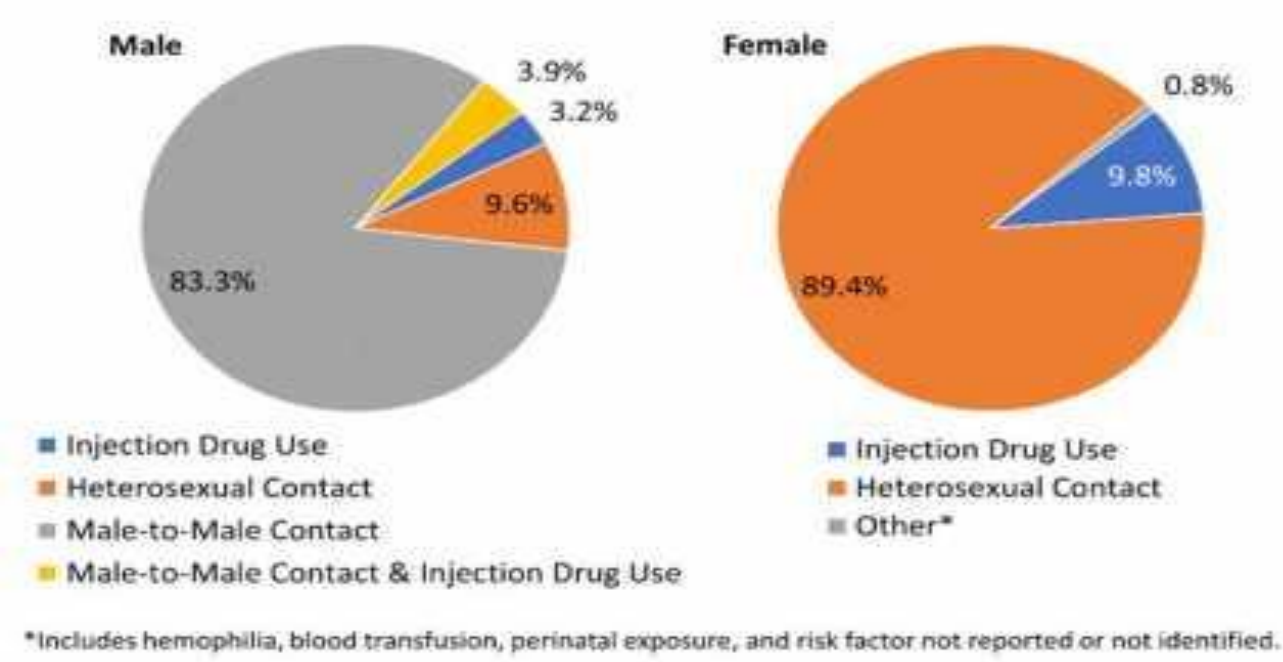
[1]*North Carolina HIV/STD/Hepatitis Surveillance Unit. (2018). 2017 North Carolina HIV/STD/Hepatitis Surveillance Report. North Carolina Department of Health and Human Services, Division of Public Health, Communicable Disease Branch. Raleigh, North Carolina.*

HIV Prevalence and HIV Diagnoses Attributed to Injection Drug Use[2]



In addition, acute hepatitis C virus (HCV) infections in North Carolina increased 228% and heroin-related deaths increased 884% between 2010 and 2015. The NC Department of Health and Human Services (DHHS) conducted a vulnerability assessment and identified eight rural western counties with high rates of acute HCV, chronic HCV, and opioid overdose fatalities. RTI International, the University of NC at Chapel Hill, NC DHHS, local health departments (LHD), and the NC Harm Reduction Coalition are partnering in response to the RFA ***"HIV, HCV and Related Comorbidities in Rural Communities Affected by Opioid Injection Drug Epidemics in the United States: Building Systems for Prevention, Treatment and Control"*** **t**o develop, implement, and evaluate sustainable strategies for combatting opioid-associated adverse outcomes in rural people who inject drugs. This grant, titled Mitigating the Outcomes Associated with the Injection Drug Use Epidemic in Southern Appalachia, will conduct 80 (10 per county) semi-structured interviews with PWID; begin recruiting PWID, local health departments, syringe service programs; and use baseline self-reported data and HCV and HIV testing results to describe the care cascade for HCV, HIV, and substance use disorders. Practice characteristics of primary care, emergency/urgent care, and behavioral health care professionals in all eight counties will be surveyed to determine awareness of and adherence to substance use, HCV and HIV screening guidelines, attitudes regarding implementation of syringe services programs, HCV care, and HIV care across practice settings. Informed by participants, identify

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[2]*National Institute on Drug Abuse; North Carolina Opioid Summary, Revised March 2019.*

health centers serving PWID, randomize implementation order, and train providers on prevention and treatment of HCV, HIV, and opioid overdoses. Assessing knowledge and practice patterns at baseline and 18 months after training (incentivized with continuing education units) will gauge training impact. Using follow-up surveys in Year 5, epidemiological surveillance, and data on PWID linked to services by bridge counselors and providers trained, the impact on each care cascade will be determined and findings will be disseminated.

This project will train health care providers to provide hepatitis C virus care and other services to people who inject opioids. It will also employ bridge counselors to link people who use opioids to services across different settings (e.g., local health departments, substance use disorder treatment programs) and establish syringe service programs in rural western North Carolina. If these activities are effective, they could be scaled up in rural areas across the state and reduce opioid-related morbidity and mortality.

Tuberculosis Services

As stated in Step 1, tuberculosis screening has been incorporated into the comprehensive clinical assessment tool and/or assessment screening process for a number of years in North Carolina. A sample screening tool with guidance instructions, was shared with LME/MCOs several years ago. LME/MCOs are responsible for assuring that contracted SABG providers administer this screening and take appropriate action if indicated. Each LME/MCO reports on Universal TB Screening, Testing, Referral and Case Management Services in its *Semi-Annual Compliance Reports* to the Division. These reports are reviewed by Division staff to determine/ascertain compliance and need for technical assistance.

Clinical monitoring by the Division, which is conducted annually, includes chart reviews to determine if individuals are screened for TB, and referred for testing if the screen is positive. The most recent clinical monitoring indicated that 93% of assessments reviewed included a TB screen. LME/MCOs that scored less than 100% were placed on a plan of correction, which requires them to address this finding with their SUD providers. On a more positive note, of those that screened positive, 100% were referred for testing.

As North Carolina has not expanded Medicaid, many individuals with SUD are not Medicaid eligible and are un- or under-insured. Many cannot afford basic health care, so providers typically refer individuals for TB testing to local health departments.

Veterans and Military Families

North Carolina is home to a large number of active military, National Guard and Reserves, veterans, and military families, ranking fourth in the country on this criterion. In a recent study, the NC Institute of Medicine noted that 35% of North Carolinians have some relationship to the military. The number

of reserve component members in the state sum up to 22,000. In 2018 in NC, there was a total of over 1112,000 individuals in the active military, with a total of over 728,000 Veterans and 190,896 dependents of service members living in this state. DMH/DD/SAS serves the needs of the military through the Governor's Working Group on Veterans, Service Members and Their Families, a project that it supports and funds through the SABG. The Governor's Working Group promotes evidence-based and best practices in the screening, assessment, and treatment of active duty, National Guard, reservists and veterans who served in the military and their families. Areas of focus include Veterans suicide, homelessness and resource and care coordination services through four regional network programs (NCServes).

State Epidemiological Outcomes Workgroup

The State Epidemiological Outcomes Workgroup (SEOW) was formed in 2005 with funding from the NC Strategic Prevention Framework/State Incentive Grant (SPF/SIG) and continues today. The SEOW is comprised of representatives from NC Department of Public Health, Injury and Violence Prevention Branch, NC Department of Public Instruction, Addiction Professionals of North Carolina and are awaiting the addition of a new lead evaluator. The SEOW meets regularly to identify needs and to develop data resources to assist with planning. The SEOW will also assist with the expansion of the bi-annual Youth Prevention Survey that was launched in 2017; provide enhancement of the data dashboard (NC-SUPPORT) or other data dashboards linking public data from various agencies with improved access to updated data; conduct continuous quality improvement checks on the state-wide prevention infrastructure; provide guidance on data-driven interventions to substance use prevention both within the PFS grant and the prevention Block Grant. The state will coordinate and collaborate with is partners to address tobacco and ENDs priorities, as well as their associated needs and gaps in substance abuse prevention services. In accordance with SABG guidelines outlined by SAMHSA for the 20% Primary Prevention Set-Aside, the substance abuse prevention system will continue to provide universal, selective and indicated prevention activities in school and community settings. Providers are in the process of completing a mid-point needs assessment to reevaluate and determine substance use consumption, consequences, and intervening variables for every county in the state. As a part of this mid-point "check-in", populations at greatest risk are reassessed and new and emerging needs are identified, and strategies prioritized to reach those populations.

Additionally, with state funds, North Carolina supports a behavioral health disparities initiative, for which 11 communities are receiving in depth training in identifying and addressing behavioral health disparities. North Carolina views this project as a way to develop and test strategies for effectively addressing the needs of disparate populations across the state, with the intention of developing the capacity and involvement of prevention providers to address behavioral health disparities statewide.

In addition, the SABG will also continue to provide treatment through activities outlined outside of the 20% Primary Prevention Activities. These will be provided to the priority groups identified by data, emphasizing the use of trauma-informed care and evidence-based practices. Division staff will continue to work with LME/MCOs, providers, individuals in recovery and their family members and

other stakeholders to further identify and prioritize areas of greatest need and strategize ways to reduce these gaps with the resources available.

Resources

North Carolina will continue to utilize available funds including the SABG, state dollars and federal discretionary grants, to better address the needs of individuals with substance use disorders. Program and fiscal staff now conduct quarterly "budget variance" calls with all seven LME/MCOs to discuss utilization of funds, particularly when it appears an LME/MCO is under-spending in certain areas. Although funds are limited, LME/MCOs are asked to address gaps – either in specific geographic locations or specifically identified services or types of services – by expanding their provider network and credentialing additional providers. For example, with the influx of funds targeted towards individuals with an opioid use disorder, the number of opioid treatment programs with a contract for public funds has increased substantially.

As mentioned earlier, North Carolina has been approved for an 1115 SUD Demonstration Waiver that will allow for reimbursement of SUD services in facilities with more than 16 beds. Additionally, Medicaid expansion is one of the three top priorities for the department. LME/MCOs are able to credential and contract with more Medicaid providers than state-funded providers because of funding; increasing the number of individuals eligible for Medicaid benefits would better assure the availability of more resources, as well as access to care. Although it is unknown at this point if Medicaid expansion will become a reality in NC in the next year or so, Medicaid transformation is underway. Much work has been done to develop standard and tailored plans that will better meet the needs of individuals with SUD.

Access to Care

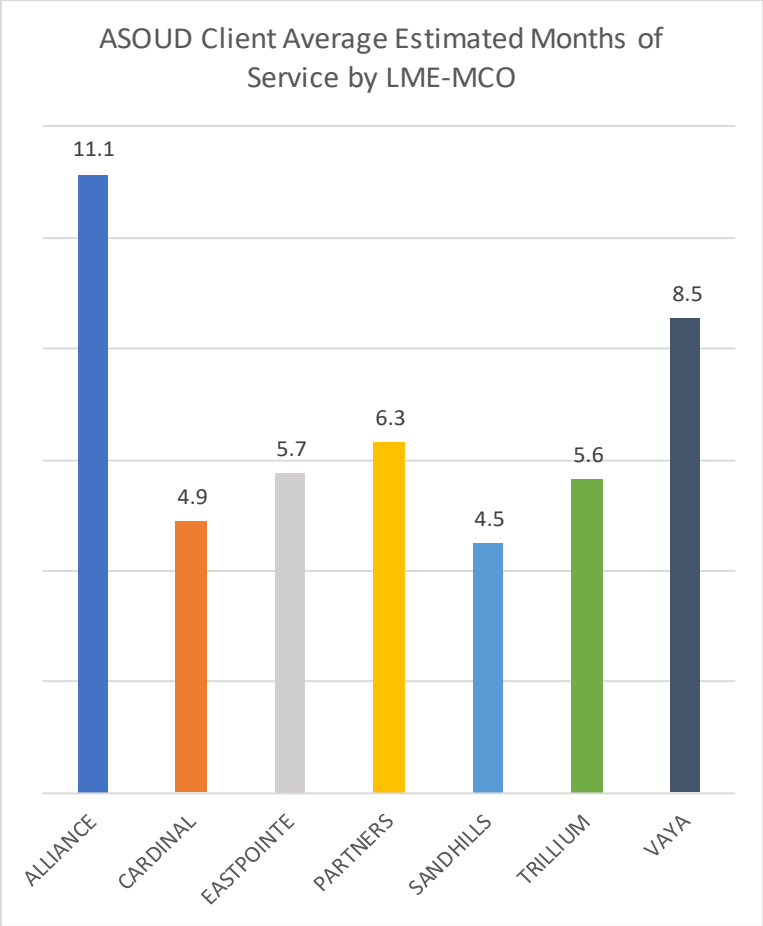
The Secretary of the Department of Health and Human Services has identified three (3) "super measures" for the LME/MCOs that the DMHDDSAS will monitor for adherence. One of these super measures is access to care. The Division has long required that LME/MCOs assure that individuals who contact them through their 24/7/365 access lines who are identified as in need of SUD treatment are provided an appointment with a community provider within 48 hours of the call. In other words, no SUD-related call is considered "routine;" all are classified as urgent or emergent. However, with the highlighting of this access to care standard as a super measure with the potential for monetary sanctions if a certain threshold is not met, it is expected that LME/MCOs will take appropriate actions to expand their network if services are not available in this timely manner. Staff on the Quality Management Team within the Division are monitoring the data specific to this standard and will report such to programmatic/clinical staff, particularly for any LME/MCO that does not meet or maintain this standard.

As stated above, with the influx of funds to address the opioid crisis, new providers have been credentialed to provide SUD treatment and recovery services. Additional work will continue to focus

on areas of the state that are under-served. Some of these areas do not have the population to support an opioid treatment program; we are therefore attempting to better engage "non-traditional" providers such as office-based opioid treatment practices, FQHCs and other community health providers. We have implemented an "ECHO for MAT" initiative that particularly targets waivered physicians not currently prescribing or not prescribing to their limit in an effort to improve access to care in our more rural areas. Some of these practices, such as the FQHCs, serve not only individuals with an opioid use disorder, but other/all SUDs. If Medicaid expansion is successful, we expect settings such as this will be optimal locations for individuals because both behavioral health and physical health needs can be addressed at the same location.

Retention in Care

Data has long supported that the longer individuals are involved in care, the better their outcomes. As part of the data collection efforts specific to the Opioid grants, we have begun tracking retention in treatment at various levels; at the LME/MCO level as aggregated and reported by service; by provider or provider type. Patient-level data is also available. The table below illustrates retention by LME/MCO specifically for those individuals being served through the SOR grant. Data utilized to create this chart show that the LME/MCOs that have more strongly promoted and supported medication assisted treatment have higher or better retention in care. **The full report, titled DMH/DD/SAS Opioid and STR/SOR Grant Service Level Report, which is produced on a monthly basis can be found in the Attachments section.**



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Quality

The Division assures quality in several ways. Monitoring is conducted annually to determine adherence to SABG standards, rules and policies, both at the LME/MCO level, as well as the provider level. During these same annual SABG monitoring visits, clinical monitoring is also conducted. Charts are reviewed to determine if comprehensive clinical assessments are conducted, that individuals are assessed for and provided the appropriate ASAM level of care and that evidence-based practices are utilized appropriately. This is in addition to clinical, programmatic and fiscal monitoring conducted by the LME/MCOs.

North Carolina also still conducts independent peer reviews annually, although the majority of SABG-funded providers are nationally accredited. Each year, specific services are identified for both adolescents and adults, and providers of those services are selected based on specific criteria, such as volume of billed services, proximity to other "like" providers, geographic location, etc. Peer reviewers undergo training and then review each other's programs. In addition to a standardized review, there is much opportunity for sharing of best practices, challenges, etc. Beginning next fiscal

year, results will be aggregated and shared with all providers and LME/MCOs to function more as a learning lab of sorts and better disseminate this information.

A portion of the SABG funds will be specifically dedicated towards training the workforce on ASAM. We chose to focus on ASAM and medication-assisted treatment, as a means to not only improve the knowledge of clinicians and other medical practitioners, but to also improve the awareness and acceptance of medication-assisted treatment as the evidence-based practice for opioid use disorders. We believe this training will improve level of care determination, but will also improve the concept of "multiple pathways to recovery" and lessen the divide between practitioners who previously espoused solely abstinence-based theory.

Awareness

In addition to the training mentioned above, North Carolina is contemplating additional ways to assure individuals are aware of the services available to them. This has, and continues to be, a function of the LME/MCOs. Some advertise through billboards, social media, radio, etc., but we do not believe this is sufficient because the numbers of calls received by the LME/MCOs has decreased over the past several years. Media campaigns have been a focus of the prevention funds through the Opioid STR grant, which has been quite successful based on the number of viewers. We believe these types of campaigns generate awareness and reduce stigma, thereby increasing the likihood individuals will seek help.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's **NBHQF**. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at **http://www.samhsa.gov/data/quality-metrics/block-grant-measures**. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,

etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

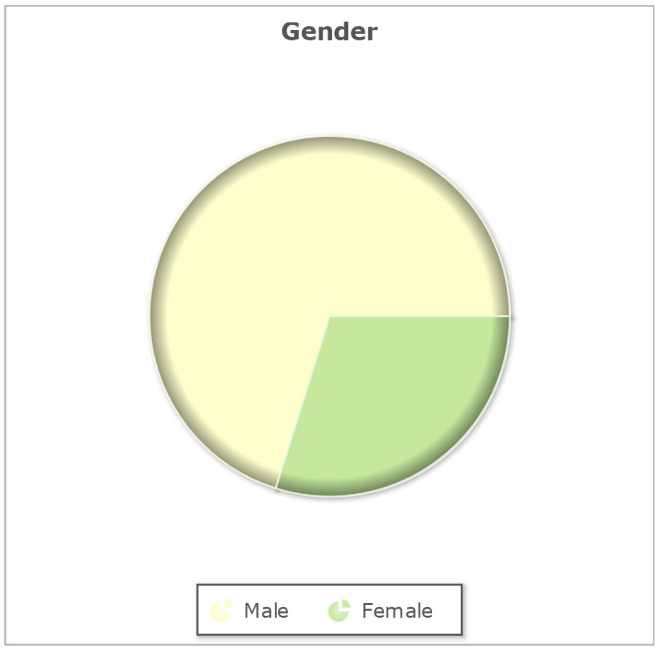
4. If not, what changes will the state need to make to be able to collect and report on these measures?
   Please indicate areas of technical assistance needed related to this section.

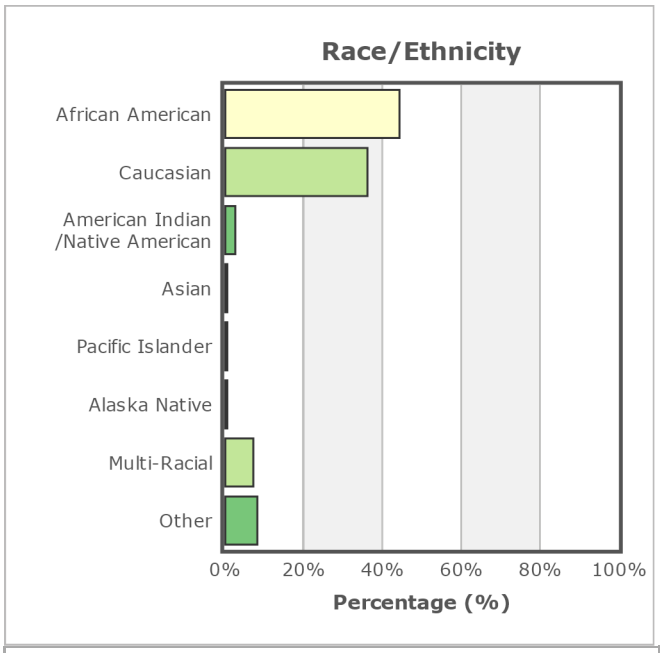
Footnotes:

NC-TOPPS Simple Query Report

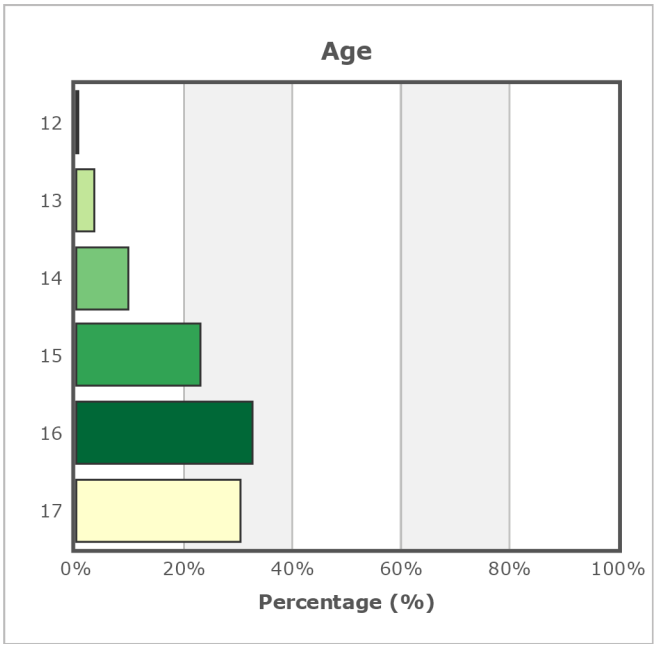
Alliance Health
Cardinal Innovations
Eastpointe
Partners Behavioral Health Management
Sandhills
Trillium Health Resources
Vaya Health
Adolescent Substance Use Disorder Consumers
Episode Completion Interviews started *Saturday, July 1, 2017* through *Saturday, June 30, 2018*
Number of Episode Completion Interviews: 1,056

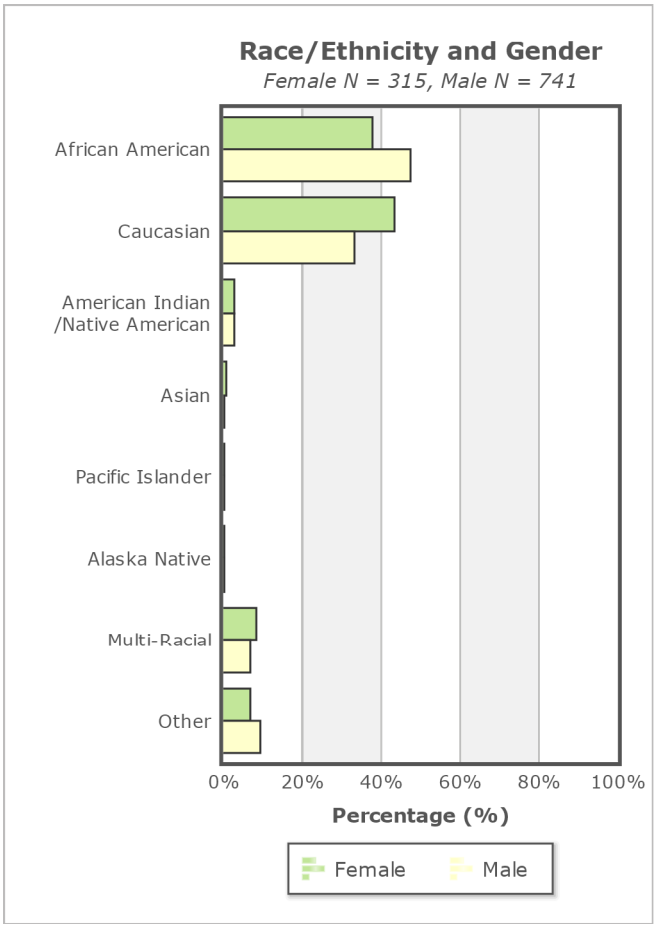
Demographics

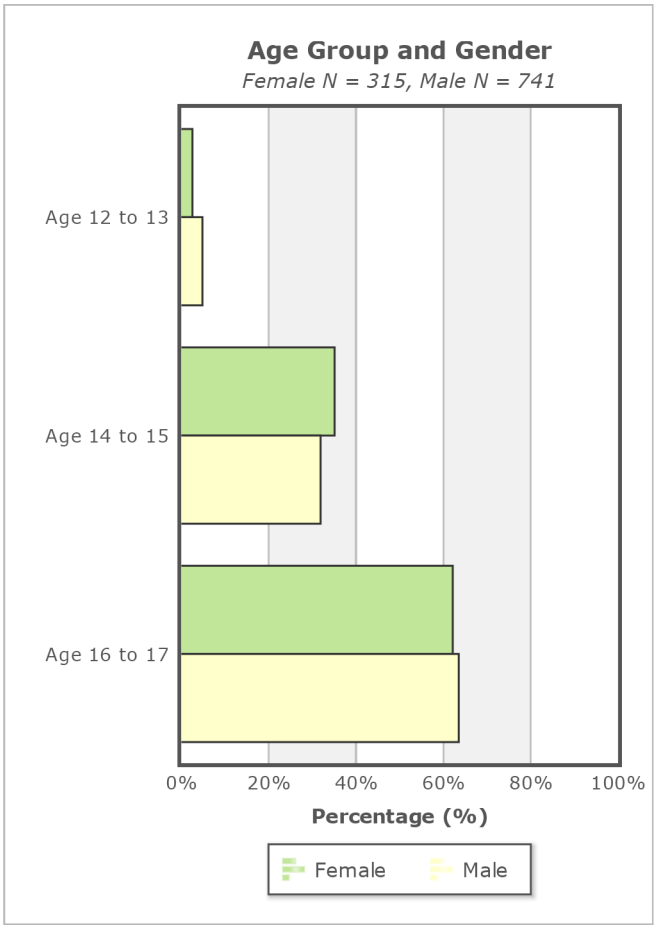




139 *(13.2%)* consumer(s) indicate that they are of Hispanic, Latino, or Spanish origin.


Age
12
13
14
15
16
17
0%
20%
40%
60%
80%
100%
Percentage (%)


Race/Ethnicity and Gender
Female N = 315, Male N = 741
African American
Caucasian
American Indian /Native American
Asian
Pacific Islander
Alaska Native
Multi-Racial
Other
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male


Age Group and Gender
Female N = 315, Male N = 741
Age 12 to 13
Age 14 to 15
Age 16 to 17
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male

Services

Periodic Services	Initial	EC
90832-90838 - Psychotherapy	23.1%	21.6%
90846 - Family Therapy without Patient	3.1%	3.5%
90847 - Family Therapy with Patient	10.2%	10.7%
90849 - Group Therapy (multiple family group)	4.5%	4.2%
90853 - Group Therapy (non-multiple family group)	15.2%	15.0%
H0004 - Behavioral Health Counseling - Individual Therapy	9.2%	9.8%
H0004 HQ - Behavioral Health Counseling - Group Therapy	6.7%	7.5%
H0004 HR - Behavioral Health Counseling - Family Therapy with Consumer	3.7%	3.8%
H0004 HS - Behavioral Health Counseling - Family Therapy without Consumer	0.3%	0.3%
YP831 - Behavioral Health Counseling (non-licensed provider)	0.0%	0.0%
YP832 - Behavioral Health Counseling - Group Therapy (non-licensed provider)	0.3%	0.3%
YP833 - Behavioral Health Counseling - Family Therapy with Consumer (non-licensed provider)	0.7%	0.8%
YP834 - Behavioral Health Counseling - Family Therapy without Consumer (non-licensed provider)	0.2%	0.2%
H0005 - Alcohol and/or Drug Group Counseling	10.2%	10.1%
YP835 - Alcohol and/or Drug Group Counseling (non-licensed provider)	1.7%	2.3%

Community Based Services	Initial	EC
H0015 - Substance Abuse Intensive Outpatient Program (SAIOP)	22.6%	23.0%
H2022 - Intensive In-Home Services (IIH)	14.9%	15.2%
H2033 - Multisystemic Therapy Services (MST)	10.8%	11.6%
H2035 - Substance Abuse Comprehensive Outpatient Treatment (SACOT)	0.5%	0.6%
YP630 - Individual Placement and Support (IPS) Supported Employment	0.0%	0.0%
H2023 U4 - Supported Employment	0.0%	0.0%
H2026 U4 - Ongoing Supported Employment	0.0%	0.1%

Facility Based Day Services	Initial	EC
H0035 - Mental Health - Partial Hospitalization	0.4%	0.3%
H2012 HA - Child and Adolescent Day Treatment	8.0%	9.0%

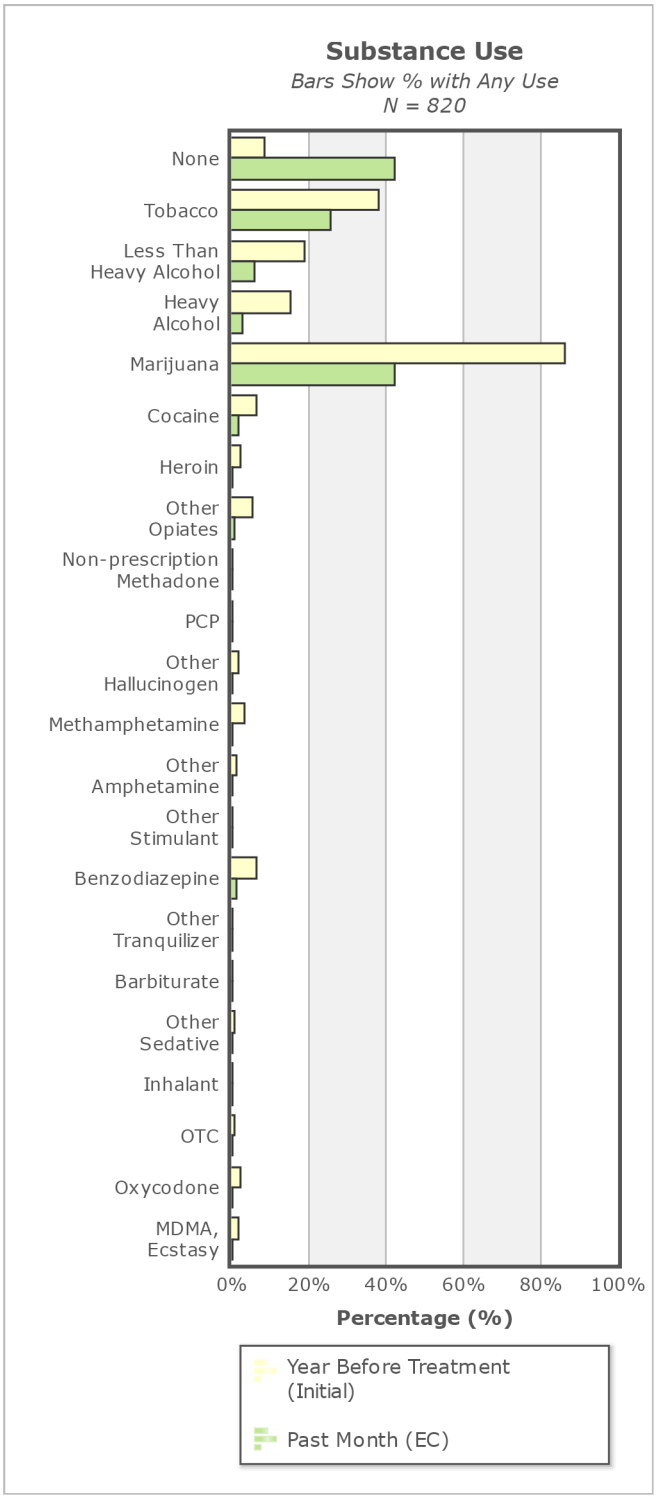
Residental Services	Initial	EC
H0013 - SA Medically Monitored Community Residential Treatment	2.5%	2.7%
H0019 - Behavioral Health - Long Term Residential	0.5%	0.9%
H2020 - Residential Treatment - Level II - Program Type (Therapeutic Behavioral Services)	0.7%	0.5%
YA230 - Psychiatric Residential Treatment Facility	2.2%	2.1%
YP780 - Group Living - High	3.0%	3.2%

Opioid Services	Initial	EC
H0020 - Opioid Treatment	0.0%	0.1%

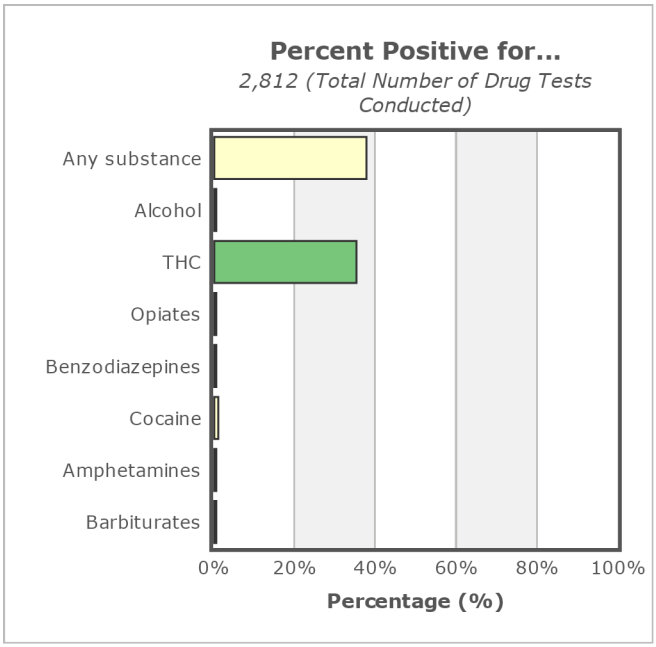
Therapeutic Foster Care Services	Initial	EC
S5145 - Residential Treatment - Level II - Family Type (Foster Care Therapeutic Child)	1.0%	1.2%

Other Services	Initial	EC
Other	5.9%	6.3%

Substance Use

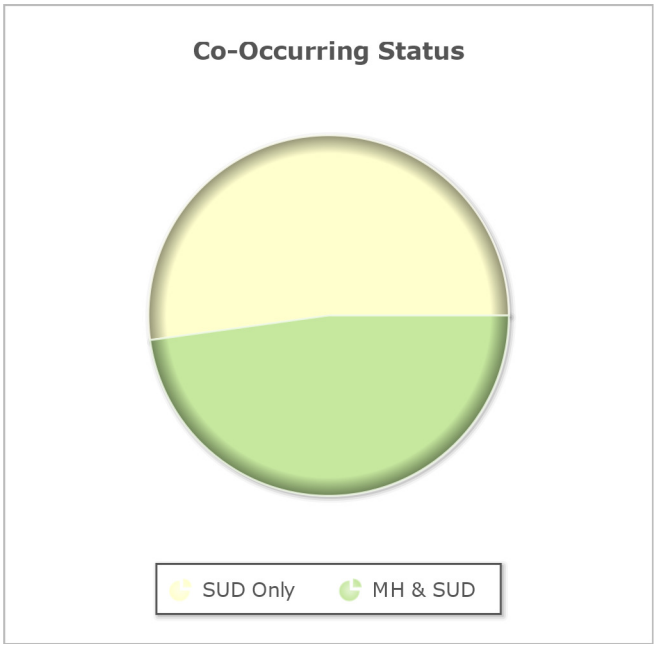


Drug Test Results N = 820	Past 3 Months (EC)
Number of Consumer(s) Tested	520
Percent of Consumer(s) Tested	63.4%
Average # of Tests for Each Consumer Tested	5.4



Needles Used To Inject Drugs, Non-Medically N = 493	
Needle Use Past 3 Months	0.6%

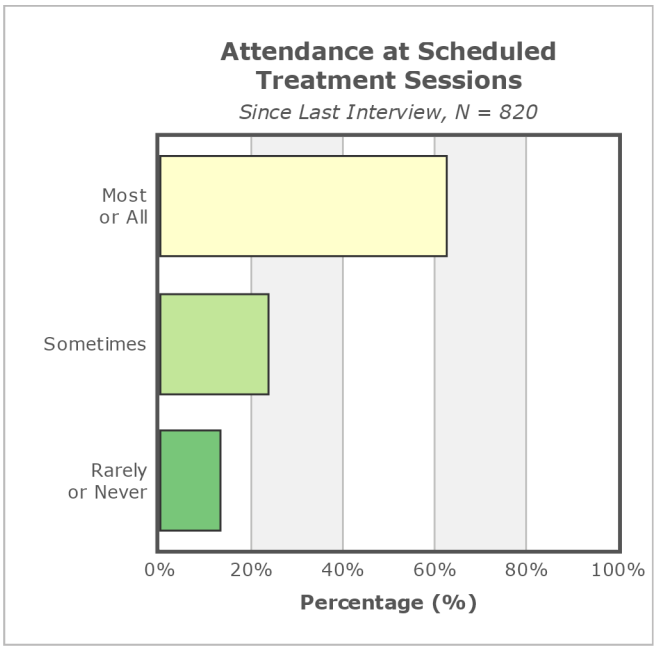
Treatment Demographics

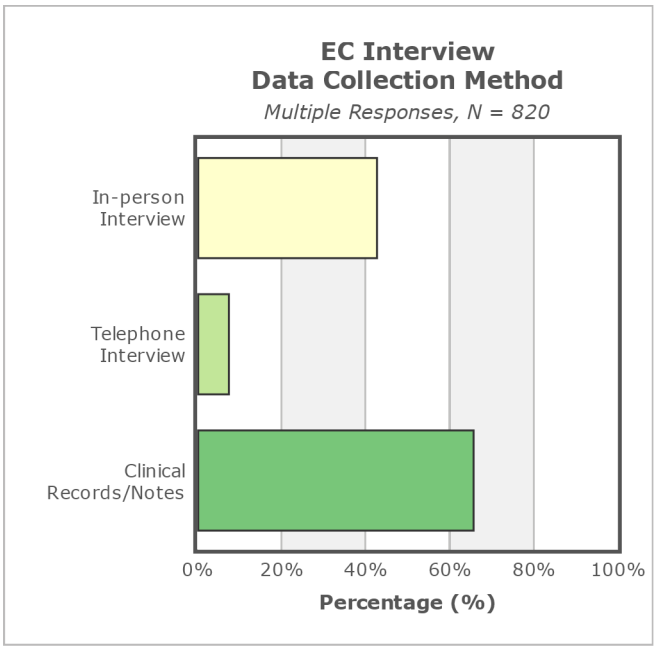


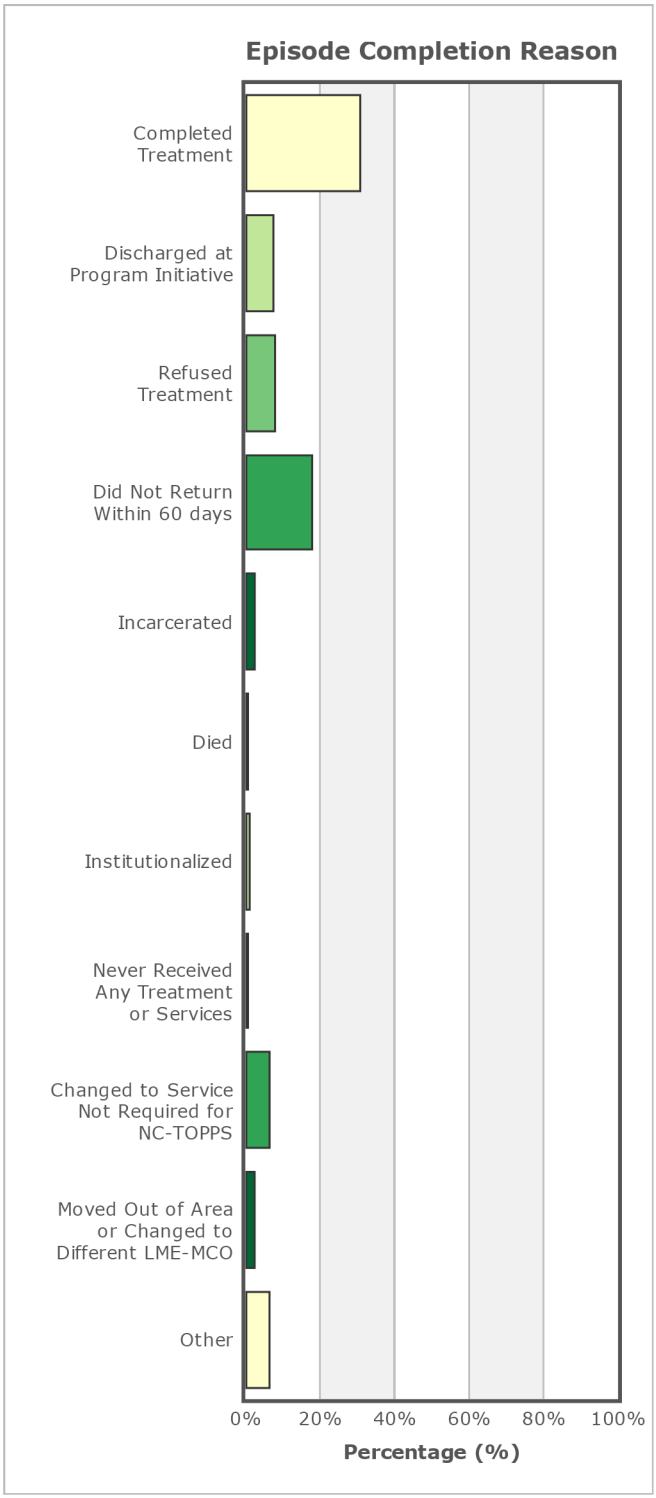
DSM-IV/DSM 5 Diagnoses Diagnostic Category N = 820	
Drug Dependence (DSM-IV)	0.0%
Alcohol Dependence (DSM-IV)	0.0%
Drug Abuse (DSM-IV)	0.0%
Alcohol Abuse (DSM-IV)	0.0%
Drug-Related Disorders (DSM 5)	82.6%
Alcohol-Related Disorders (DSM 5)	12.1%
Oppositional Defiant Disorder	24.5%
Conduct Disorder	17.0%
Attention Deficit Disorder	18.7%
Bipolar Disorders	3.9%
Depression	9.3%
Disruptive Behavior	4.5%
PTSD	8.8%

* Only most commonly diagnosed conditions shown.

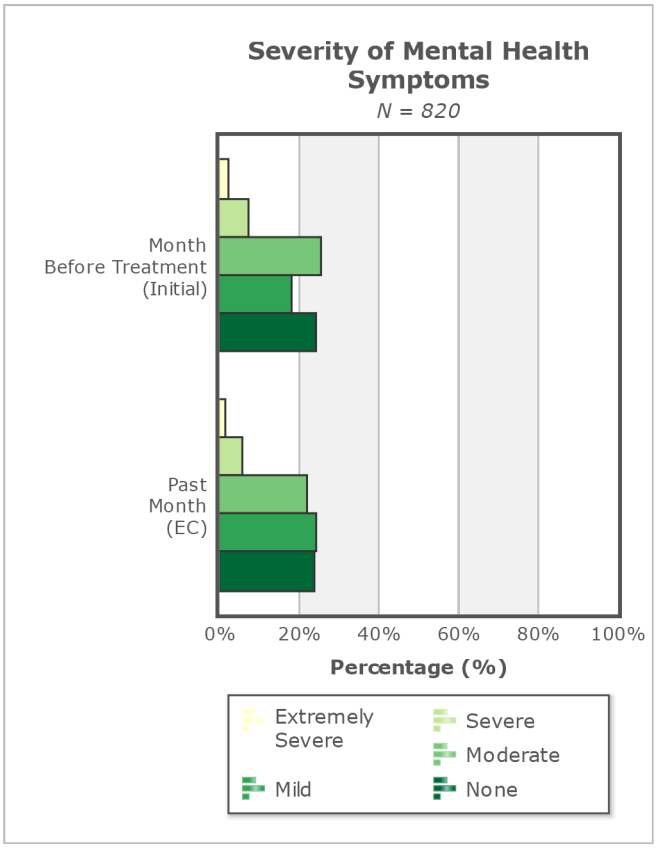
Family Involvement with... N = 820	
Treatment Services	81.1%
Person-centered Planning	64.0%
None	14.0%

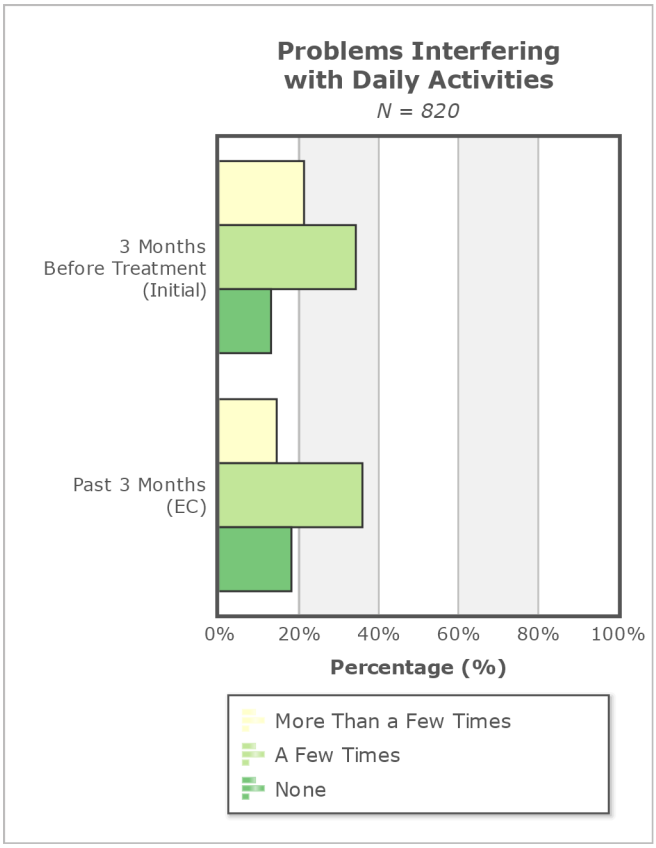




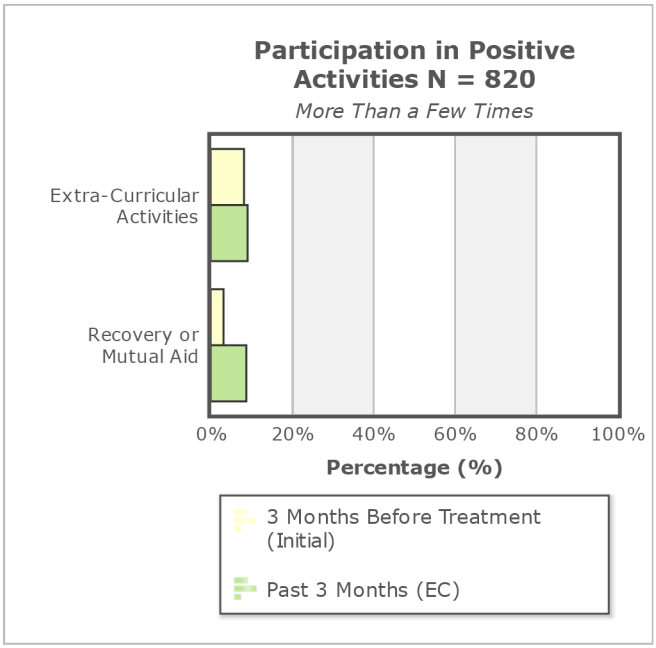

Episode Completion Reason
Completed Treatment
Discharged at Program Initiative
Refused Treatment
Did Not Return Within 60 days
Incarcerated
Died
Institutionalized
Never Received Any Treatment or Services
Changed to Service Not Required for NC-TOPPS
Moved Out of Area or Changed to Different LME-MCO
Other
0%
20%
40%
60%
80%
100%
Percentage (%)

Behaviors





Consumer Ratings on Quality of Life % Rated 'Excellent' or 'Good' N = 493		
	Year Before Treatment (Initial)	**Past 3 Months (EC)**
Emotional Well-Being	64.3%	73.8%
Physical Health	86.0%	91.3%
Family Relationships	64.5%	71.8%
Living/Housing Situation	78.7%	82.4%



Support for Recovery N = 493		
	Initial	**EC**
Have Positive Adult Role Model(s)	95.5%	98.6%
	Expect Support (Initial)	**Received Support (EC)**
Family and/or Friends Somewhat or Very Supportive	98.0%	99.0%

Experienced Abuse N = 493		
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Physical Violence Experienced	19.1%	10.8%
Hit/Physically Hurt Another Person	27.0%	15.8%

Justice System Involvement
N = 820
401 *(48.9%)* consumer(s) were under supervision at the time of their EC interview.

	Month Before Treatment (Initial)	Past Month (EC)
Arrests N = 820	12.1%	8.9%
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Nights in Jail or Detention N = 493	17.8%	7.3%

Suicide Ideation and Hurting Self
N = 493

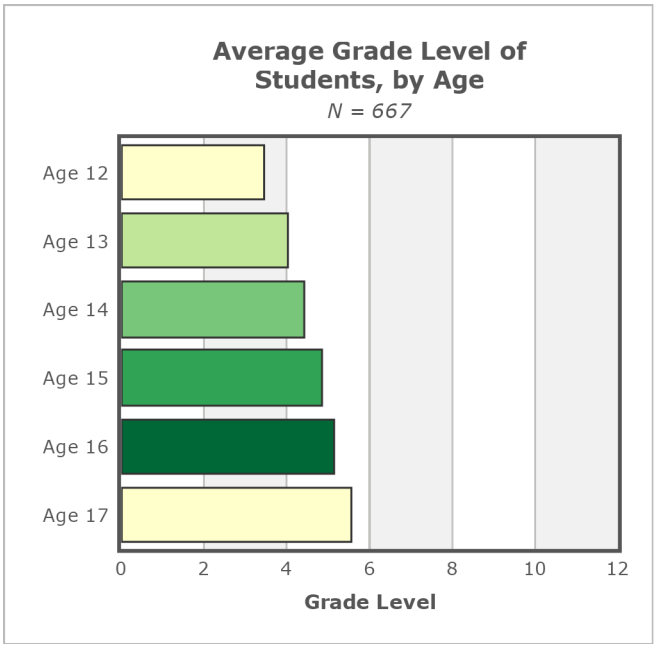
	Ever (Initial)	Since Last Interview (EC)
Suicidal Attempts	17.2%	2.0%
	3 Months Before Treatment (Initial)	**Since Last Interview (EC)**
Suicidal Thoughts	15.4%	6.5%
Tried to Hurt or Cause Self Pain	9.9%	3.0%

Psychotropic Medications at EC
288 *(35.1%)* consumer(s) have had a prescription for psychotropic medications in the past month. Of those, 207 *(71.9%)* take their medication as prescribed all or most of the time.

Education

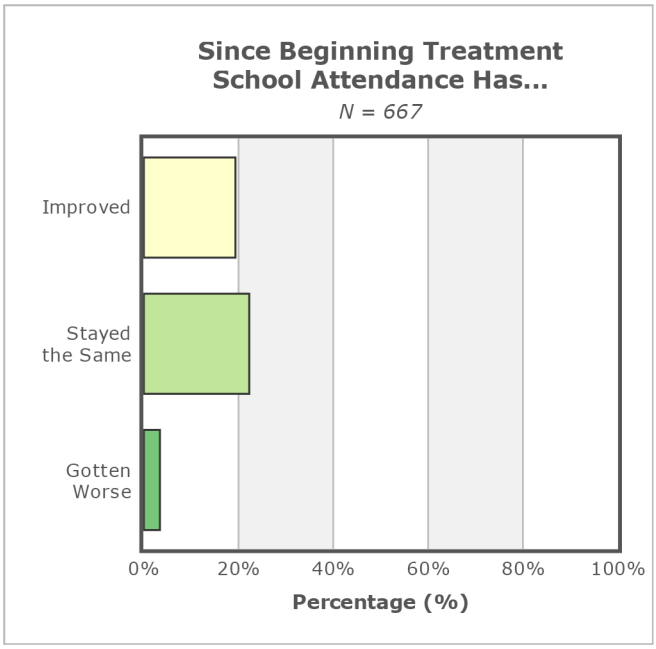
Enrollment in Academic Programs N = 820		
	Initial Interview	EC Interview
Enrolled in Any Academic Program	92.3%	86.1%
Not Enrolled in Any Academic Program	7.7%	13.9%

Of Those Enrolled in Academic Programs Note: Multiple Responses		
Enrolled in...	Initial Interview	EC Interview
N	**757**	**706**
Academic Schools (K-12)	79.8%	77.8%
Alternative Learning Program (ALP)	17.4%	17.4%
Technical or Vocational School	0.0%	0.6%
GED or Adult Literacy	0.5%	3.0%
College	0.1%	0.0%
Other Academic Program	2.8%	2.3%

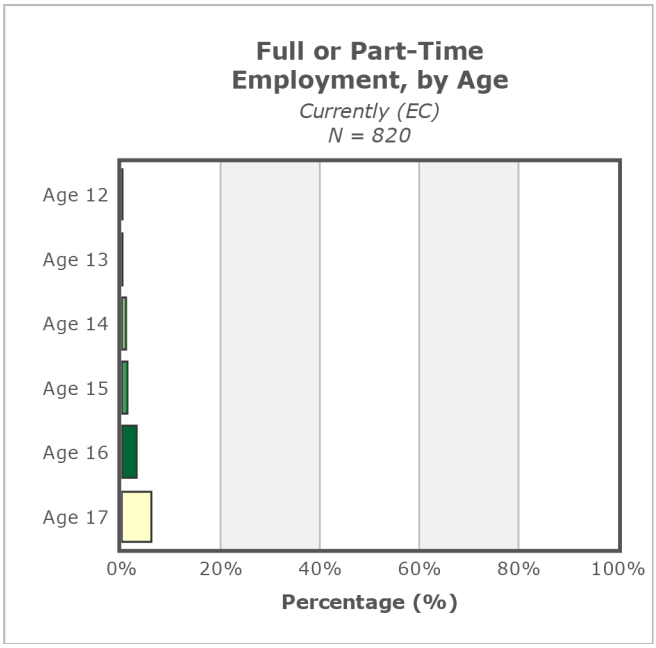


Students Who Received Mostly A's, B's, and C's at Most Recent Grading Period		
	Initial Interview	EC Interview
N	**731**	**667**
Received Mostly A's, B's, and C's	70.3%	76.2%

School Suspension and Expulsion		
	3 Months Before Treatment (Initial)	Currently (EC)
N	**731**	**667**
Suspension	41.5%	25.5%
Expulsion	6.3%	2.4%



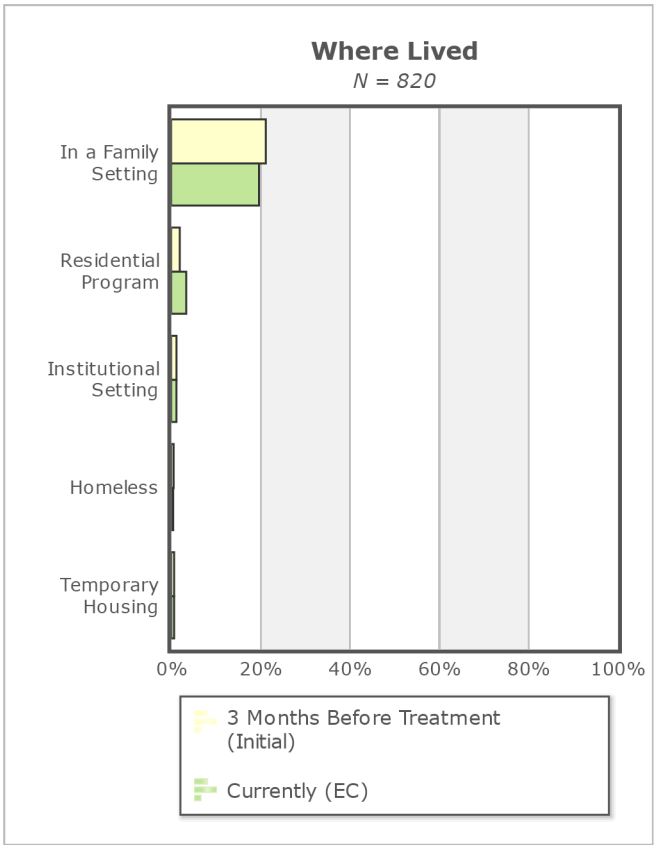
Employment/Housing



Job Classification	Initial N = 73	EC N = 73
Professional, Technical, or Managerial	0.0%	0.0%
Clerical or Sales	1.4%	0.0%
Service Occupation	53.4%	68.5%
Agricultural or Related Occupation	4.1%	2.7%
Processing Occupation	0.0%	1.4%
Machine Trades	0.0%	1.4%
Bench Work	0.0%	0.0%
Structural Work	9.6%	12.3%
Miscellaneous Occupation	31.5%	13.7%

Employee Benefits	Initial N = 73	EC N = 73
Insurance	0.0%	0.0%
Paid Time Off	1.4%	0.0%
Meal/Retail Discounts	9.6%	19.2%
Other	1.4%	2.7%
None	87.7%	78.1%

Rate of Pay	Initial N = 73	EC N = 73
Above Minimum Wage	46.6%	45.2%
Minimum Wage	45.2%	50.7%
Below Minimum Wage	8.2%	4.1%



Times Moved Residences Past 3 Months (EC) N = 820	
No Moves	81.2%
Moved Once	14.3%
Moved Two or More Times	4.5%

Number Living in Special Circumstances		
Where Lived Most of Time	**3 Months Before Treatment (Initial)**	**Currently (EC)**
Homeless Sheltered	2	2
Homeless Unsheltered	4	1
Therapeutic Foster Home	3	4
Level III Group Home	21	29
Level IV Group Home	6	3
State Residential Treatment Center	9	1
SA Residential Treatment Center	5	46
Halfway House	0	0
Other	10	22
Total Living in Special Circumstances	**60**	**108**
--Of the Total, Number in Home Community	17	15

Homeless Nights, Currently (EC)
Among 493 consumer(s), 6 *(1.2%)* consumer(s) reported night(s) homeless.

Service Needs

Services Deemed Important at Initial and Received at EC
Multiple Responses, N = 820

	Initial	EC
Education	57.6%	56.3%
Job	21.5%	11.5%
Housing	7.4%	6.5%
Transportation	9.5%	10.1%
Child Care	1.5%	0.5%
Medical	8.9%	12.3%
Dental	7.9%	3.7%
Screening/Treatment Referral for HIV/TB/HEP	N/A	4.4%
Legal	32.9%	37.9%
Volunteer Opportunities	5.6%	6.8%
None	27.1%	30.4%

Barriers to Treatment
Multiple Responses, N = 820

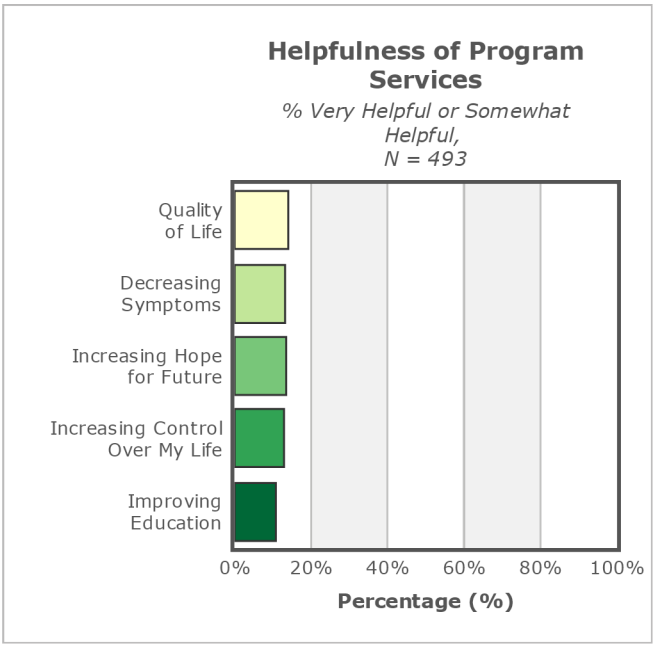
	Initial	EC
No Difficulties	78.5%	64.3%
Active MH Symptoms	2.2%	5.1%
Active SA Symptoms	3.8%	7.9%
Physical Health	0.1%	0.7%
Family Issues	1.6%	6.3%
Needs Not Met	0.4%	1.1%
Engagement	4.0%	13.7%
Cost	0.5%	0.6%
Stigma /Discrimination	0.1%	0.0%
Treatment /Auth. Access	1.2%	1.0%
Deaf/Hard of Hearing	0.0%	0.0%
Language/Comm.	0.6%	0.4%
Legal Reasons	2.0%	3.7%
Transportation	10.1%	11.7%
Scheduling Issues	3.2%	4.4%
Lack of Stable Housing	0.2%	1.8%
Personal Safety	0.0%	0.9%

Crisis/Hospital Care
Past 3 Months
N = 493

	3 Months Before Treatment (Initial)	Past 3 Months (EC)
Crisis Contacts	10.1%	6.5%
ER Visits	16.0%	9.5%
Medical/Surgical Hospital Nights	4.3%	1.8%
Psychiatric Inpatient Hospital Nights	11.4%	3.7%

Routine Health Care
Among 493 consumer(s), 174 *(35.3%)* have seen their provider for a routine check-up since the last interview.

Routine Dental Care
Among 493 consumer(s), 103 *(20.9%)* have seen their dentist for a routine check-up since the last interview.



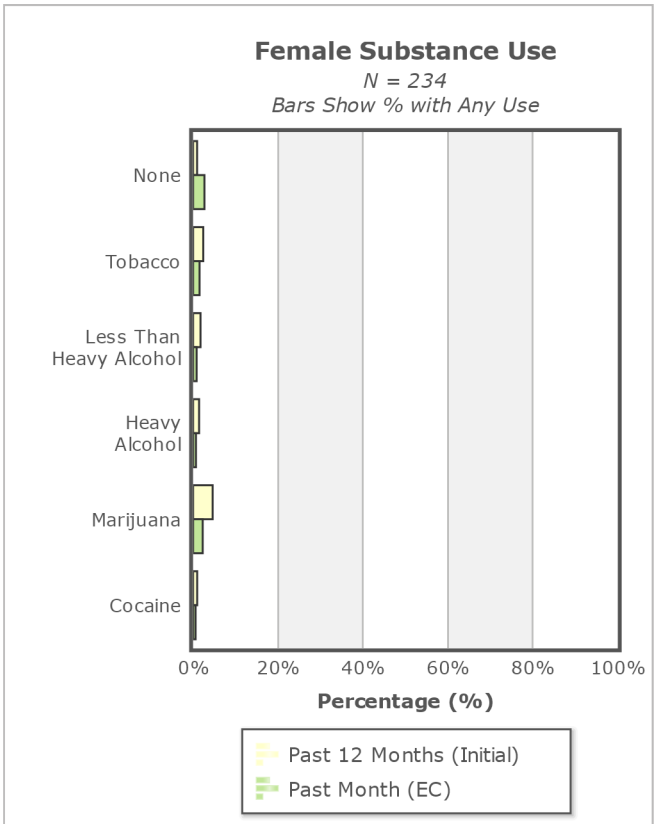
Maternal/Perinatal

Female Substance Use Consumers
Several questions on the NC-TOPPS interview are asked only to female consumers. The tables and charts on this page show the results for those questions. In addition, several other charts are shown for females only. The number of female consumer(s) is 315 *(29.8%)*.

0.0% of 234 female consumer(s) were admitted to a Maternal/Pregnant Program.

Pregnancy ***Female N = 151***	**Number**
Gave Birth in Past Year	1
Currently Pregnant	1
Uncertain about Pregnancy Status	2
In First Trimester*	0
In Second Trimester*	1
In Third Trimester*	0
Referred to Prenatal Care*	1
Receiving Prenatal Care*	1

* of those who are pregnant.



Females with Children Under 18
Of the 315 female consumer(s), 6 *(1.9%)* have children under the age of 18.

DSS Involvement Since Last Interview Among Females with Children Under 18 N = 6	
Investigated by DSS for Child Abuse/Neglect	0.0%

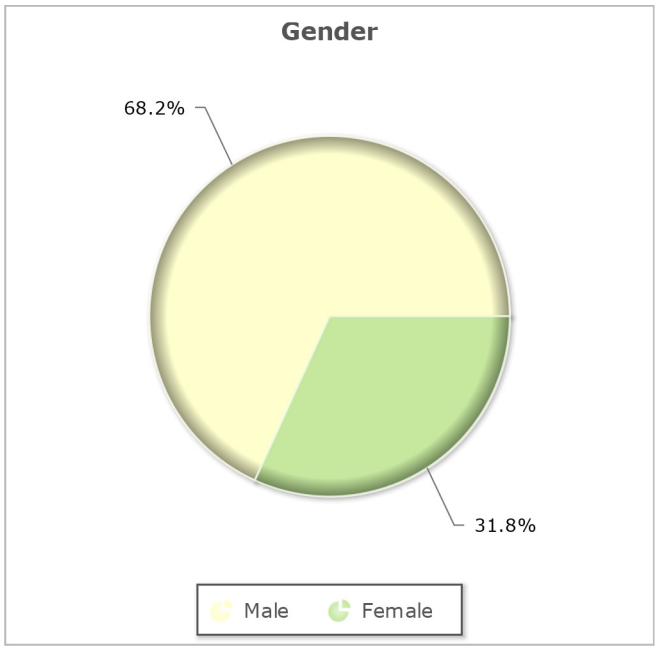
Females Experienced Abuse Past 3 Months N = 151	
Physical Violence	12.6%
Hit/Physically Hurt Another Person	15.9%

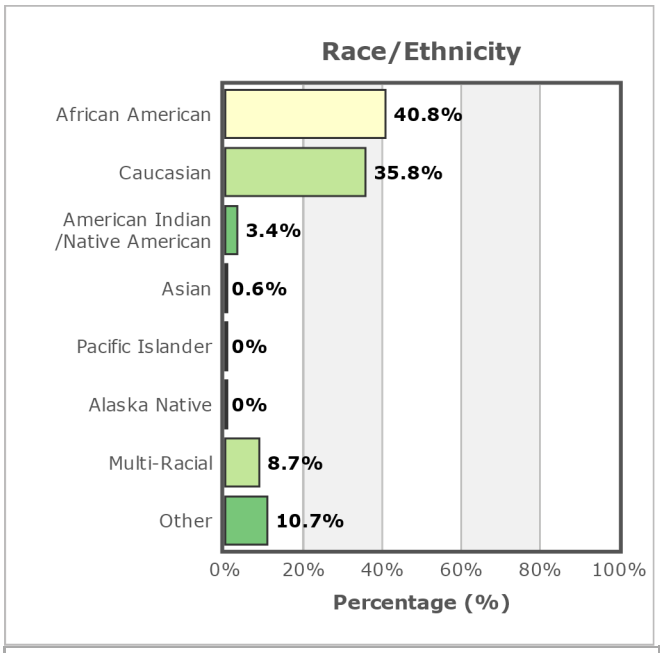
Suicide Ideation and Hurting Self, Since Last Interview Among Females N = 151	
Suicidal Attempts	3.3%
Suicidal Thoughts	11.9%
Tried to Hurt or Cause Self Pain	6.6%

NC-TOPPS Simple Query Report

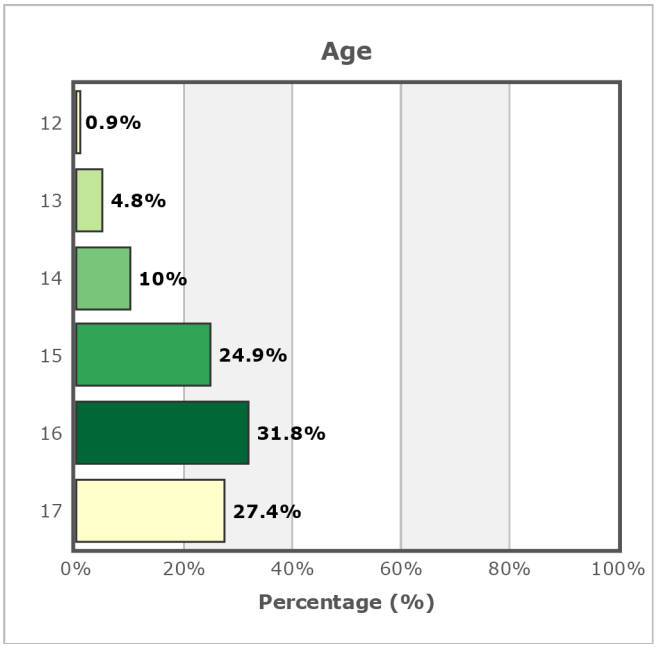
Alliance Health
Cardinal Innovations
Eastpointe
Partners Behavioral Health Management
Sandhills
Trillium Health Resources
Vaya Health
Adolescent Substance Use Disorder Consumers
Episode Completion Interviews started *Sunday, July 1, 2018* through *Sunday, June 30, 2019*
Number of Episode Completion Interviews: 978

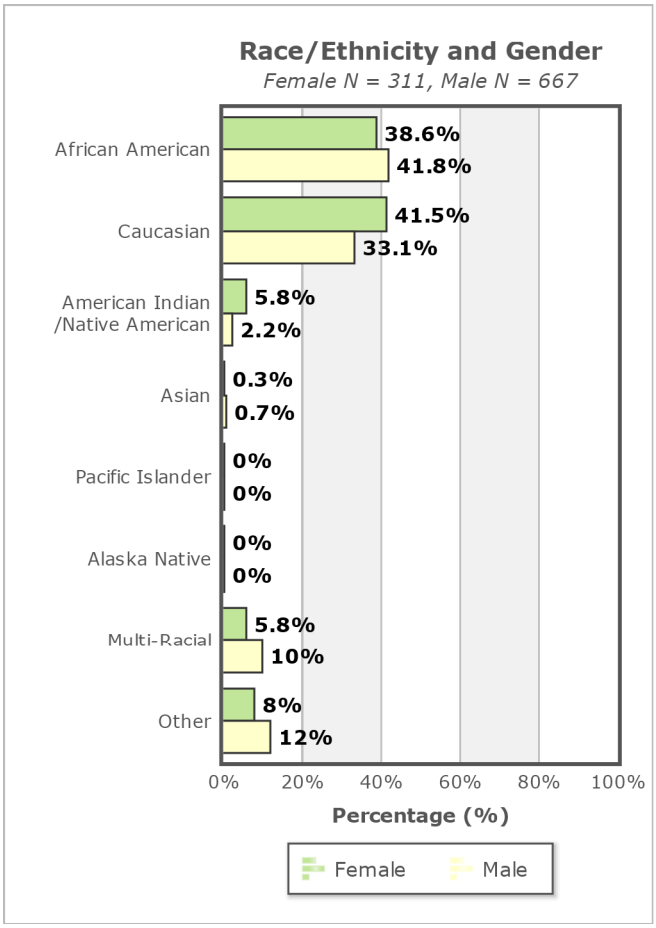
Demographics

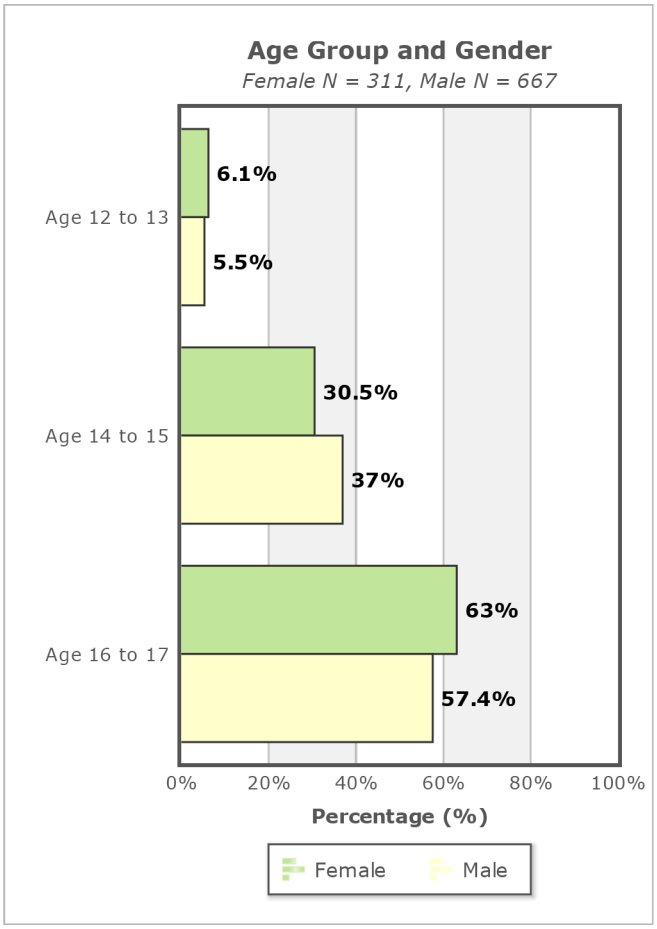




154 *(15.7%)* consumer(s) indicate that they are of Hispanic, Latino, or Spanish origin.


Age
12
0.9%
13
4.8%
14
10%
15
24.9%
16
31.8%
17
27.4%
0%
20%
40%
60%
80%
100%
Percentage (%)


Race/Ethnicity and Gender
Female N = 311, Male N = 667
African American
38.6%
41.8%
Caucasian
41.5%
33.1%
American Indian /Native American
5.8%
2.2%
Asian
0.3%
0.7%
Pacific Islander
0%
0%
Alaska Native
0%
0%
Multi-Racial
5.8%
10%
Other
8%
12%
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male


Age Group and Gender
Female N = 311, Male N = 667
Age 12 to 13
6.1%
5.5%
Age 14 to 15
30.5%
37%
Age 16 to 17
63%
57.4%
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male

Services

Periodic Services	Initial	EC
90832-90838 - Psychotherapy	20.8%	22.2%
90846 - Family Therapy without Patient	3.9%	4.0%
90847 - Family Therapy with Patient	12.1%	13.0%
90849 - Group Therapy (multiple family group)	5.5%	5.6%
90853 - Group Therapy (non-multiple family group)	15.5%	16.3%
H0004 - Behavioral Health Counseling - Individual Therapy	7.9%	8.8%
H0004 HQ - Behavioral Health Counseling - Group Therapy	7.8%	8.1%
H0004 HR - Behavioral Health Counseling - Family Therapy with Consumer	3.4%	4.0%
H0004 HS - Behavioral Health Counseling - Family Therapy without Consumer	0.5%	0.5%
YP831 - Behavioral Health Counseling (non-licensed provider)	0.1%	0.1%
YP832 - Behavioral Health Counseling - Group Therapy (non-licensed provider)	0.4%	0.4%
YP833 - Behavioral Health Counseling - Family Therapy with Consumer (non-licensed provider)	0.5%	0.6%
YP834 - Behavioral Health Counseling - Family Therapy without Consumer (non-licensed provider)	0.1%	0.2%
H0005 - Alcohol and/or Drug Group Counseling	13.7%	13.6%
YP835 - Alcohol and/or Drug Group Counseling (non-licensed provider)	1.7%	2.0%

Community Based Services	Initial	EC
H0015 - Substance Abuse Intensive Outpatient Program (SAIOP)	20.9%	20.6%
H2022 - Intensive In-Home Services (IIH)	15.3%	14.9%
H2033 - Multisystemic Therapy Services (MST)	12.7%	13.3%
H2035 - Substance Abuse Comprehensive Outpatient Treatment (SACOT)	1.5%	1.6%
YP630 - Individual Placement and Support (IPS) Supported Employment	0.0%	0.0%
H2023 U4 - Supported Employment	0.0%	0.0%
H2026 U4 - Ongoing Supported Employment	0.0%	0.0%

Facility Based Day Services	Initial	EC
H0035 - Mental Health - Partial Hospitalization	0.1%	0.1%
H2012 HA - Child and Adolescent Day Treatment	6.7%	7.2%

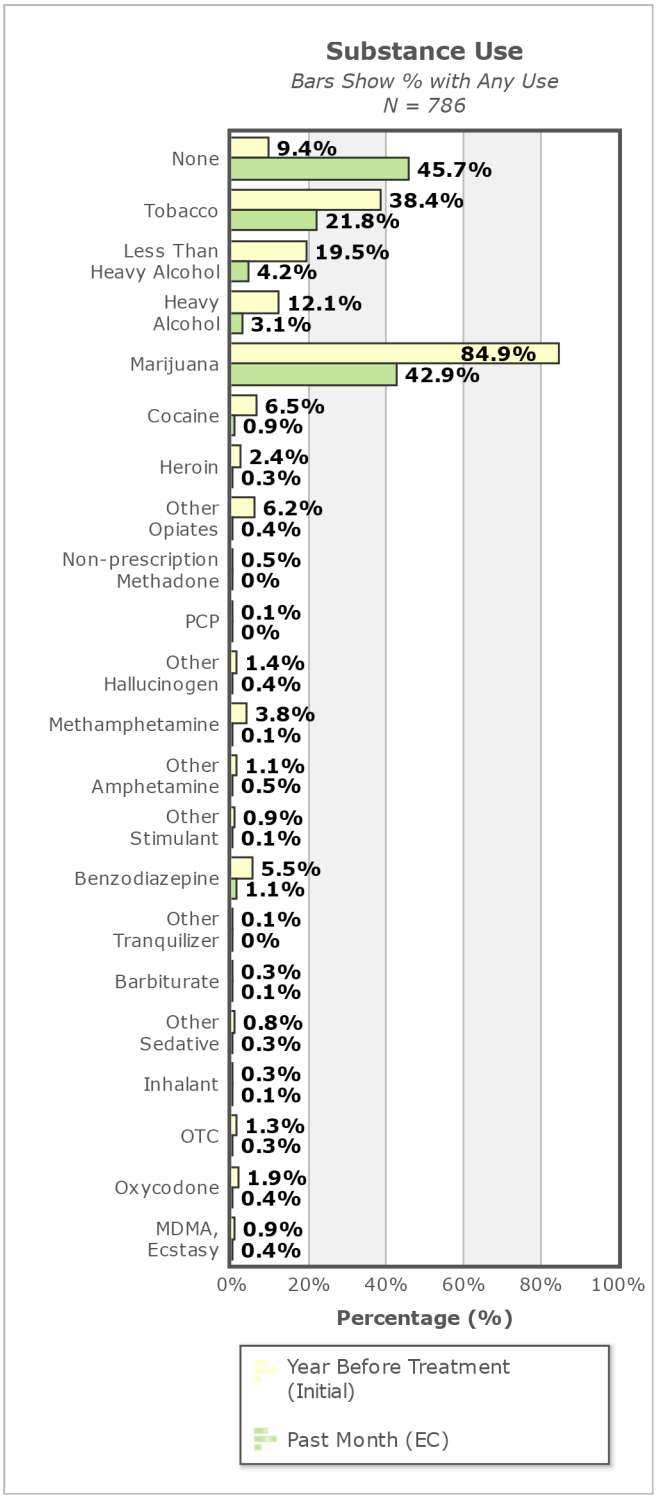
Residental Services	Initial	EC
H0013 - SA Medically Monitored Community Residential Treatment	1.9%	2.2%
H0019 - Behavioral Health - Long Term Residential	0.9%	1.0%
H2020 - Residential Treatment - Level II - Program Type (Therapeutic Behavioral Services)	0.8%	0.7%
YA230 - Psychiatric Residential Treatment Facility	3.0%	2.8%
YP780 - Group Living - High	1.9%	2.5%

Opioid Services	Initial	EC
H0020 - Opioid Treatment	0.0%	0.0%

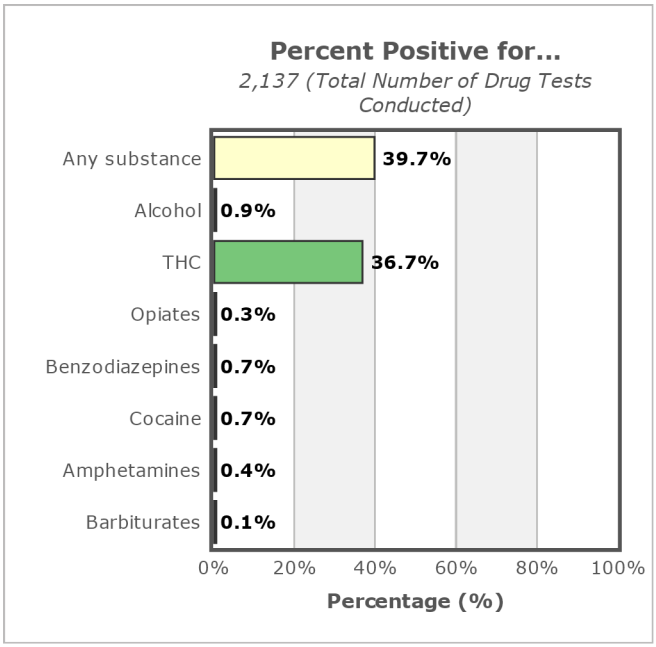
Therapeutic Foster Care Services	Initial	EC
S5145 - Residential Treatment - Level II - Family Type (Foster Care Therapeutic Child)	0.7%	0.8%

Other Services	Initial	EC
Other	5.7%	6.2%

Substance Use

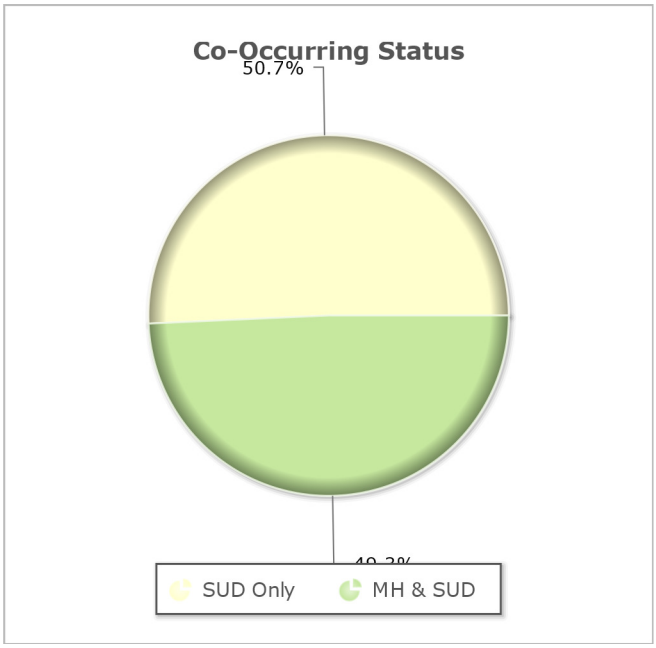


Drug Test Results N = 786	Past 3 Months (EC)
Number of Consumer(s) Tested	491
Percent of Consumer(s) Tested	62.5%
Average # of Tests for Each Consumer Tested	4.4



Needles Used To Inject Drugs, Non-Medically N = 481	
Needle Use Past 3 Months	0.6%

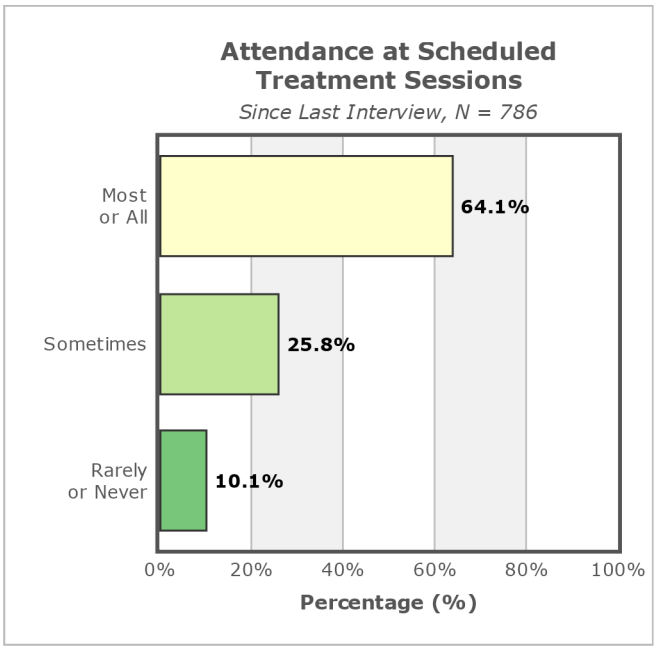
Treatment Demographics

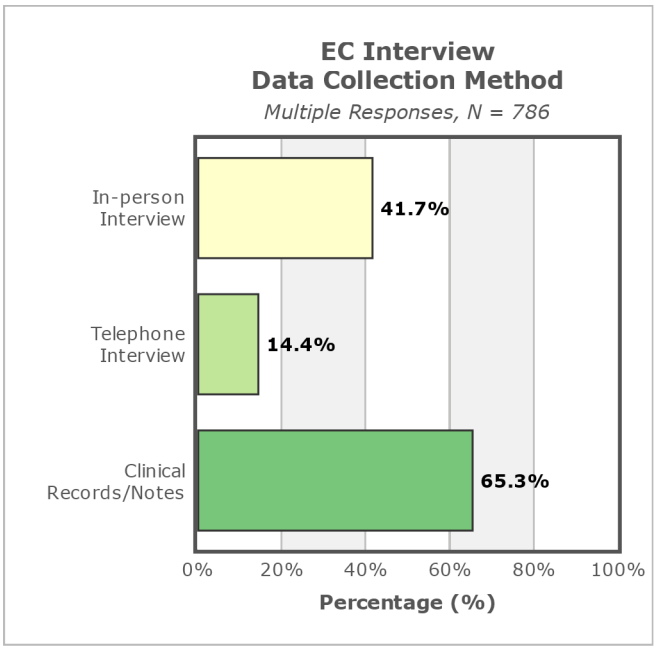


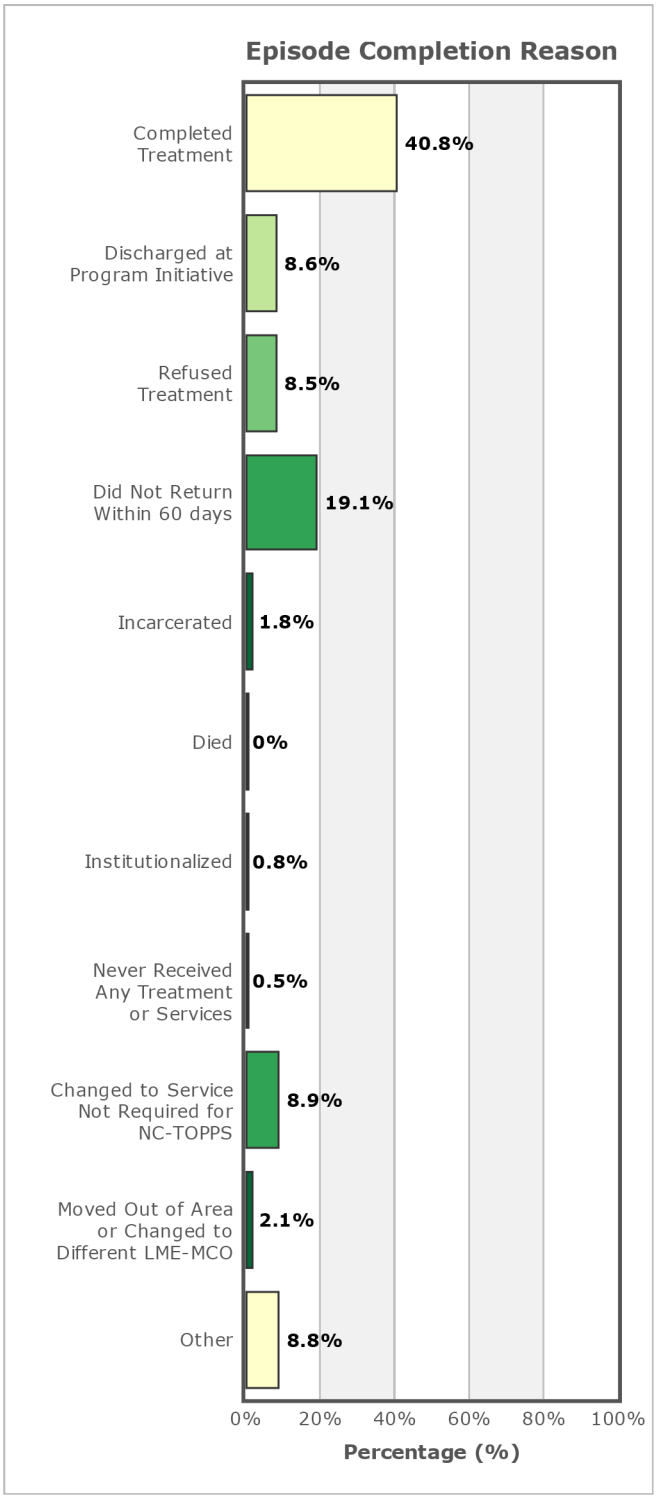
DSM-IV/DSM 5 Diagnoses Diagnostic Category N = 786	
Drug Dependence (DSM-IV)	0.0%
Alcohol Dependence (DSM-IV)	0.0%
Drug Abuse (DSM-IV)	0.0%
Alcohol Abuse (DSM-IV)	0.0%
Drug-Related Disorders (DSM 5)	79.3%
Alcohol-Related Disorders (DSM 5)	10.2%
Oppositional Defiant Disorder	23.0%
Conduct Disorder	14.4%
Attention Deficit Disorder	22.1%
Bipolar Disorders	3.9%
Depression	9.8%
Disruptive Behavior	5.0%
PTSD	7.5%

* Only most commonly diagnosed conditions shown.

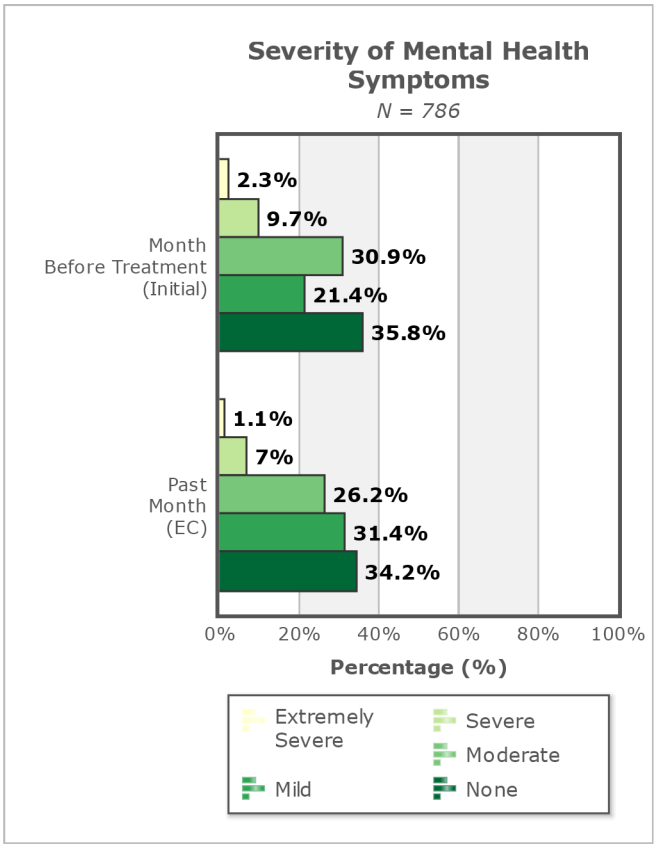
Family Involvement with... N = 786	
Treatment Services	82.6%
Person-centered Planning	60.7%
None	11.6%

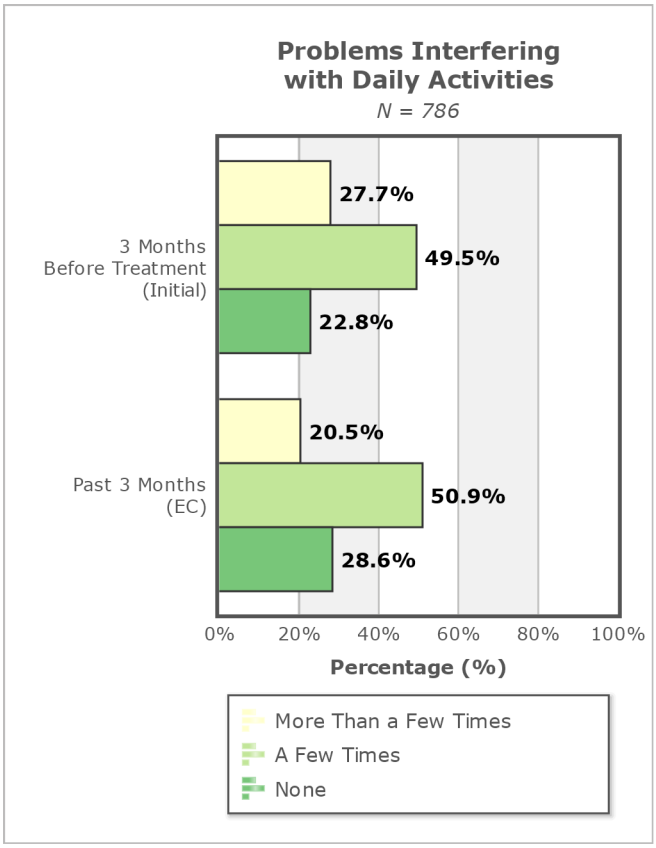




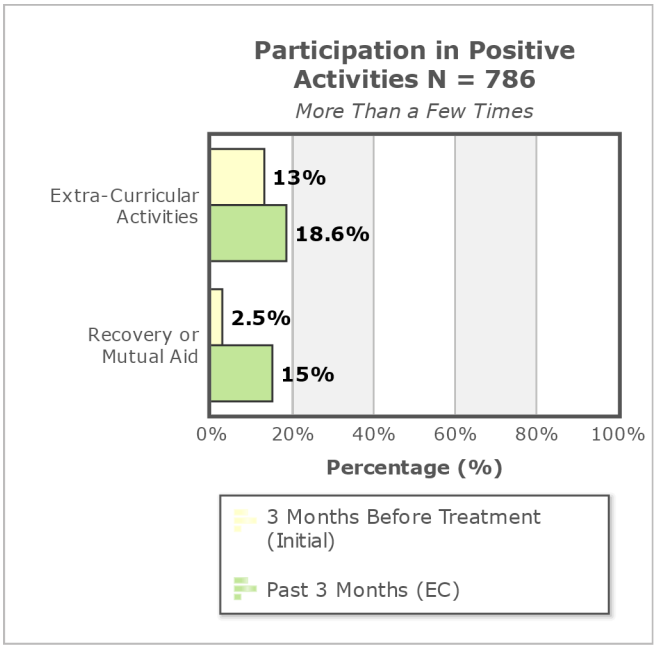

Episode Completion Reason
Completed Treatment
40.8%
Discharged at Program Initiative
8.6%
Refused Treatment
8.5%
Did Not Return Within 60 days
19.1%
Incarcerated
1.8%
Died
0%
Institutionalized
0.8%
Never Received Any Treatment or Services
0.5%
Changed to Service Not Required for NC-TOPPS
8.9%
Moved Out of Area or Changed to Different LME-MCO
2.1%
Other
8.8%
0%
20%
40%
60%
80%
100%
Percentage (%)

Behaviors





Consumer Ratings on Quality of Life % Rated 'Excellent' or 'Good' N = 481		
	Year Before Treatment (Initial)	**Past 3 Months (EC)**
Emotional Well-Being	61.7%	72.1%
Physical Health	85.0%	88.4%
Family Relationships	60.5%	75.3%
Living/Housing Situation	77.5%	83.4%



Support for Recovery N = 481		
	Initial	**EC**
Have Positive Adult Role Model(s)	95.8%	97.9%
	Expect Support (Initial)	**Received Support (EC)**
Family and/or Friends Somewhat or Very Supportive	98.5%	98.5%

Experienced Abuse N = 481		
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Physical Violence Experienced	19.8%	8.3%
Hit/Physically Hurt Another Person	28.7%	11.6%

Justice System Involvement
N = 786
378 *(48.1%)* consumer(s) were under supervision at the time of their EC interview.

	Month Before Treatment (Initial)	Past Month (EC)
Arrests N = 786	8.7%	6.0%
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Nights in Jail or Detention N = 481	19.8%	7.9%

Suicide Ideation and Hurting Self
N = 481

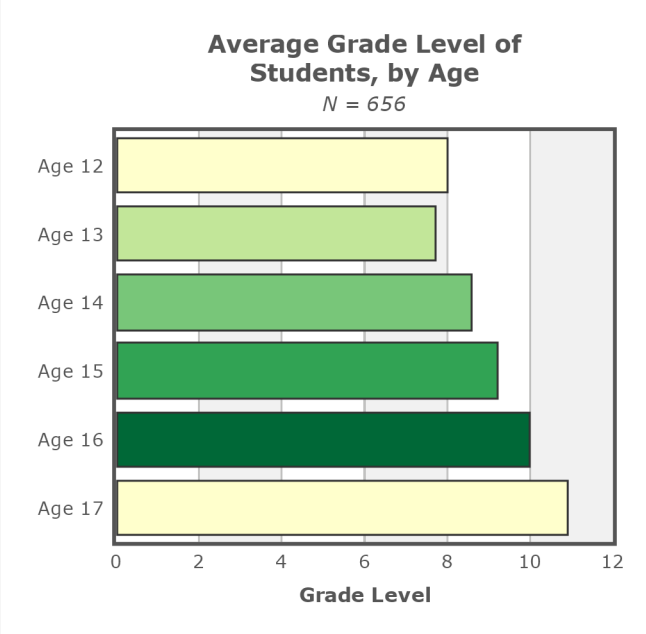
	Ever (Initial)	Since Last Interview (EC)
Suicidal Attempts	15.0%	2.7%
	3 Months Before Treatment (Initial)	**Since Last Interview (EC)**
Suicidal Thoughts	14.1%	6.7%
Tried to Hurt or Cause Self Pain	9.1%	2.7%

Psychotropic Medications at EC
312 *(39.7%)* consumer(s) have had a prescription for psychotropic medications in the past month. Of those, 226 *(72.4%)* take their medication as prescribed all or most of the time.

Education

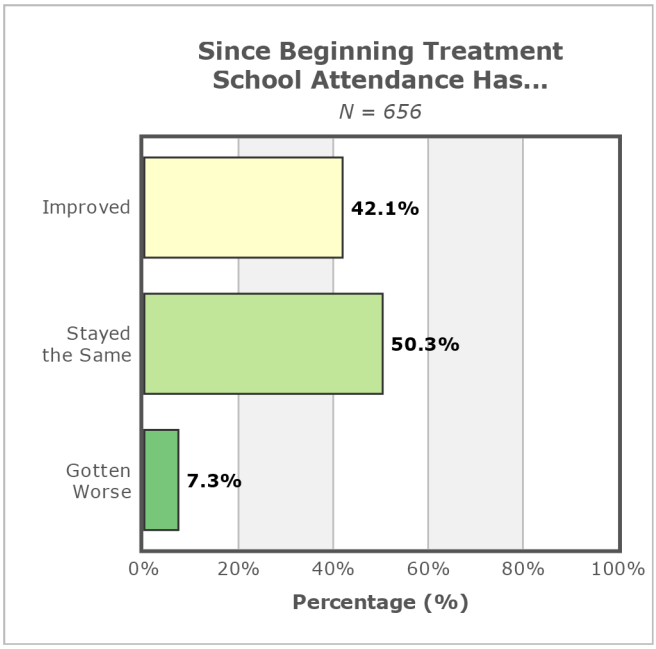
Enrollment in Academic Programs N = 786	Initial Interview	EC Interview
Enrolled in Any Academic Program	91.1%	86.1%
Not Enrolled in Any Academic Program	8.9%	13.9%

Of Those Enrolled in Academic Programs Note: Multiple Responses		
Enrolled in...	**Initial Interview**	**EC Interview**
N	**716**	**677**
Academic Schools (K-12)	83.4%	79.8%
Alternative Learning Program (ALP)	12.7%	15.2%
Technical or Vocational School	0.0%	0.0%
GED or Adult Literacy	1.3%	2.1%
College	0.1%	0.6%
Other Academic Program	1.3%	0.6%

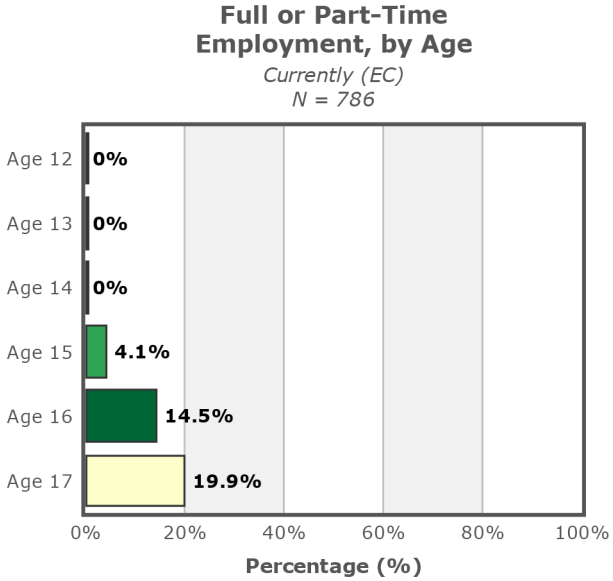


Students Who Received Mostly A's, B's, and C's at Most Recent Grading Period		
	Initial Interview	**EC Interview**
N	**697**	**656**
Received Mostly A's, B's, and C's	70.6%	76.1%

School Suspension and Expulsion		
	3 Months Before Treatment (Initial)	**Currently (EC)**
N	**697**	**656**
Suspension	41.6%	20.7%
Expulsion	5.5%	1.8%



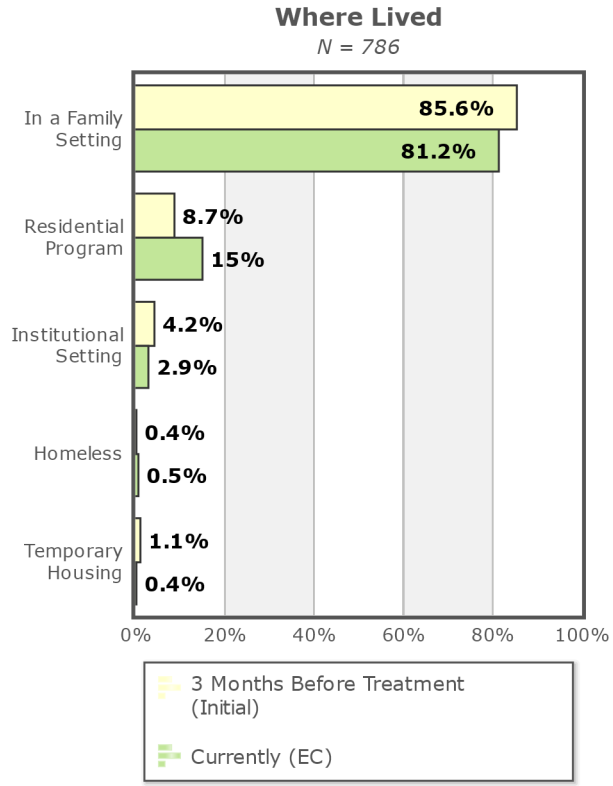
Employment/Housing



Job Classification	Initial N = 67	EC N = 85
Professional, Technical, or Managerial	0.0%	1.2%
Clerical or Sales	6.0%	5.9%
Service Occupation	49.3%	65.9%
Agricultural or Related Occupation	4.5%	1.2%
Processing Occupation	1.5%	3.5%
Machine Trades	1.5%	0.0%
Bench Work	1.5%	0.0%
Structural Work	14.9%	12.9%
Miscellaneous Occupation	20.9%	9.4%

Employee Benefits	Initial N = 67	EC N = 85
Insurance	0.0%	1.2%
Paid Time Off	0.0%	1.2%
Meal/Retail Discounts	25.4%	17.6%
Other	3.0%	0.0%
None	73.1%	81.2%

Rate of Pay	Initial N = 67	EC N = 85
Above Minimum Wage	55.2%	50.6%
Minimum Wage	35.8%	45.9%
Below Minimum Wage	9.0%	3.5%



Times Moved Residences Past 3 Months (EC) N = 786	
No Moves	83.0%
Moved Once	14.1%
Moved Two or More Times	2.9%

Number Living in Special Circumstances		
Where Lived Most of Time	**3 Months Before Treatment (Initial)**	**Currently (EC)**
Homeless Sheltered	2	2
Homeless Unsheltered	1	2
Therapeutic Foster Home	11	3
Level III Group Home	18	30
Level IV Group Home	6	0
State Residential Treatment Center	3	1
SA Residential Treatment Center	6	48
Halfway House	0	0
Other	9	11
Total Living in Special Circumstances	**56**	**97**
--Of the Total, Number in Home Community	11	15

Homeless Nights, Currently (EC)
Among 481 consumer(s), 6 *(1.2%)* consumer(s) reported night(s) homeless.

Service Needs

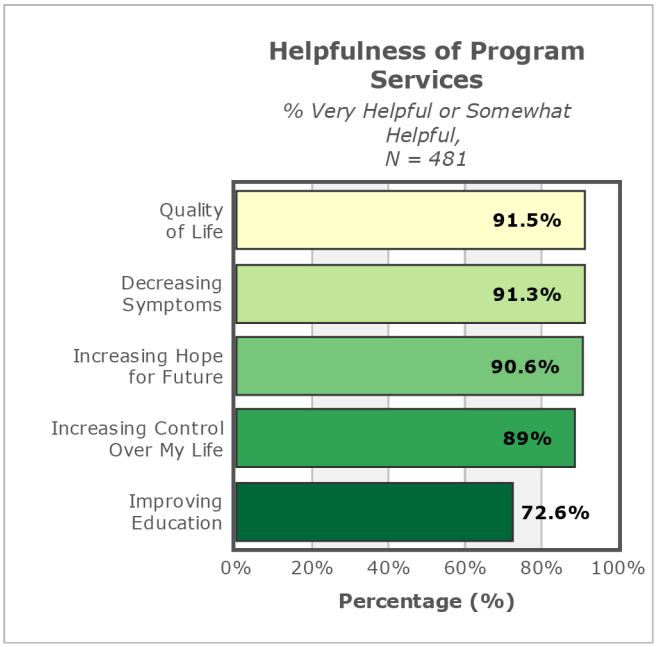
Services Deemed Important at Initial and Received at EC Multiple Responses, N = 786		
	Initial	**EC**
Education	58.4%	55.3%
Job	22.4%	12.8%
Housing	9.7%	8.3%
Transportation	14.8%	11.7%
Child Care	1.1%	0.5%
Medical	12.5%	14.6%
Dental	12.1%	8.1%
Screening/Treatment Referral for HIV/TB/HEP	N/A	5.1%
Legal	35.9%	38.7%
Volunteer Opportunities	6.6%	5.9%
None	27.0%	30.9%

Barriers to Treatment Multiple Responses, N = 786		
	Initial	**EC**
No Difficulties	76.7%	66.0%
Active MH Symptoms	3.1%	5.7%
Active SA Symptoms	4.2%	5.0%
Physical Health	0.3%	0.5%
Family Issues	1.4%	6.7%
Needs Not Met	0.5%	1.3%
Engagement	3.8%	13.7%
Cost	0.5%	0.1%
Stigma /Discrimination	0.0%	0.0%
Treatment /Auth. Access	1.5%	1.0%
Deaf/Hard of Hearing	0.0%	0.0%
Language/Comm.	0.3%	0.4%
Legal Reasons	2.4%	1.7%
Transportation	11.2%	12.7%
Scheduling Issues	2.8%	3.8%
Lack of Stable Housing	0.5%	1.0%
Personal Safety	0.1%	0.6%

Crisis/Hospital Care Past 3 Months N = 481		
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Crisis Contacts	11.9%	5.6%
ER Visits	16.4%	11.4%
Medical/Surgical Hospital Nights	4.4%	2.9%
Psychiatric Inpatient Hospital Nights	12.1%	6.2%

Routine Health Care
Among 481 consumer(s), 189 *(39.3%)* have seen their provider for a routine check-up since the last interview.

Routine Dental Care
Among 481 consumer(s), 118 *(24.5%)* have seen their dentist for a routine check-up since the last interview.



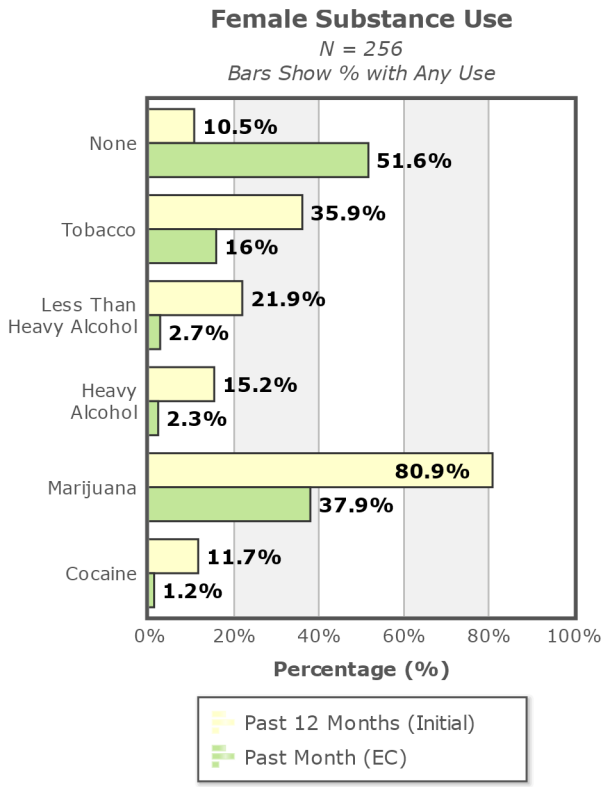
Maternal/Perinatal

Female Substance Use Consumers
Several questions on the NC-TOPPS interview are asked only to female consumers. The tables and charts on this page show the results for those questions. In addition, several other charts are shown for females only. The number of female consumer(s) is 311 *(31.8%)*.

0.0% of 256 female consumer(s) were admitted to a Maternal/Pregnant Program.

Pregnancy ***Female N = 162***	**Number**
Gave Birth in Past Year	2
Currently Pregnant	3
Uncertain about Pregnancy Status	2
In First Trimester*	2
In Second Trimester*	0
In Third Trimester*	1
Referred to Prenatal Care*	3
Receiving Prenatal Care*	2

* of those who are pregnant.



Females with Children Under 18
Of the 311 female consumer(s), 8 *(2.6%)* have children under the age of 18.

DSS Involvement Since Last Interview Among Females with Children Under 18 N = 8	
Investigated by DSS for Child Abuse/Neglect	37.5%

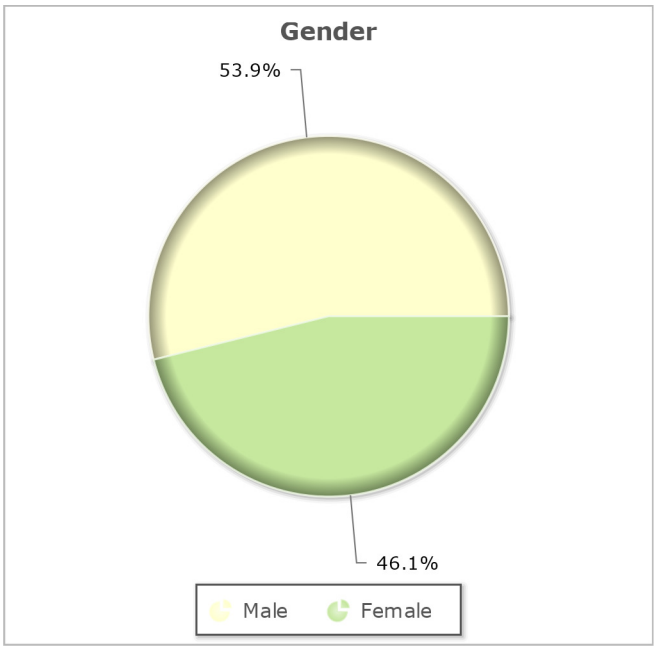
Females Experienced Abuse Past 3 Months N = 162	
Physical Violence	9.3%
Hit/Physically Hurt Another Person	12.3%

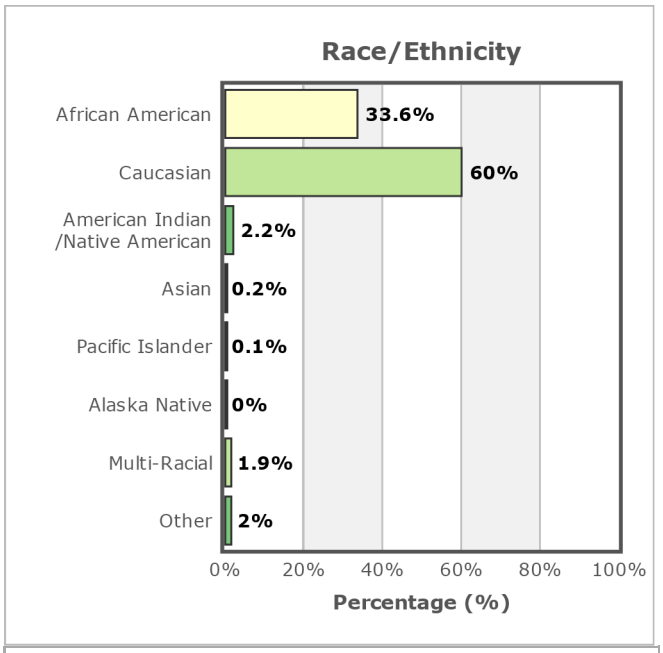
Suicide Ideation and Hurting Self, Since Last Interview Among Females N = 162	
Suicidal Attempts	1.2%
Suicidal Thoughts	10.5%
Tried to Hurt or Cause Self Pain	6.8%

NC-TOPPS Simple Query Report

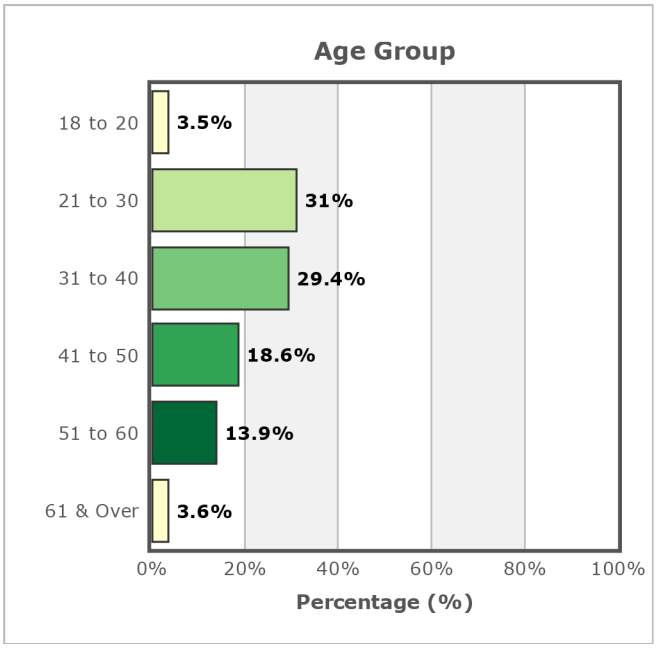
Alliance Health
Cardinal Innovations
Eastpointe
Partners Behavioral Health Management
Sandhills
Trillium Health Resources
Vaya Health
Adult Substance Use Disorder Consumers
Episode Completion Interviews started *Saturday, July 1, 2017* through *Saturday, June 30, 2018*
Number of Episode Completion Interviews: 27,898

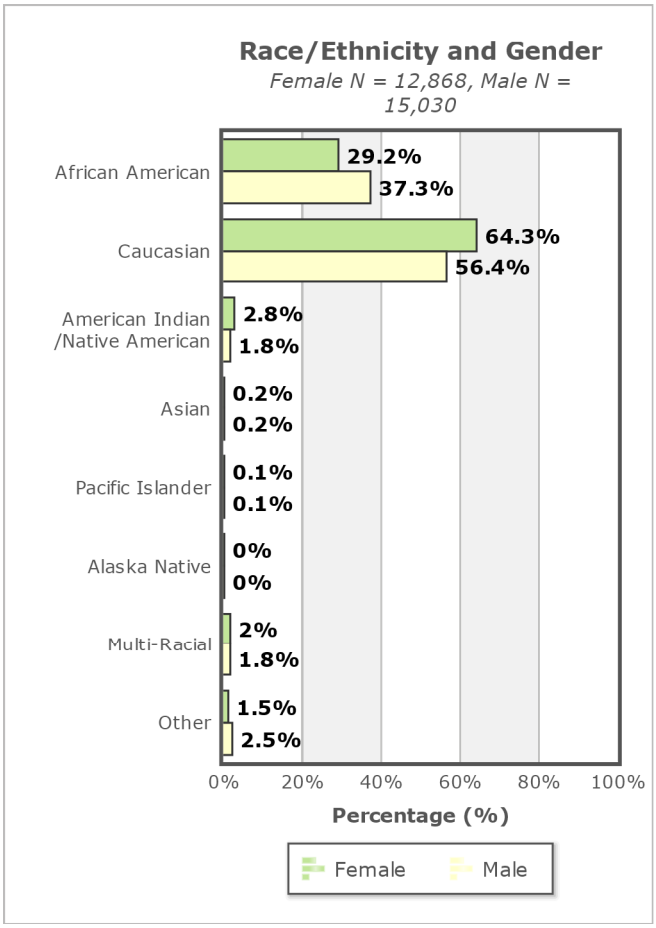
Demographics

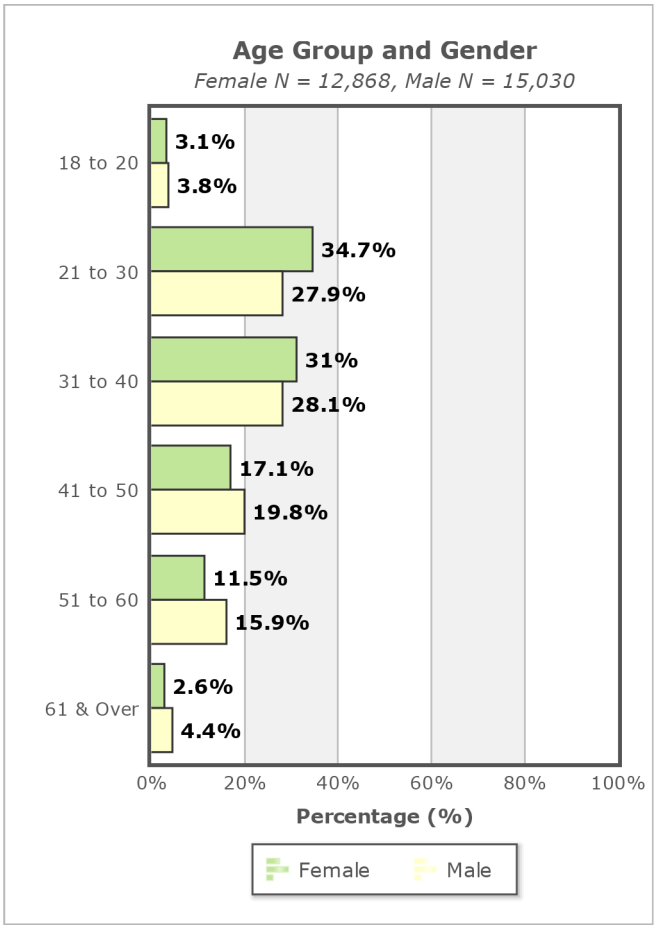




767 *(2.7%)* consumer(s) indicate that they are of Hispanic, Latino, or Spanish origin.


Age Group
18 to 20
3.5%
21 to 30
31%
31 to 40
29.4%
41 to 50
18.6%
51 to 60
13.9%
61 & Over
3.6%
0%
20%
40%
60%
80%
100%
Percentage (%)


Race/Ethnicity and Gender
Female N = 12,868, Male N = 15,030
African American
29.2%
37.3%
Caucasian
64.3%
56.4%
American Indian /Native American
2.8%
1.8%
Asian
0.2%
0.2%
Pacific Islander
0.1%
0.1%
Alaska Native
0%
0%
Multi-Racial
2%
1.8%
Other
1.5%
2.5%
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male


Age Group and Gender
Female N = 12,868, Male N = 15,030
18 to 20
3.1%
3.8%
21 to 30
34.7%
27.9%
31 to 40
31%
28.1%
41 to 50
17.1%
19.8%
51 to 60
11.5%
15.9%
61 & Over
2.6%
4.4%
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male

Services

Periodic Services	Initial	EC
90832-90838 - Psychotherapy	23.0%	25.5%
90846 - Family Therapy without Patient	2.9%	2.0%
90847 - Family Therapy with Patient	3.4%	2.5%
90849 - Group Therapy (multiple family group)	3.6%	2.7%
90853 - Group Therapy (non-multiple family group)	14.4%	16.7%
H0004 - Behavioral Health Counseling - Individual Therapy	9.7%	9.9%
H0004 HQ - Behavioral Health Counseling - Group Therapy	7.3%	6.9%
H0004 HR - Behavioral Health Counseling - Family Therapy with Consumer	3.2%	2.2%
H0004 HS - Behavioral Health Counseling - Family Therapy without Consumer	2.8%	1.9%
YP831 - Behavioral Health Counseling (non-licensed provider)	3.1%	2.9%
YP832 - Behavioral Health Counseling - Group Therapy (non-licensed provider)	3.1%	2.7%
YP833 - Behavioral Health Counseling - Family Therapy with Consumer (non-licensed provider)	2.9%	1.9%
YP834 - Behavioral Health Counseling - Family Therapy without Consumer (non-licensed provider)	2.9%	2.0%
H0005 - Alcohol and/or Drug Group Counseling	16.9%	16.8%
YP835 - Alcohol and/or Drug Group Counseling (non-licensed provider)	4.5%	4.4%

Community Based Services	Initial	EC
H0015 - Substance Abuse Intensive Outpatient Program (SAIOP)	32.7%	33.1%
H0040 - Assertive Community Treatment Team (ACTT)	0.9%	1.1%
H2015, H2015 HT - Community Support Team (CST)	2.7%	2.8%
H2035 - Substance Abuse Comprehensive Outpatient Treatment (SACOT)	12.6%	12.7%
YP630 - Individual Placement and Support (IPS) Supported Employment	0.4% N = 27,461*	0.4%
H2023 U4 - Supported Employment	0.3% N = 27,461*	0.4%
H2026 U4 - Ongoing Supported Employment	0.0% N = 27,461*	0.0%

* - Interview(s) were completed before the question was added to NC-TOPPS.

Facility Based Day Services	Initial	EC
H0035 - Mental Health - Partial Hospitalization	0.1%	0.1%
H2012 HA - Child and Adolescent Day Treatment	0.0%	0.0%

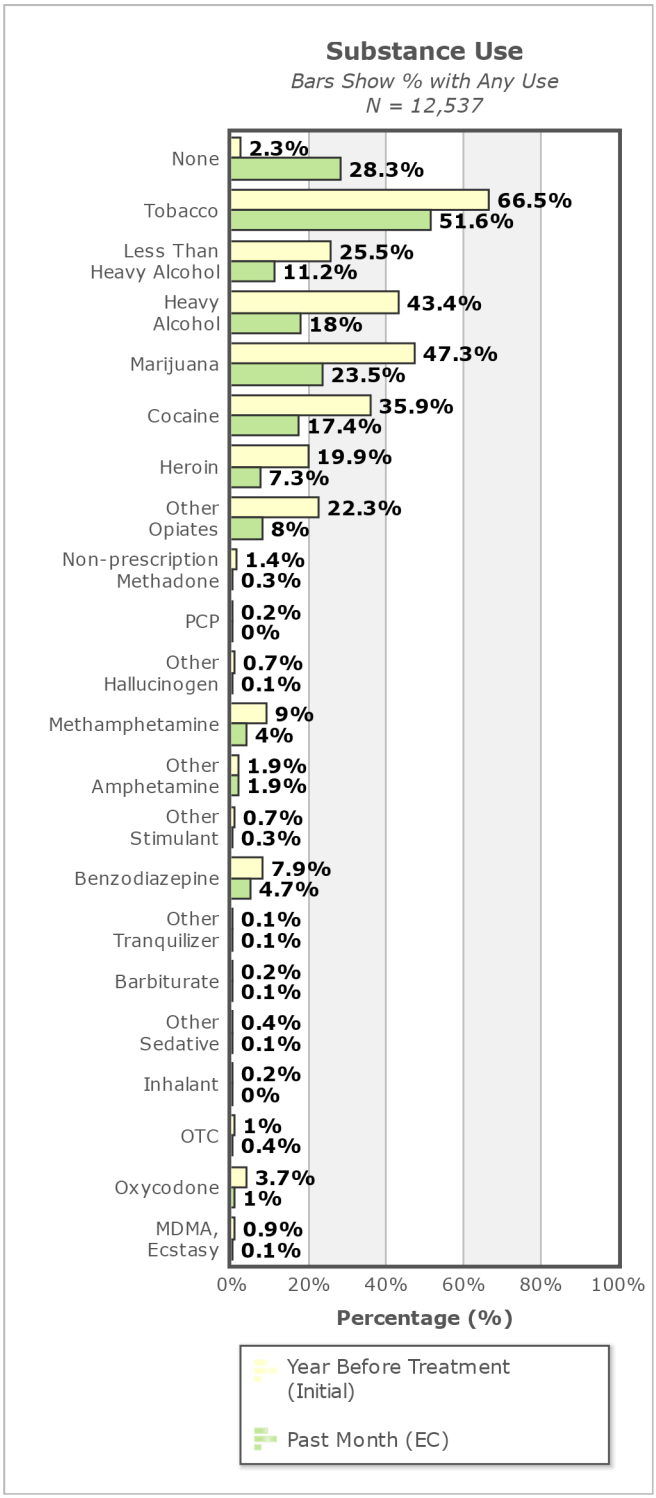
Residental Services	Initial	EC
H0012 HB - SA Non-Medical Community Residential Treatment - Adult	0.5%	0.7%
H0013 - SA Medically Monitored Community Residential Treatment	0.4%	0.4%
H0019 - Behavioral Health - Long Term Residential	0.0%	0.0%
H2020 - Residential Treatment - Level II - Program Type (Therapeutic Behavioral Services)	0.0%	0.0%
YA230 - Psychiatric Residential Treatment Facility	0.0%	0.0%
YP780 - Group Living - High	8.8%	8.9%

Opioid Services	Initial	EC
H0020 - Opioid Treatment	11.0%	11.8%

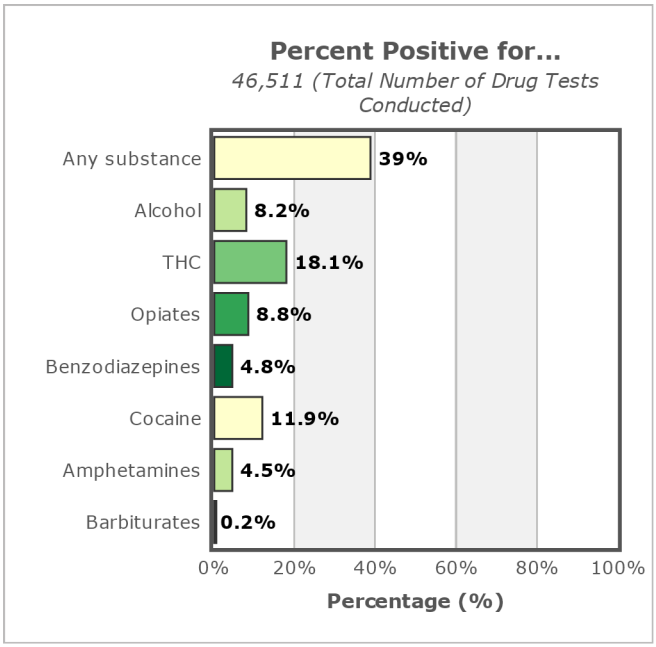
Therapeutic Foster Care Services	Initial	EC
S5145 - Residential Treatment - Level II - Family Type (Foster Care Therapeutic Child)	0.0%	0.0%

Other Services	Initial	EC
Other	4.9%	6.2%

Substance Use



Drug Test Results N = 12,537	Past 3 Months (EC)
Number of Consumer(s) Tested	8120
Percent of Consumer(s) Tested	64.8%
Average # of Tests for Each Consumer Tested	5.7

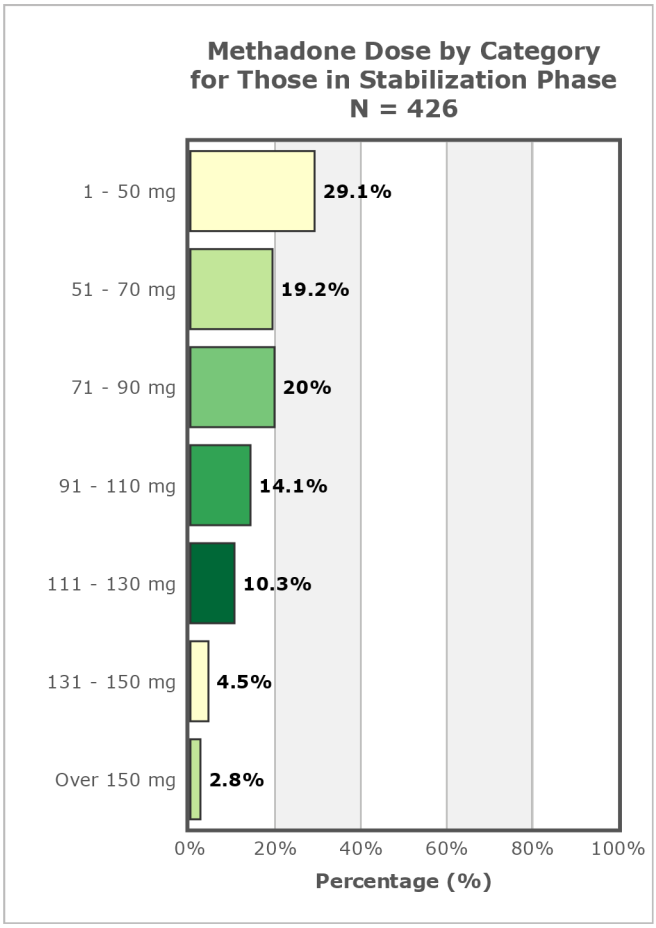


Needles Used To Inject Drugs, Non-Medically N = 4,816	
Needle Use Past 3 Months	8.6%

Consumers in Special Programs	Number N = 12,537
Enrolled in Maternal/Pregnant Program	315
CASAWORKS consumer	141
Work First Consumer	159
Methadone Consumer	908

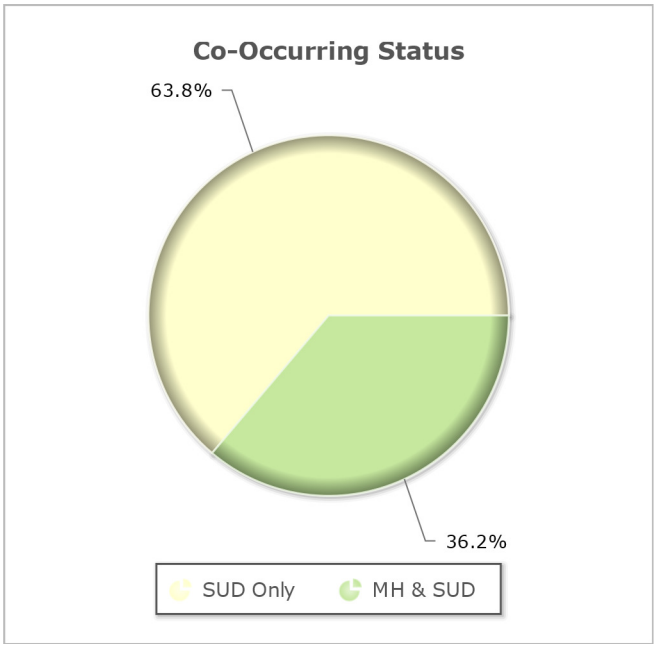
Methadone Dose Information	
# Currently Receiving a Methadone Dose	884
# in Induction Phase	84
# in Stabilization Phase	426
# in Taper Phase	374

Average Methadone Dose for Those in Stabilization Phase N = 426	
Average dose	78.8
NOTE: Zero dose indicates no consumers are in stabilization phase.	



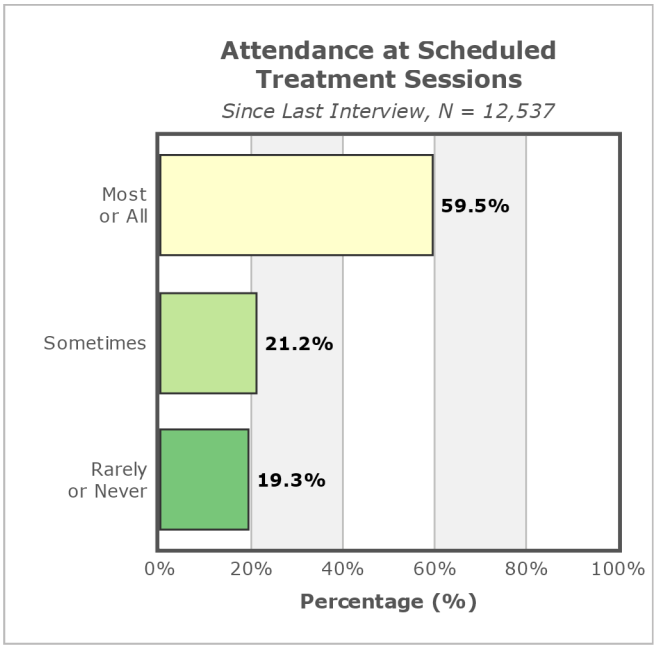
Consumers Receiving Other Medications	
Naltrexon	3
Buprenorphine	12
Antabuse	3
None of these	0

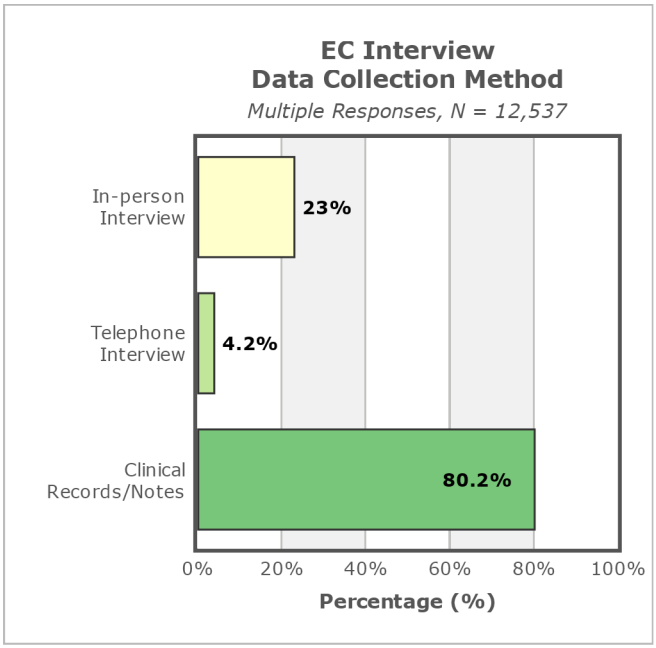
Treatment Demographics



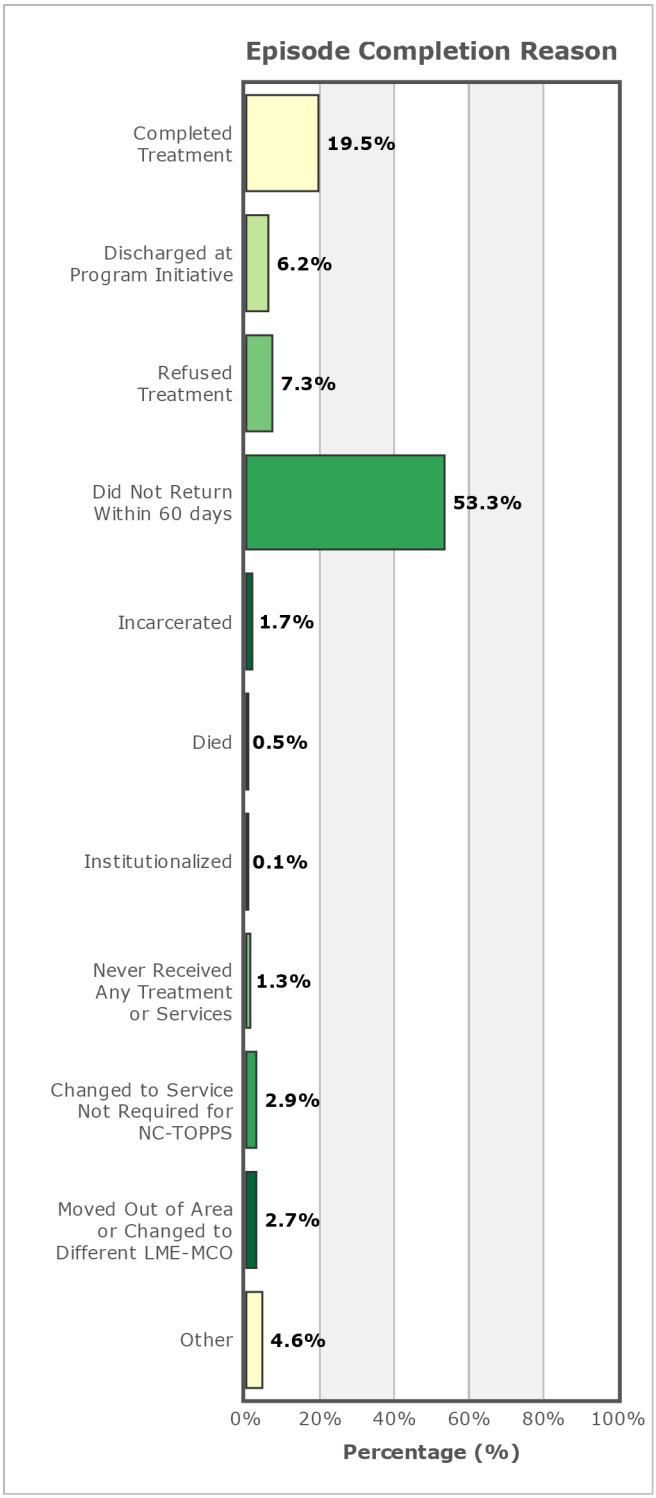
DSM-IV/DSM 5 Diagnoses Diagnostic Category N = 12,537	
Drug Dependence (DSM-IV)	0.0%
Alcohol Dependence (DSM-IV)	0.0%
Drug Abuse (DSM-IV)	0.0%
Alcohol Abuse (DSM-IV)	0.0%
Drug-Related Disorders (DSM 5)	80.6%
Alcohol-Related Disorders (DSM 5)	44.5%
Anxiety Disorder	10.4%
Major Depression	17.6%
Bipolar Disorders	9.4%
Schizophrenia	5.7%
Personality Disorders	2.0%
PTSD	10.7%

* Only most commonly diagnosed conditions shown.

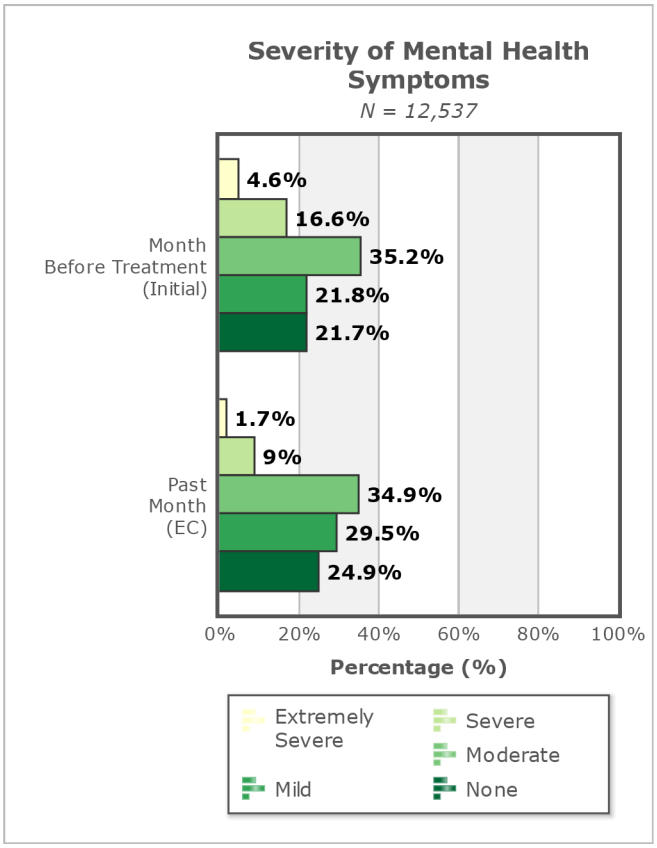


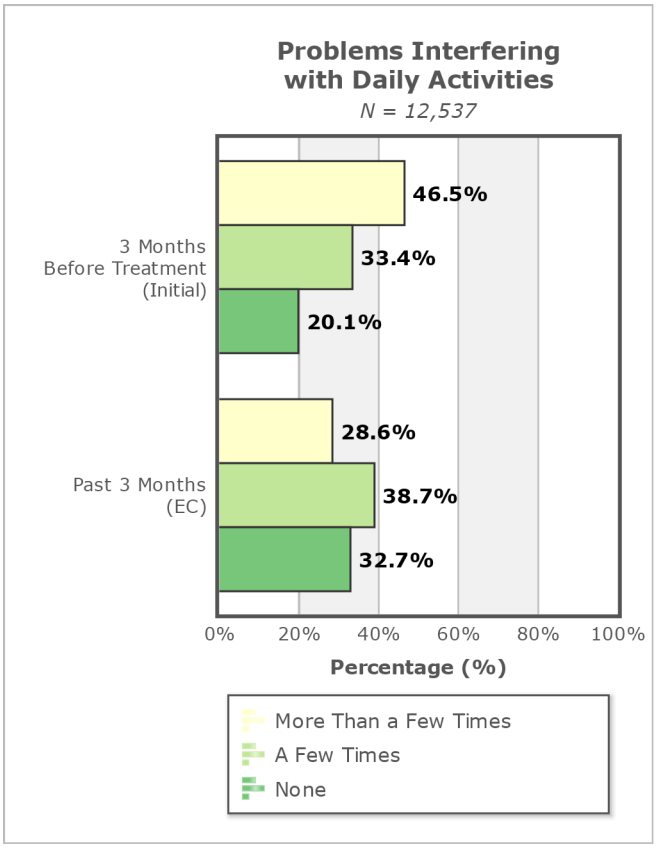


Consumers in Special Programs	Number N = 12,537
TASC program consumer	859



Behaviors

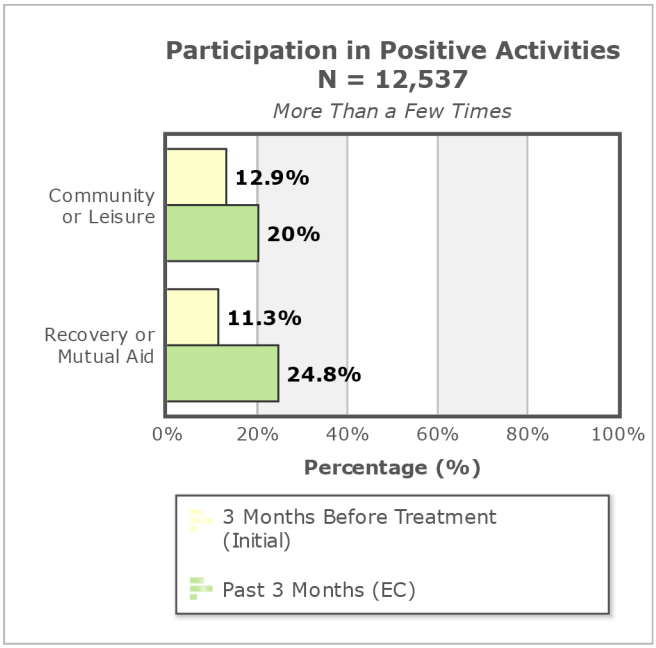




Consumer Ratings on Quality of Life
% Rated 'Excellent' or 'Good'
N = 4,816

	Year Before Treatment (Initial)	Past 3 Months (EC)
Emotional Well-Being	30.6%	56.8%
Physical Health	46.9%	62.3%
Family Relationships	39.3%	58.0%
Living/Housing Situation	44.5% N = 4,746 *	60.6%

* - Interview(s) were completed after the question was added to NC-TOPPS.



Family and/or Friends Somewhat or Very Supportive
N = 4,816

	Expect Support (Initial)	Received Support (EC)
Family Support	88.5%	91.9%

Experienced Abuse
N = 4,816

	3 Months Before Treatment (Initial)	Past 3 Months (EC)
Physical Violence	10.9%	4.9%
Hit/Physically Hurt Someone	8.3%	3.8%

Justice System Involvement
N = 12,537
3,094 *(24.7%)* consumer(s) were under supervision at the time of their EC interview.

	Month Before Treatment (Initial)	Past Month (EC)
Arrests N = 12,537	5.7%	4.5%
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Nights in Jail or Detention N = 4,816	12.6%	6.3%

Suicide Ideation and Hurting Self
N = 4,816

	Ever (Initial)	Since Last Interview (EC)
Suicidal Attempts	23.0%	1.4%
	3 Months Before Treatment (Initial)	**Since Last Interview (EC)**
Suicidal Thoughts	21.8%	4.8%
Tried to Hurt or Cause Self Pain	5.3%	1.3%

Psychotropic Medications at EC
5,578 *(44.5%)* consumer(s) have had a prescription for psychotropic medications in the past month. Of those, 4,255 *(76.3%)* take their medication as prescribed all or most of the time.

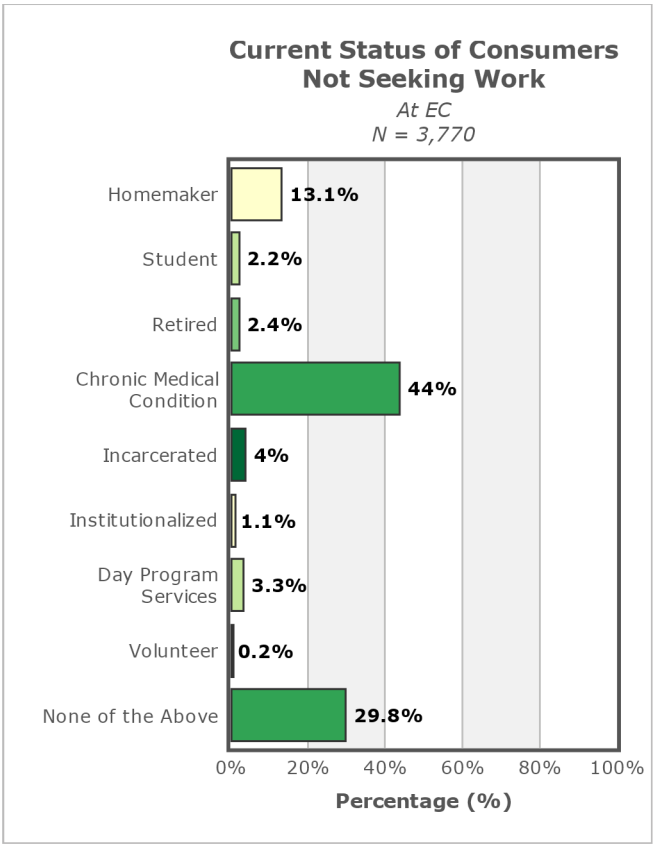
Employment/Housing

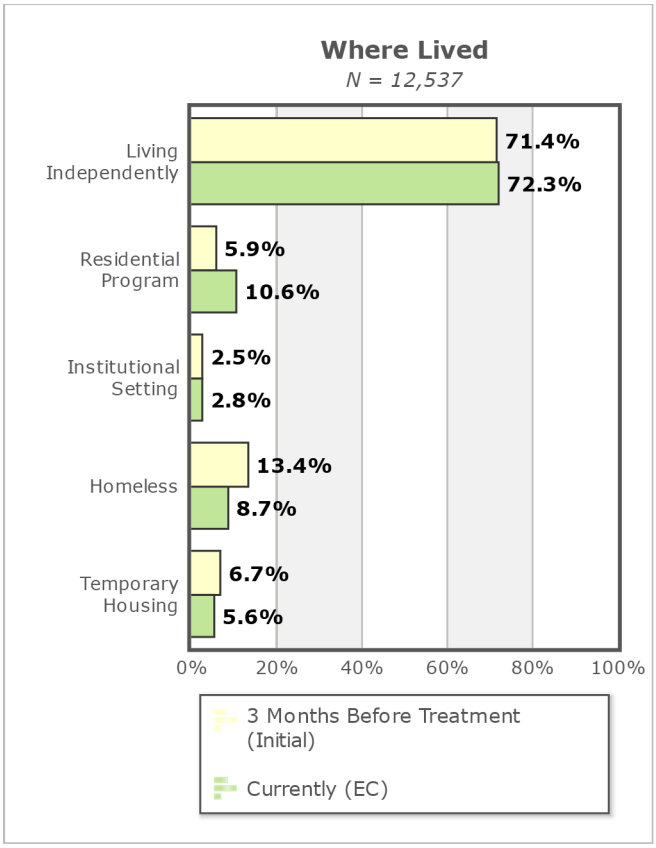
Employment N = 12,537	3 Months Before Treatment (Initial)	Currently (EC)
% In Labor Force	72.2%	69.9%
Of those in the labor force (N)...	**9,055**	**8,767**
Employed Full-time	17.5%	20.9%
Employed Part-time	13.6%	16.3%
Unemployed (seeking work)	68.8%	62.8%

Job Classification	Initial N = 2,781	EC N = 3,263
Professional, Technical, or Managerial	9.1%	8.3%
Clerical or Sales	6.1%	5.4%
Service Occupation	35.3%	41.3%
Agricultural or Related Occupation	2.8%	3.1%
Processing Occupation	2.9%	3.5%
Machine Trades	4.1%	2.3%
Bench Work	2.8%	3.5%
Structural Work	15.0%	14.6%
Miscellaneous Occupation	21.7%	17.9%

Employee Benefits	Initial N = 2,781	EC N = 3,263
Insurance	6.3%	8.6%
Paid Time Off	6.2%	7.2%
Meal/Retail Discounts	6.0%	6.9%
Other	4.4%	6.7%
None	81.7%	77.6%

Rate of Pay	Initial N = 2,781	EC N = 3,263
Above Minimum Wage	72.3%	75.3%
Minimum Wage	21.5%	21.1%
Below Minimum Wage	6.2%	3.5%



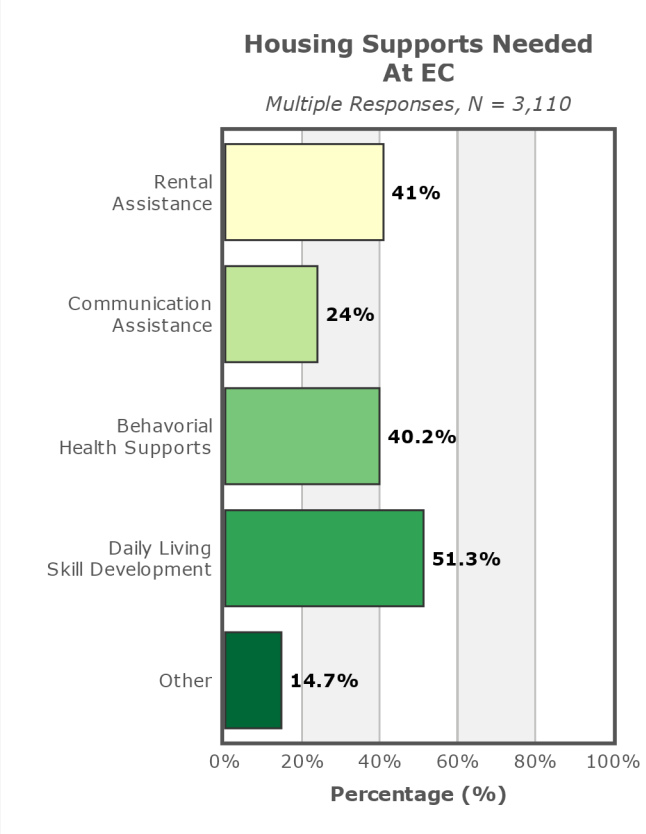


Times Moved Residences Past 3 Months (EC) N = 12,537	
No Moves	70.1%
Moved Once	19.3%
Moved Two or More Times	10.6%

Homeless Consumers	3 Months Before Treatment (Initial)	Currently (EC)
In Shelters	877	682
Not In Shelters	808	404
Total Homeless (N)	1685	1086

Service Needs

Services Deemed Important at Initial and Received at EC Multiple Responses, N = 12,537		
	Initial	**EC**
Education	28.5%	10.0%
Job	41.0%	18.5%
Housing	38.5%	24.8%
Transportation	34.2%	22.3%
Child Care	8.6%	3.6%
Medical	31.7%	24.9%
Dental	24.2% N = 12,285 *	5.4%
Screening/Treatment Referral for HIV/TB/HEP	N/A	12.0%
Legal	19.9%	14.9%
Volunteer Opportunities	9.1% N = 12,285 *	4.8%
None	27.1%	40.0%
* - Interview(s) were completed before the question was added to NC-TOPPS.		



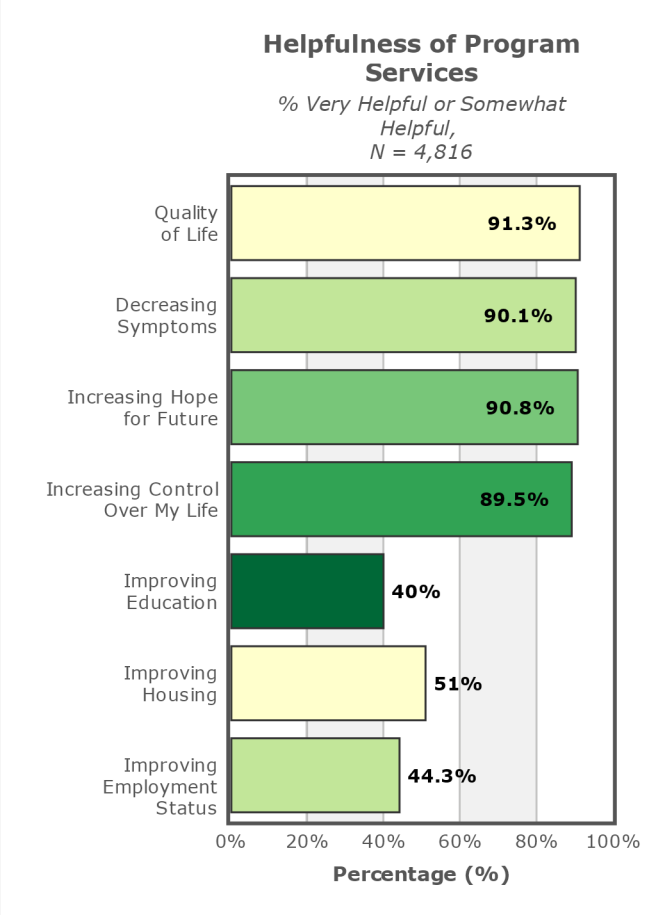
Barriers to Treatment Multiple Responses, N = 12,537		
	Initial	**EC**
No Difficulties	68.3%	65.5%
Active MH Symptoms	8.9%	9.1%
Active SA Symptoms	16.5%	17.5%
Physical Health	2.0%	2.5%
Family Issues	1.4%	2.3%
Needs Not Met	0.8%	0.6%
Engagement	2.9%	7.8%
Cost	4.1%	1.6%
Stigma /Discrimination	0.4%	0.1%
Treatment /Auth. Access	1.7%	0.4%
Deaf/Hard of Hearing	0.1%	0.1%
Language/Comm.	0.1%	0.0%
Legal Reasons	1.8%	2.6%
Transportation	9.5%	8.7%
Scheduling Issues	3.2%	5.1%
Lack of Stable Housing	3.4% N = 12,285 *	2.7%
Personal Safety	0.5% N = 12,285 *	0.4%
* - Interview(s) were completed before the question was added to NC-TOPPS.		

Crisis/Hospital Care Past 3 Months N = 4,816		
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Crisis Contacts	17.6%	10.4%
ER Visits	32.5%	21.0%
Medical/Surgical Hospital Nights	11.8%	7.2%
Psychiatric Inpatient Hospital Nights	14.3% N = 4,746 *	7.3%
* - Interview(s) were completed after the question was added to NC-TOPPS.		

Routine Health Care
Among 4,816 consumer(s), 2,448 *(50.8%)* have seen their provider for a routine check-up since the last interview.

Routine Dental Care

Among 4,816 consumer(s), 798 *(16.6%)* have seen their dentist for a routine check-up since the last interview.

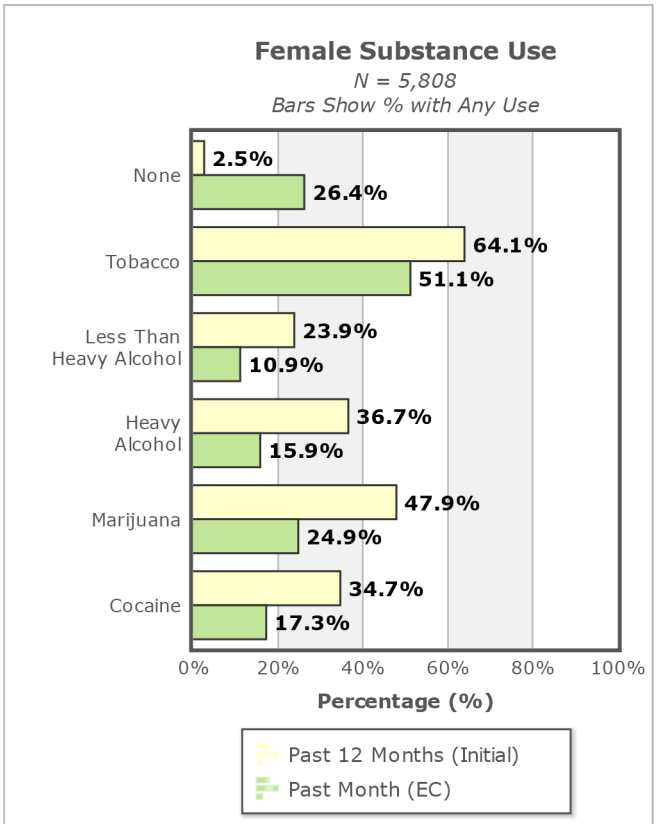


Maternal/Perinatal

Female Substance Use Consumers
Several questions on the NC-TOPPS interview are asked only to female consumers. The tables and charts on this page show the results for those questions. In addition, several other charts are shown for females only. The number of female consumer(s) is 12,868 *(46.1%)*.

Pregnancy ***Female N = 2,390***	**Number**
Gave Birth in Past Year	227
Currently Pregnant	100
Uncertain about Pregnancy Status	24
In First Trimester*	13
In Second Trimester*	40
In Third Trimester*	47
Referred to Prenatal Care*	92
Receiving Prenatal Care*	90

* of those who are pregnant.



Females with Children Under 18
Of the 5,808 female consumer(s), 3,176 *(54.7%)* have children under the age of 18.

DSS Involvement Since Last Interview Among Females with Children Under 18 N = 3,176	
Investigated by DSS for Child Abuse/Neglect	8.9%

Sexual Risk Activity Among Females
Participation in any one or more of these activities: (a) had sex with someone who was not your spouse or primary partner, (b) knowingly had sex with someone who injected drugs, or (c) traded, gave, or received sex for drugs.

N = 2,390	
In Past 3 Months	7.1%

Females Forced or Pressured to Do Sexual Acts N = 2,390	
In Past 3 Months	2.1%

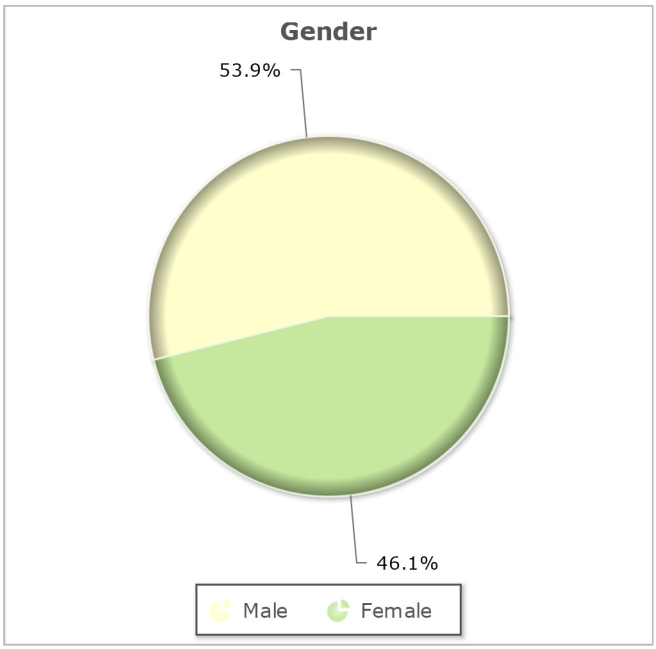
Females Experienced Abuse Past 3 Months N = 2,390	
Physical Violence	5.6%
Hit/Physically Hurt Another Person	4.4%

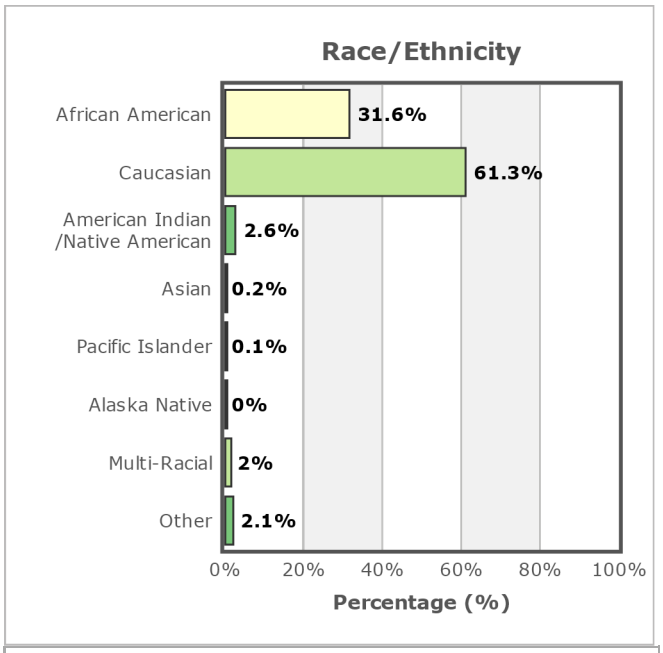
Suicide Ideation and Hurting Self, Since Last Interview Among Females N = 2,390	
Suicidal Attempts	1.2%
Suicidal Thoughts	4.9%
Tried to Hurt or Cause Self Pain	1.3%

NC-TOPPS Simple Query Report

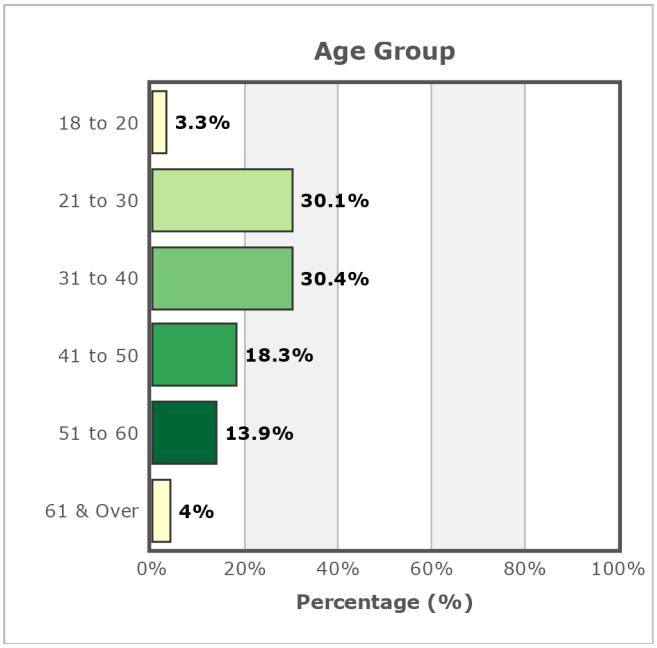
Alliance Health
Cardinal Innovations
Eastpointe
Partners Behavioral Health Management
Sandhills
Trillium Health Resources
Vaya Health
Adult Substance Use Disorder Consumers
Episode Completion Interviews started *Sunday, July 1, 2018* through *Sunday, June 30, 2019*
Number of Episode Completion Interviews: 27,622

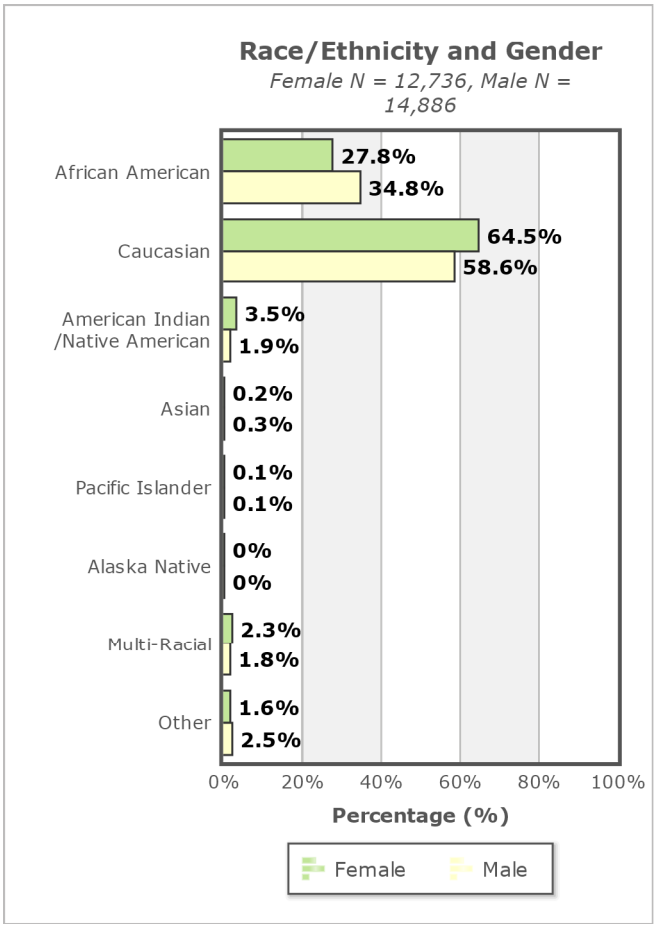
Demographics

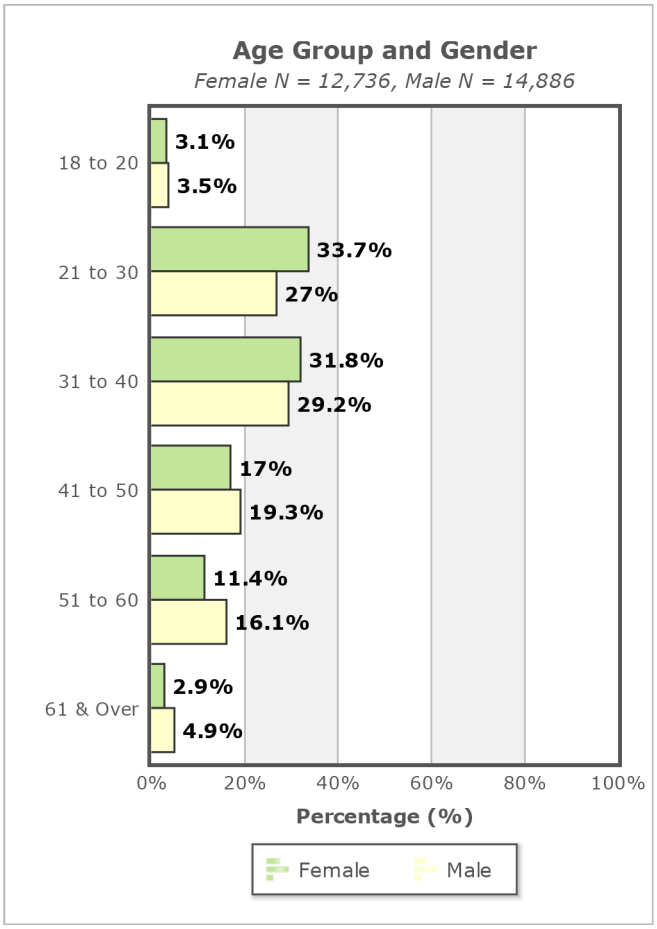




764 *(2.8%)* consumer(s) indicate that they are of Hispanic, Latino, or Spanish origin.


Age Group
18 to 20
3.3%
21 to 30
30.1%
31 to 40
30.4%
41 to 50
18.3%
51 to 60
13.9%
61 & Over
4%
0%
20%
40%
60%
80%
100%
Percentage (%)


Race/Ethnicity and Gender
Female N = 12,736, Male N = 14,886
African American
27.8%
34.8%
Caucasian
64.5%
58.6%
American Indian /Native American
3.5%
1.9%
Asian
0.2%
0.3%
Pacific Islander
0.1%
0.1%
Alaska Native
0%
0%
Multi-Racial
2.3%
1.8%
Other
1.6%
2.5%
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male


Age Group and Gender
Female N = 12,736, Male N = 14,886
18 to 20
3.1%
3.5%
21 to 30
33.7%
27%
31 to 40
31.8%
29.2%
41 to 50
17%
19.3%
51 to 60
11.4%
16.1%
61 & Over
2.9%
4.9%
0%
20%
40%
60%
80%
100%
Percentage (%)
Female
Male

Services

Periodic Services	Initial	EC
90832-90838 - Psychotherapy	24.6%	27.3%
90846 - Family Therapy without Patient	3.4%	3.1%
90847 - Family Therapy with Patient	4.1%	3.8%
90849 - Group Therapy (multiple family group)	4.0%	3.8%
90853 - Group Therapy (non-multiple family group)	16.0%	18.5%
H0004 - Behavioral Health Counseling - Individual Therapy	9.2%	9.5%
H0004 HQ - Behavioral Health Counseling - Group Therapy	7.6%	7.5%
H0004 HR - Behavioral Health Counseling - Family Therapy with Consumer	3.6%	3.3%
H0004 HS - Behavioral Health Counseling - Family Therapy without Consumer	3.3%	3.0%
YP831 - Behavioral Health Counseling (non-licensed provider)	3.4%	3.4%
YP832 - Behavioral Health Counseling - Group Therapy (non-licensed provider)	3.5%	3.4%
YP833 - Behavioral Health Counseling - Family Therapy with Consumer (non-licensed provider)	3.3%	3.0%
YP834 - Behavioral Health Counseling - Family Therapy without Consumer (non-licensed provider)	3.3%	3.0%
H0005 - Alcohol and/or Drug Group Counseling	17.1%	17.8%
YP835 - Alcohol and/or Drug Group Counseling (non-licensed provider)	5.1%	5.6%

Community Based Services	Initial	EC
H0015 - Substance Abuse Intensive Outpatient Program (SAIOP)	31.5%	31.4%
H0040 - Assertive Community Treatment Team (ACTT)	0.9%	1.0%
H2015, H2015 HT - Community Support Team (CST)	2.5%	2.7%
H2035 - Substance Abuse Comprehensive Outpatient Treatment (SACOT)	13.5%	13.5%
YP630 - Individual Placement and Support (IPS) Supported Employment	0.4% N = 27,299*	0.6%
H2023 U4 - Supported Employment	0.3% N = 27,299*	0.3%
H2026 U4 - Ongoing Supported Employment	0.0% N = 27,299*	0.0%

* - Interview(s) were completed before the question was added to NC-TOPPS.

Facility Based Day Services	Initial	EC
H0035 - Mental Health - Partial Hospitalization	0.1%	0.2%
H2012 HA - Child and Adolescent Day Treatment	0.0%	0.0%

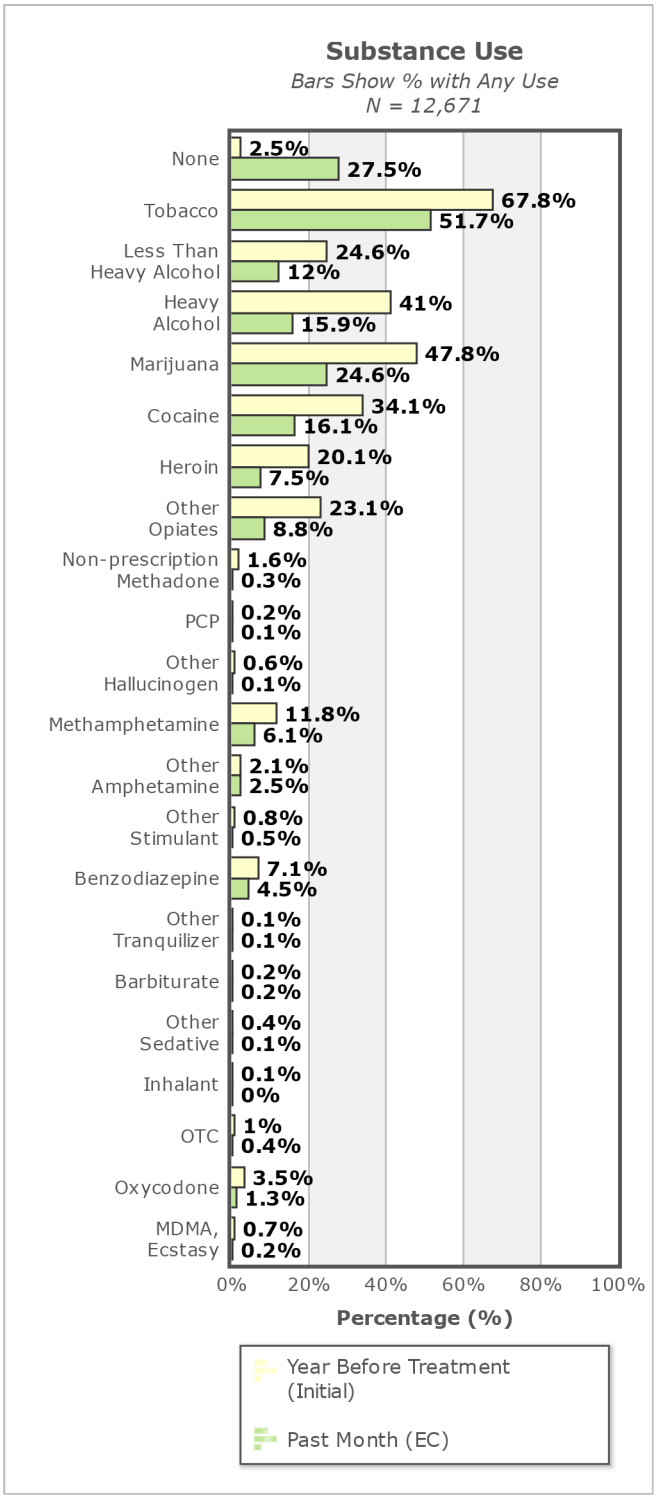
Residental Services	Initial	EC
H0012 HB - SA Non-Medical Community Residential Treatment - Adult	0.6%	0.6%
H0013 - SA Medically Monitored Community Residential Treatment	0.3%	0.3%
H0019 - Behavioral Health - Long Term Residential	0.0%	0.0%
H2020 - Residential Treatment - Level II - Program Type (Therapeutic Behavioral Services)	0.0%	0.0%
YA230 - Psychiatric Residential Treatment Facility	0.0%	0.0%
YP780 - Group Living - High	8.1%	8.4%

Opioid Services	Initial	EC
H0020 - Opioid Treatment	12.2%	13.3%

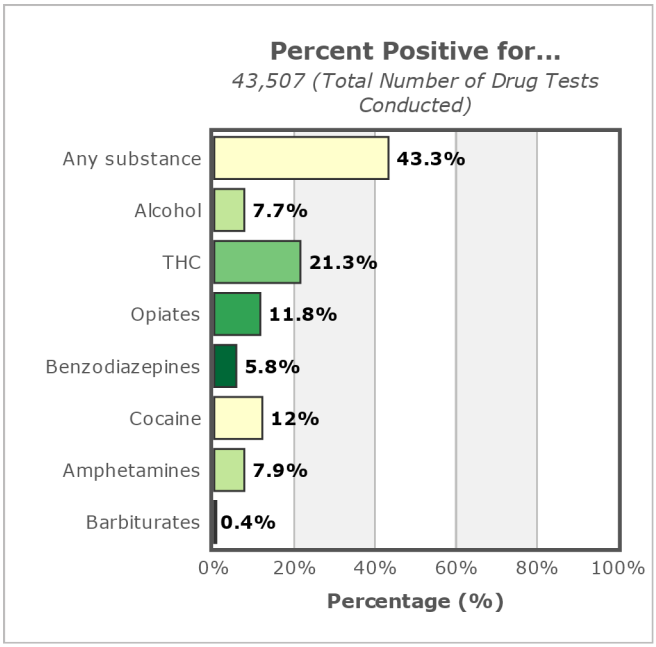
Therapeutic Foster Care Services	Initial	EC
S5145 - Residential Treatment - Level II - Family Type (Foster Care Therapeutic Child)	0.1%	0.1%

Other Services	Initial	EC
Other	5.1%	6.4%

Substance Use



Drug Test Results N = 12,671	Past 3 Months (EC)
Number of Consumer(s) Tested	8309
Percent of Consumer(s) Tested	65.6%
Average # of Tests for Each Consumer Tested	5.2

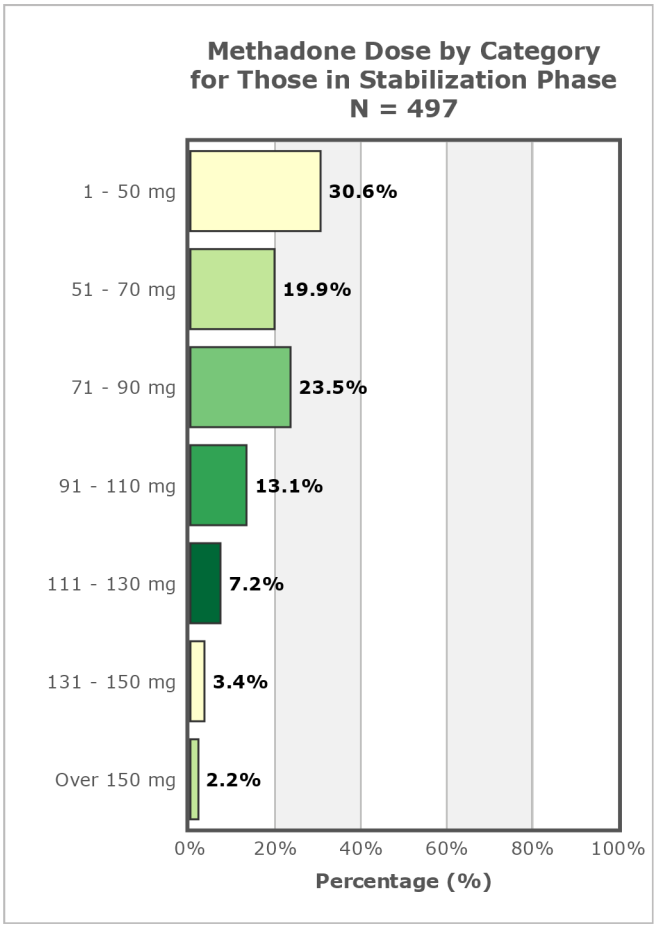


Needles Used To Inject Drugs, Non-Medically N = 4,307	
Needle Use Past 3 Months	8.1%

Consumers in Special Programs	Number N = 12,671
Enrolled in Maternal/Pregnant Program	244
CASAWORKS consumer	131
Work First Consumer	148
Methadone Consumer	1,095

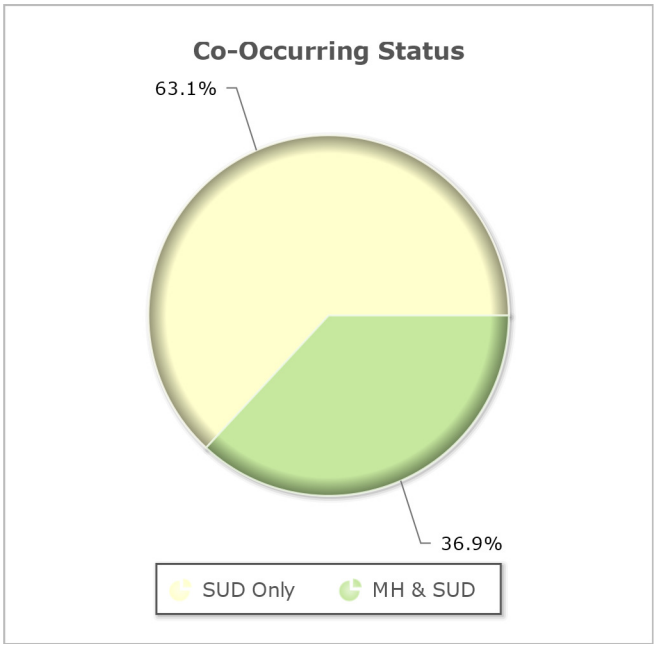
Methadone Dose Information	
# Currently Receiving a Methadone Dose	1070
# in Induction Phase	106
# in Stabilization Phase	497
# in Taper Phase	467

Average Methadone Dose for Those in Stabilization Phase N = 497	
Average dose	73.2
NOTE: Zero dose indicates no consumers are in stabilization phase.	



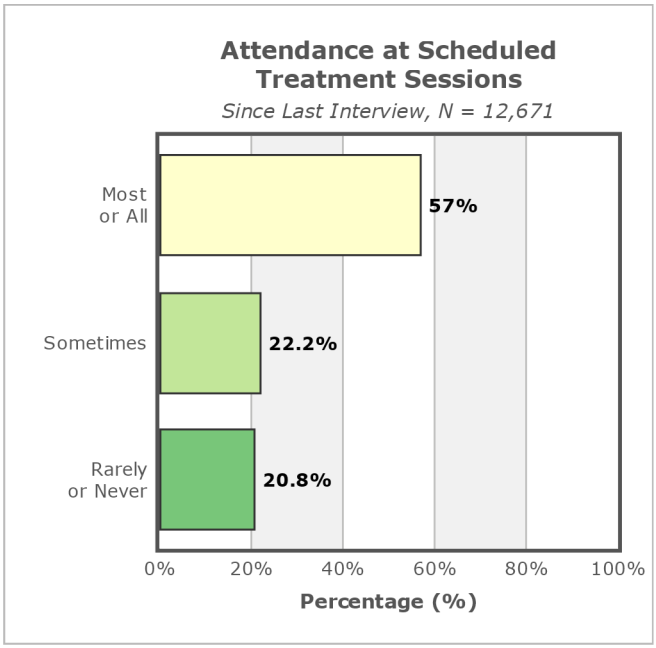
Consumers Receiving Other Medications	
Naltrexon	3
Buprenorphine	8
Antabuse	1
None of these	0

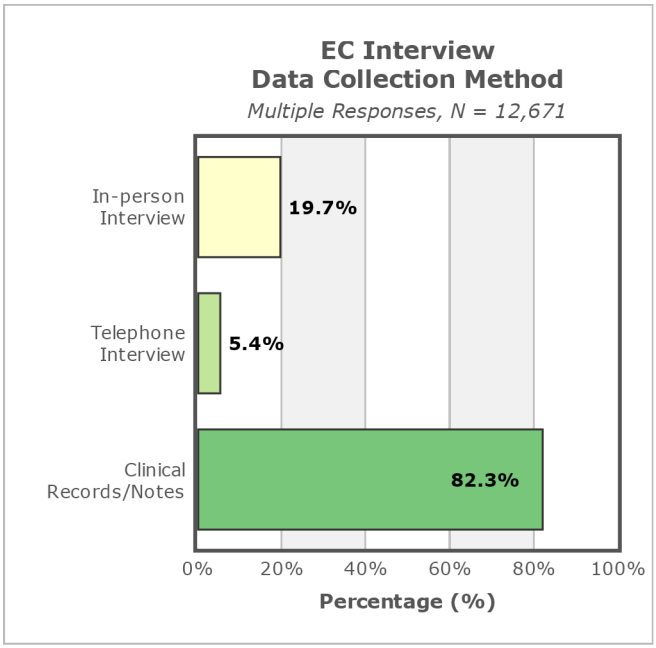
Treatment Demographics



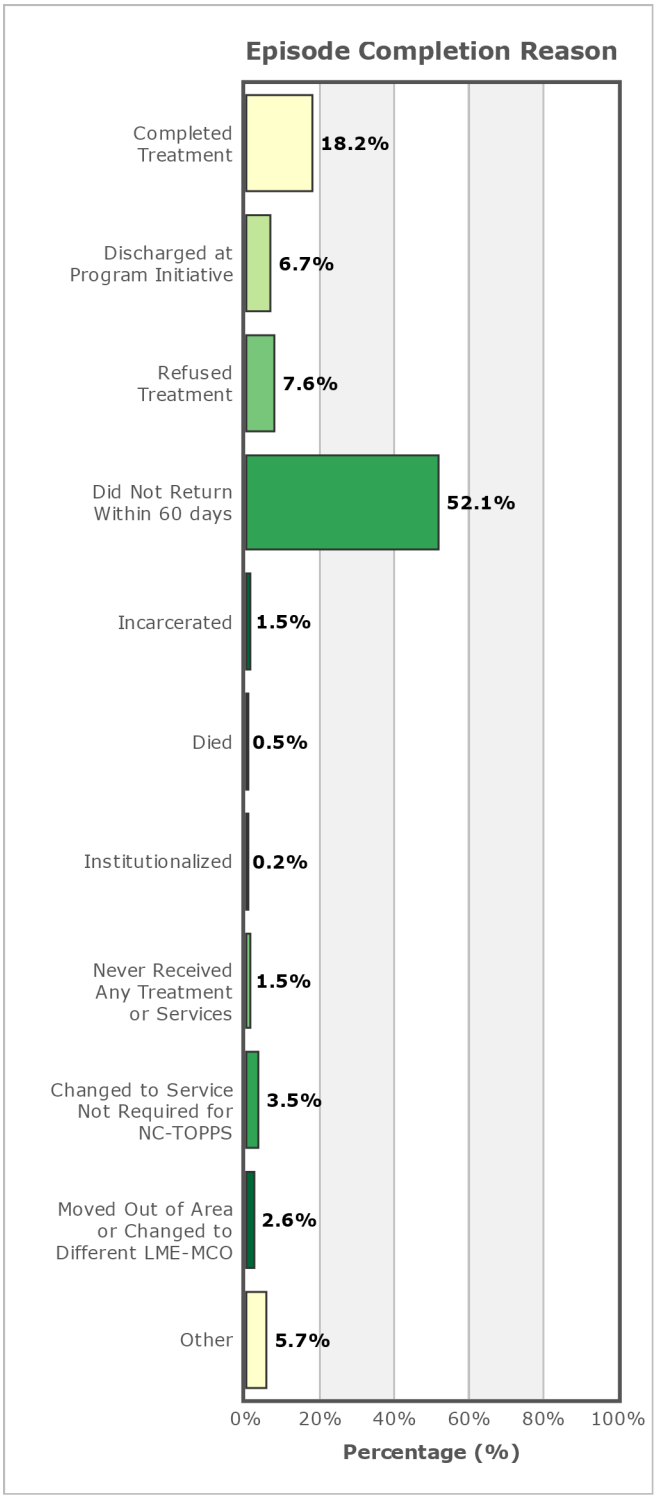
DSM-IV/DSM 5 Diagnoses Diagnostic Category N = 12,671	
Drug Dependence (DSM-IV)	0.0%
Alcohol Dependence (DSM-IV)	0.0%
Drug Abuse (DSM-IV)	0.0%
Alcohol Abuse (DSM-IV)	0.0%
Drug-Related Disorders (DSM 5)	82.1%
Alcohol-Related Disorders (DSM 5)	41.4%
Anxiety Disorder	11.5%
Major Depression	17.5%
Bipolar Disorders	8.8%
Schizophrenia	4.9%
Personality Disorders	1.7%
PTSD	10.1%

* Only most commonly diagnosed conditions shown.

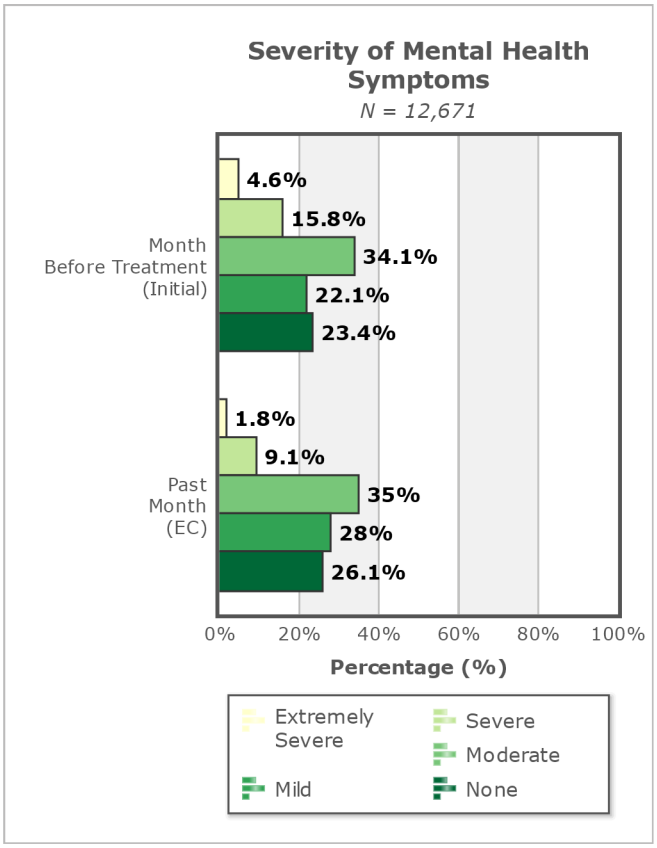


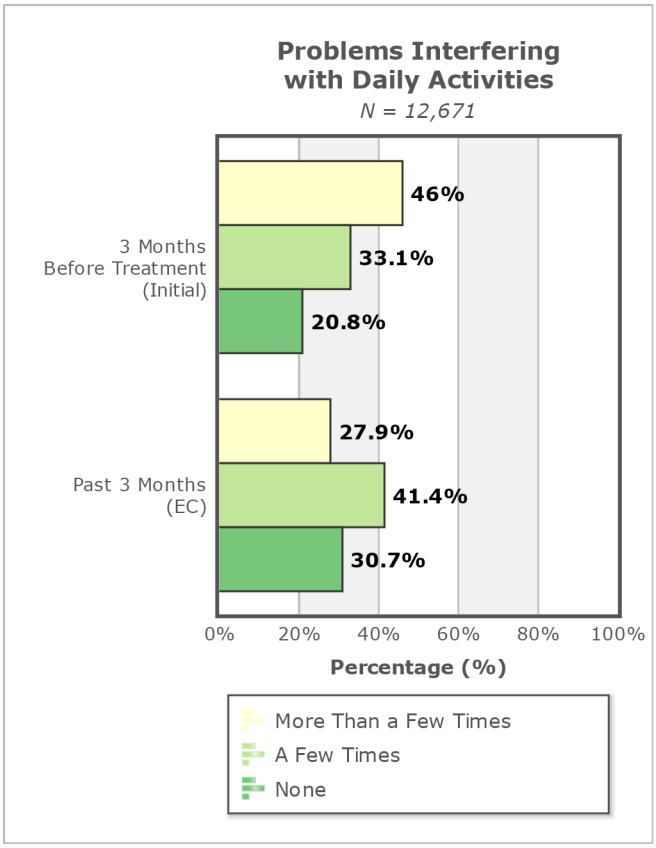


Consumers in Special Programs	Number N = 12,671
TASC program consumer	896



Behaviors

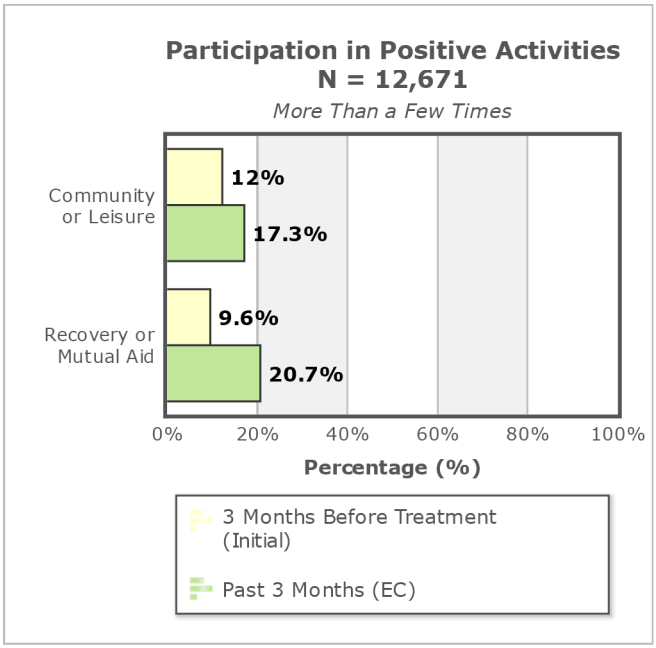




Consumer Ratings on Quality of Life
% Rated 'Excellent' or 'Good'
N = 4,307

	Year Before Treatment (Initial)	Past 3 Months (EC)
Emotional Well-Being	33.7%	56.0%
Physical Health	46.0%	59.4%
Family Relationships	40.3%	56.4%
Living/Housing Situation	46.3% N = 4,261 *	59.4%

* - Interview(s) were completed after the question was added to NC-TOPPS.



Family and/or Friends Somewhat or Very Supportive
N = 4,307

	Expect Support (Initial)	Received Support (EC)
Family Support	90.5%	91.7%

Experienced Abuse
N = 4,307

	3 Months Before Treatment (Initial)	Past 3 Months (EC)
Physical Violence	9.4%	4.6%
Hit/Physically Hurt Someone	7.1%	3.8%

Justice System Involvement
N = 12,671
3,048 *(24.1%)* consumer(s) were under supervision at the time of their EC interview.

	Month Before Treatment (Initial)	Past Month (EC)
Arrests N = 12,671	4.9%	4.1%
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Nights in Jail or Detention N = 4,307	12.7%	6.7%

Suicide Ideation and Hurting Self
N = 4,307

	Ever (Initial)	Since Last Interview (EC)
Suicidal Attempts	21.5%	1.5%
	3 Months Before Treatment (Initial)	**Since Last Interview (EC)**
Suicidal Thoughts	19.7%	5.4%
Tried to Hurt or Cause Self Pain	5.6%	1.2%

Psychotropic Medications at EC
5,476 *(43.2%)* consumer(s) have had a prescription for psychotropic medications in the past month. Of those, 4,183 *(76.4%)* take their medication as prescribed all or most of the time.

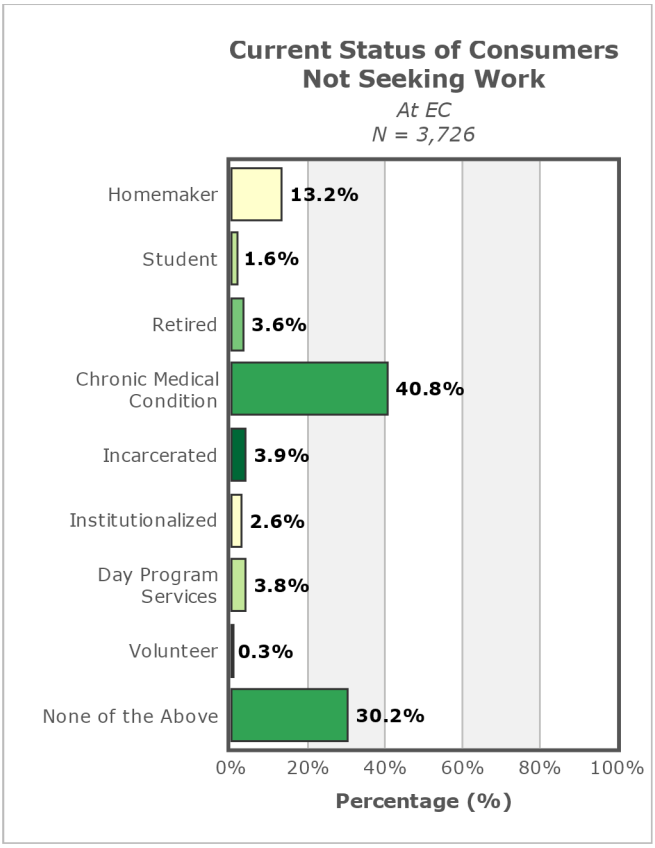
Employment/Housing

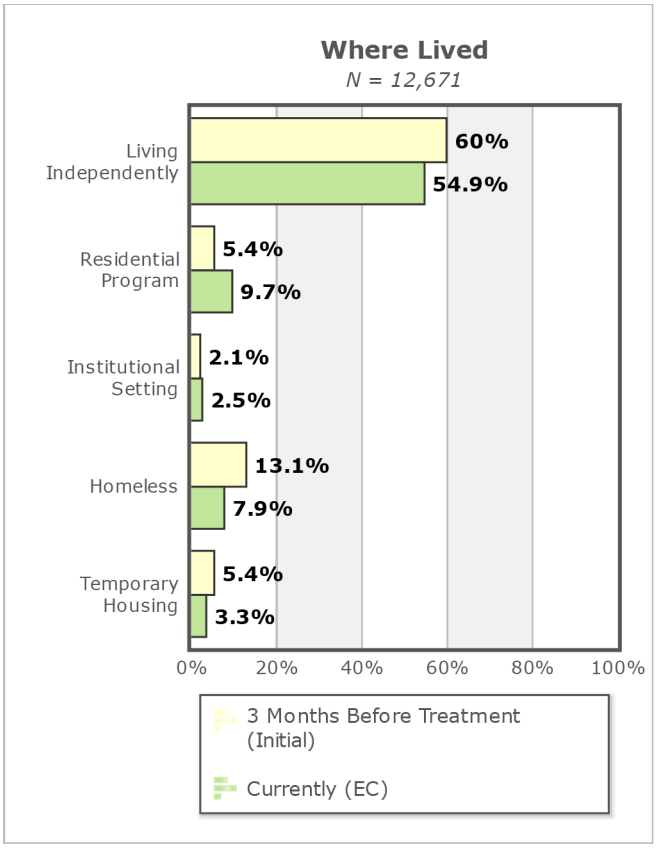
Employment N = 12,671	3 Months Before Treatment (Initial)	Currently (EC)
% In Labor Force	73.8%	70.6%
Of those in the labor force (N)...	**9,349**	**8,945**
Employed Full-time	18.0%	23.9%
Employed Part-time	13.9%	17.2%
Unemployed (seeking work)	68.1%	58.9%

Job Classification	Initial N = 2,936	EC N = 3,678
Professional, Technical, or Managerial	9.2%	7.1%
Clerical or Sales	6.6%	6.2%
Service Occupation	33.6%	40.3%
Agricultural or Related Occupation	2.2%	2.1%
Processing Occupation	3.8%	4.2%
Machine Trades	3.7%	2.4%
Bench Work	2.8%	3.1%
Structural Work	15.2%	14.6%
Miscellaneous Occupation	23.0%	19.9%

Employee Benefits	Initial N = 2,936	EC N = 3,678
Insurance	6.2%	9.0%
Paid Time Off	5.8%	7.7%
Meal/Retail Discounts	5.3%	5.5%
Other	4.5%	6.3%
None	82.8%	78.4%

Rate of Pay	Initial N = 2,936	EC N = 3,678
Above Minimum Wage	74.3%	78.3%
Minimum Wage	20.1%	18.1%
Below Minimum Wage	5.7%	3.5%





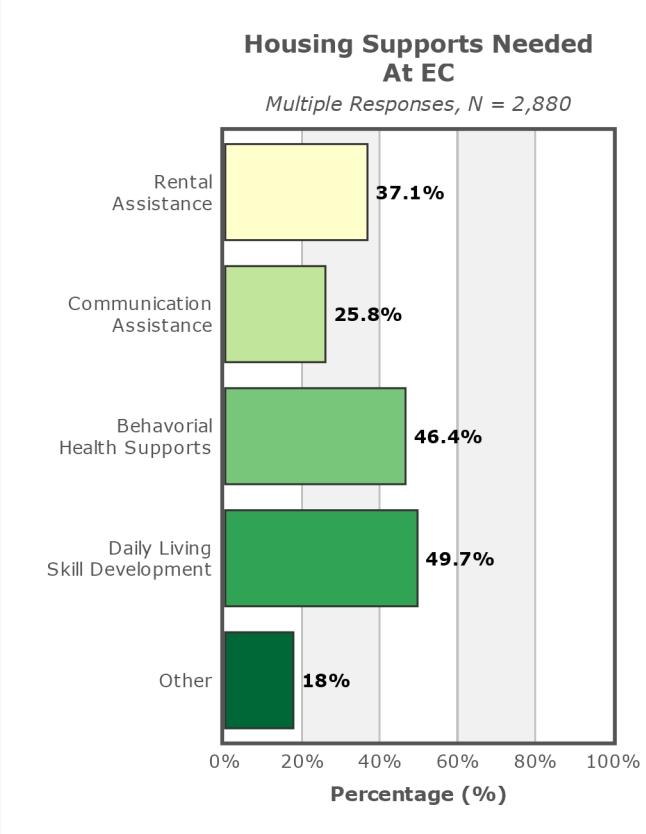
Times Moved Residences Past 3 Months (EC) N = 12,671	
No Moves	72.4%
Moved Once	18.5%
Moved Two or More Times	9.1%

Homeless Consumers	3 Months Before Treatment (Initial)	Currently (EC)
In Shelters	801	539
Not In Shelters	856	466
Total Homeless (N)	1657	1005

Service Needs

Services Deemed Important at Initial and Received at EC Multiple Responses, N = 12,671		
	Initial	**EC**
Education	26.5%	8.8%
Job	40.6%	15.3%
Housing	37.3%	22.7%
Transportation	35.4%	22.4%
Child Care	7.3%	2.8%
Medical	30.9%	20.5%
Dental	24.2% N = 12,448 *	4.7%
Screening/Treatment Referral for HIV/TB/HEP	N/A	9.4%
Legal	18.3%	12.2%
Volunteer Opportunities	8.6% N = 12,448 *	3.9%
None	27.2%	45.9%

* - Interview(s) were completed before the question was added to NC-TOPPS.



Barriers to Treatment Multiple Responses, N = 12,671		
	Initial	**EC**
No Difficulties	67.1%	64.0%
Active MH Symptoms	8.8%	8.6%
Active SA Symptoms	16.9%	17.8%
Physical Health	1.8%	2.5%
Family Issues	1.5%	2.0%
Needs Not Met	0.9%	0.5%
Engagement	2.2%	7.1%
Cost	4.6%	1.6%
Stigma /Discrimination	0.4%	0.1%
Treatment /Auth. Access	1.6%	0.4%
Deaf/Hard of Hearing	0.1%	0.0%
Language/Comm.	0.1%	0.1%
Legal Reasons	1.8%	2.4%
Transportation	10.2%	9.3%
Scheduling Issues	3.2%	5.2%
Lack of Stable Housing	3.9% N = 12,448 *	2.3%
Personal Safety	0.6% N = 12,448 *	0.3%

* - Interview(s) were completed before the question was added to NC-TOPPS.

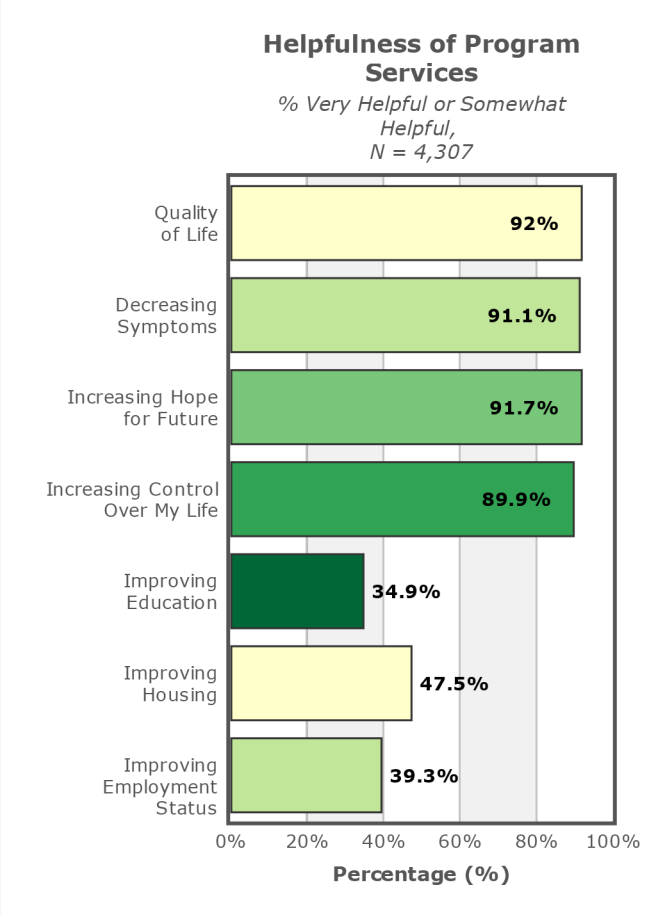
Crisis/Hospital Care Past 3 Months N = 4,307		
	3 Months Before Treatment (Initial)	**Past 3 Months (EC)**
Crisis Contacts	16.4%	9.9%
ER Visits	29.4%	19.4%
Medical/Surgical Hospital Nights	11.6%	7.5%
Psychiatric Inpatient Hospital Nights	12.4% N = 4,261 *	6.8%

* - Interview(s) were completed after the question was added to NC-TOPPS.

Routine Health Care
Among 4,307 consumer(s), 1,848 *(42.9%)* have seen their provider for a routine check-up since the last interview.

Routine Dental Care

Among 4,307 consumer(s), 660 *(15.3%)* have seen their dentist for a routine check-up since the last interview.

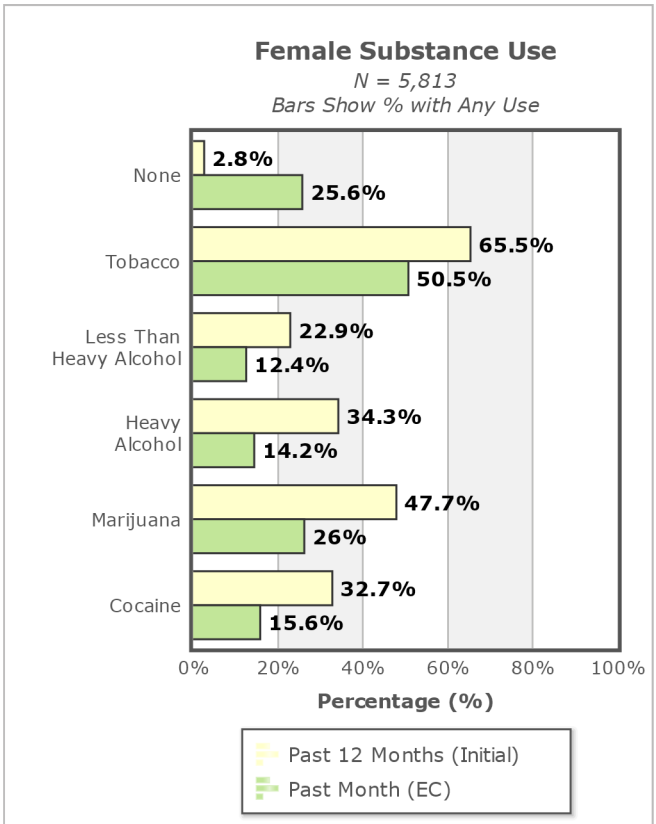


Maternal/Perinatal

Female Substance Use Consumers
Several questions on the NC-TOPPS interview are asked only to female consumers. The tables and charts on this page show the results for those questions. In addition, several other charts are shown for females only. The number of female consumer(s) is 12,736 *(46.1%)*.

Pregnancy ***Female N = 2,153***	**Number**
Gave Birth in Past Year	209
Currently Pregnant	98
Uncertain about Pregnancy Status	20
In First Trimester*	20
In Second Trimester*	38
In Third Trimester*	40
Referred to Prenatal Care*	86
Receiving Prenatal Care*	87

* of those who are pregnant.



Females with Children Under 18
Of the 5,813 female consumer(s), 3,081 *(53%)* have children under the age of 18.

DSS Involvement Since Last Interview Among Females with Children Under 18 N = 3,081	
Investigated by DSS for Child Abuse/Neglect	7.9%

Sexual Risk Activity Among Females
Participation in any one or more of these activities: (a) had sex with someone who was not your spouse or primary partner, (b) knowingly had sex with someone who injected drugs, or (c) traded, gave, or received sex for drugs.

N = 2,153	
In Past 3 Months	6.7%

Females Forced or Pressured to Do Sexual Acts N = 2,153	
In Past 3 Months	2.0%

Females Experienced Abuse Past 3 Months N = 2,153	
Physical Violence	5.5%
Hit/Physically Hurt Another Person	4.3%

Suicide Ideation and Hurting Self, Since Last Interview Among Females N = 2,153	
Suicidal Attempts	1.4%
Suicidal Thoughts	5.4%
Tried to Hurt or Cause Self Pain	1.1%

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

States must answer the questions below to help assess readiness for CLD collection described above:

1. *Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).*

To ensure the needs of those we serve are being met, the Division monitors key indicators to help assure that the system is working as intended, opportunities for improvement area identified and acted upon, desired improvements are recognized and efforts to sustain successful practices are implemented and monitored to maintain achievements, as priorities change. The Quality Management Plan identifies performance measures and procedures for monitoring state established block grants, waivers, and Division priorities including the review of:

- Gap Analysis and Community Needs Assessment
- Network Development Plans
- Performance Improvement Projects
- Intra-departmental Monitoring Reviews
- Block Grant & Clinical Monitoring Reviews
- Monthly Monitoring Reports
- DMA & DMH Performance Measures
- Performance Contract Reports/Data Requirements
- Stakeholder Satisfaction Surveys
- Service Utilization and Financial Analysis
- Consumer Functional Outcome Data (State, Regional, Provider & Individual Level)
- Reports regarding emergencies, critical incidents, complaints and grievances

2. *Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).*

NC Treatment Outcomes and Program Performance System (NC-TOPPS) is a web-based program that gathers outcome and performance data on behalf of mental health and substance abuse consumers in North Carolina's public system of services. The NC-TOPPS system provides reliable information that is used to measure the impact of treatment and to improve service and manage quality throughout the service system.

NC- TOPPS information provides one method for the collection of the Division's consumer functional outcomes data. Consumer functional outcomes data are the DHHS source of information utilized to monitor the direct impact of services.

Attached in this section are sample Simple Query Reports that come from NCTOPPS and are an annual report comparing initial interviews to the episode completions, in this case for 2018 and 2019. These four (4) documents are Simple Query Reports provided as an example of the data that can be pulled from NCTOPPS. These reports compare fiscal years 18 and 19 and include data for adolescents participating in treatment programs and adults participating in treatment programs. This allows us to see system level change for Adolescent SUD, Adult SUD and Private OTP services. In reference to supporting evidence-based, promising or emerging practices, we can pull the same Simple Query by service, by provider or provider and service.

Central Registry - Federal Law (42 CFR Part 291) requires that every treatment center verify whether a patient is in treatment anywhere else in the State to avoid duplicate medication dispensing. The Division has an executed contract with a vendor to provide a central registry for purposes of preventing multiple enrollment, ensuring accurate dosage delivery, and facilitating disaster management in opioid treatment programs (OTPs).

Previously, OTPs verified enrollment via phone or fax. NC OTPs now report enrollment and medication dosing information to the registry on an on-going basis. OTPs are required to provide patient-identifying data to this registry prior to admission, and for all transfers and discharges. This vendor/application ensures a secure, economical, electronic central registry system to provide access to dual enrollment verification checks 24 hours per day 365 days per year, combined with a disaster assistance program and emergency communication system to aid substance abuse patients in times of disaster. It also monitors capacity and provides notification to the State Opioid Treatment Authority (SOTA) staff if a program reaches 90% capacity or is not in compliance with clinician to patient ratios.

A sample of records are reviewed annually to determine compliance with federal regulations.

NCTracks is the Multi-Payer Medicaid Management Information System for the North Carolina Department of Health and Human Services. It has three separate portals for specific internet access to different sectors of the business (Providers, Recipients and internal operation needs)

- The system adjudicates claims from DMA/DMH/DPH and ORHCC (professional, institutional, pharmaceutical and BH related);
- Shares the claims processing engine of the NCTracks to process and pay claims for the Division of MH/DD/SA Services;
- Establishes a central repository of recipient and provider data across the Division's circle of services and programs;
- Allows the state to more closely monitor the delivery of MH/DD/SA services, and to properly measure and track the Local Management Entities-Managed Care Organizations (LME-MCOs) performance;

- Reduces the potential for over-billing and duplicate payments for the same units of service and
- Simplifies the claims filing practices for the LME-MCOs and reduces the claims payment cycle time.

More information can be found on the DMHDDSAS NCTracks website at: https://www.ncdhhs.gov/providers/provider-info/health-care/nctracks

ECCO is the Division's substance use prevention planning and reporting system. It captures data on CSAP strategy, service type, IOM target, implementation fidelity, people served, and staff time spent by intervention. This allows the state to monitor plans for training and technical assistance, and to analyze prevention provider performance from broad CSAP strategies to service types to specific interventions.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client identifying information)?

Yes - by capturing key information on an individual's service needs and life situation during a current episode of care, NC-Treatment Outcomes and Program Performance System (NC-TOPPS) aids in developing meaningful treatment plans and evaluating the impact of services on an individual's life.

Clinicians have access to the Individual Report in the NC-TOPPS system. The report does have identifying information and only the clinical responsible for treatment has access to the report. The Individual Report includes information from the initial interview and the two most recent update Interviews. In a sense it is a report card on how the individual is progressing in treatment and can help drive the dialog between the clinician and the individual on progress and planning for next steps in treatment.

4. *If not, what changes will the state need to make to be able to collect and report on these measures?*

N/A

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4. *If not, what changes will the state need to make to be able to collect and report on these measures?*

N/A

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Health Disparities

Priority Type: SAT

Population(s): PWWDC, PWID

Goal of the priority area:

Integrated healthcare

Objective:

Improve the availability and delivery of integrated healthcare

Strategies to attain the objective:

Promotion of integrated healthcare and increased utilization of E&M codes

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals participating in treatment for a substance use disorder who receive a detailed medical history, health care screening and/or physical examination.

Baseline Measurement: In SFY19, 10,374 individuals with a substance use diagnosis received a health-related service, as evidenced by the billing of specific, identified Evaluation and Management (E&M) CPT codes.

First-year target/outcome measurement: FY21 will demonstrate a 1% increase in the number of individuals with a substance use disorder who receive improved physcial health care, as evidenced by claims for E&M codes.

Second-year target/outcome measurement: FY22 will demonstrate an additional 1% increase in the number of individuals with a substance use disorder who receive improved physcial health care, as evidenced by claims for E&M codes.

Data Source:

NCTracks

Description of Data:

Paid claims of E&M codes for individuals with a substance use diagnosis.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 2

Priority Area: Community Integration

Priority Type: SAT

Population(s): Other (Criminal/Juvenile Justice, Homeless)

Goal of the priority area:

Access to recovery supported housing

Objective:

Greater access to supported housing through the development of additional NC Oxford Houses and by providing mentoring and support to persons in need of recovery housing.

Strategies to attain the objective:

1. DMHDDSAS will continue to provide no less than the current level of funding to Oxford House, Inc., which will support additional staff to increase outreach efforts and the number of Oxford House beds;
2. The contractor will assure that LME-MCOs are aware of plans to open new Oxford Houses and the processes for referral;
3. DMHDDSAS will notify LME-MCOs of newly opened Oxford Houses once established and ready to accept referrals in their catchment areas; and
4. The contractor will mentor and support persons from incarceration to reenter the community into NC Oxford Houses.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of NC Oxford Houses available that are integrated in the community to serve men, women and men/women with children.

Baseline Measurement: At the end of SFY19, there were 1921 total beds available for men, women and women with children.

First-year target/outcome measurement: No less than 1935 total NC Oxford House beds will be availbale to adults with substance use disorders at the end of SFY20..

Second-year target/outcome measurement: No less than 1943 total NC Oxford House beds will be availbale to adults with substance use disorders at the end of SFY21.

Data Source:

Monthly NC Oxford House Activity and Attestation Reports, and Quarterly Progress Reports.

Description of Data:

Monthly Activity Report submitted to the Division Contract Administrator includes cumulative data on number of beds, vacancies and location of Oxford Houses. Attestation Forms are completed within 30-days of a new house opening and occupied. Quarterly Progress Reports consist of cumulative data from Monthly reports.

Data issues/caveats that affect outcome measures::

None anticipated

Indicator #: 2

Indicator: Number of re-entering (transitioning from incarceration) individuals recovering from substance use disorders housed in an Oxford House.

Baseline Measurement: At the end of SFY19, 230 new re-entering individuals in recovery were served and mentored through a combination of SABG funds (60 individuals) and SOR funds (170 individuals)..

First-year target/outcome measurement: No less than 65 persons will be mentored and transitioned from incarceration into a NC Oxford House at the end of SFY20 through SABG funds.

Second-year target/outcome measurement: No less than 70 persons will be mentored and transitioned from incarceration into a NC Oxford House at the end of SFY21 through SABG funds.

Data Source:

NC Oxford House Criminal Justice Program Quarterly Progress Reports.

Description of Data:

NC Oxford House Criminal Justice Program Quarterly Progress Report totals.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 3

Priority Area: Persons Who Inject Drugs

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

Decreased deaths due to opioid overdose

Objective:

Increase access to medication assisted treatment for persons injecting opioids.

Strategies to attain the objective:

1. DMHDDSAS will notify LME-MCOs of newly opened opioid treatment programs (OTPs) in their catchment areas.
2. State Opioid Treatment Authority (SOTA) staff will work with potential OTP providers to ensure readiness for implementation of quality services.
3. DMHDDSAS staff will work with LME-MCOs to better assure contracts are initiated with OTPs, with a focus on under-served areas.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of PWID with an opioid use disorder participating in medication assisted treatment.

Baseline Measurement: In SFY19, 3665 individuals who were injecting drugs initiated medication assisted treatment, out of a total of 6652 PWID involved in treatment.

First-year target/outcome measurement: In SFY20, increase by 2% the number of individuals injecting drugs that initiate medication assisted treatment.

Second-year target/outcome measurement: In SFY21, increase by an additional 1% the number of individuals injecting drugs that initiate medication assisted treatment.

Data Source:

NCTOPPS

Description of Data:

NCTOPPS is NC's individual outcomes and program performance database.

Data issues/caveats that affect outcome measures::

None anticipated, although under-reporting has been identified in some agencies for NCTOPPS.

Indicator #: 2

Indicator: Decreased deaths due to opioid overdose

Baseline Measurement: Since June 2017, over 88,000 units of naloxone have been purchased and distributed to community providers

First-year target/outcome measurement: In FY20, purchase a minimum of 10,000 units of naloxone

Second-year target/outcome measurement: In FY21, purchase a minimum of 5,000 units of naloxone

Data Source:

Reversal reports, death data reporting

Description of Data:

Overdose reversal reports are collected from agencies that distribute naloxone. Death reports are obtained by DPH for reporting on the Opioid Dashboard.

Data issues/caveats that affect outcome measures::

Reversals aren't always reported by those who perform the reversal, and there is often a lag in cause(s) of death determinations from the Office of the Medical Examiner.

Priority #: 4

Priority Area: Veterans and Their Families

Priority Type: SAT

Population(s): Other (Military Families)

Goal of the priority area:

Decrease Suicide by Veterans

Objective:

Provide resources to assist Veterans and their families in identifying risk of suicide and obtaining treatment.

Strategies to attain the objective:

1. Contract with the Alcohol/Drug Council of NC (ADCNC) to provide screening and referral services for Veterans and their families.
2. Maintain a dedicated Veterans Services Specialists at DMHDDSAS to coordinate activities and strategies for Veterans and family members across the state and to work with LME-MCO Veterans Liaisons.
3. Continue the work of the Governor's Working Group.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of calls received from Veterans and their families through the Information & Referral line, screened and referred for services or resources.

Baseline Measurement: 794 Veterans and/or family members contacted ADCNC during FY19 seeking assistance.

First-year target/outcome measurement: Number of calls and referrals will increase by 5%.

Second-year target/outcome measurement: Number of calls and referrals will increase by an additional 2.5%

Data Source:

ADCNC Quarterly Call Report

Description of Data:

ADCNC quarterly call data

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 5

Priority Area: TB

Priority Type: SAT

Population(s): PWWDC, PWID, EIS/HIV, TB

Goal of the priority area:

Tuberculosis screening and referral

Objective:

Provide tuberculosis screening and referral to care or additional services, if indicated, to all individuals evaluated for substance use disorder treatment services.

Strategies to attain the objective:

1. Review of charts and other information during annual SABG monitoring.
2. Issuance of plans of correction if the above is not met.
3. Review of policies and procedures specific to tuberculosis screening in the SABG Semi-Annual Compliance Reports.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of individuals who are evaluated for SUD treatment who are also screened for tuberculosis and referred to other services if indicated by a positive screen.

Baseline Measurement: During FY19, of the records reviewed, 93% contained evidence that a TB screening was conducted.

First-year target/outcome measurement: A compliance rate of 98% will be achieved in SFY20.

Second-year target/outcome measurement: A compliance rate of 99% will be achieved in SFY21.

Data Source:

Annual monitoring reviews

Description of Data:

A sample of records is reviewed annually to determine compliance with federal regulations. Compliance with TB screening and referral to care (if indicated) is one the elements reviewed.

Data issues/caveats that affect outcome measures::

None anticipated

Indicator #: 2

Indicator: Percentage of individuals who are referred for additional care when the TB screen is positive.

Baseline Measurement: In SFY19, 100% of individuals who screened positive for TB symptoms were referred for follow up services.

First-year target/outcome measurement: In SFY20, 100% of indivduals who screen positive for TB symptoms will be referred follow up services.

Second-year target/outcome measurement: In SFY21, 100% of indivduals who screen positive for TB symptoms will be referred follow up services.

Data Source:

Annual SABG monitoring reviews

Description of Data:

A sample of records are reviewed annually to determine compliance with federal regulations. Compliance with TB screening and referral to care (if indicated) is one the elements reviewed.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 6

Priority Area: Juvenile Justice

Priority Type: SAT

Population(s): Other (Adolescents w/SA and/or MH, Criminal/Juvenile Justice)

Goal of the priority area:

To appropriately address treatment needs of juvenile justice-involved youth as directed by assessment.

Objective:

Improve access to resources for justice-involved youth.

Strategies to attain the objective:

DMHDDSAS will collaborate with the Department of Public Safety, Juvenile Justice and other key stakeholders to identify and maximize resources for justice-involved youth and families with substance use and co-occurring issues.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of juvenile justice-involved youth who complete treatment.

Baseline Measurement: Juvenile Justice-involved youth have completed treatment at a rate of 61% on average over the last 5 state fiscal years.

First-year target/outcome measurement: Juvenile Justice-involved youth will complete treatment at a rate of 60% or higher.

Second-year target/outcome measurement: : Juvenile Justice-involved youth will complete treatment at a rate of 60% or higher.

Data Source:

NCTOPPS

Description of Data:

The NCTOPPS (Treatment Outcomes and Program Performance System) is a web-based program that gathers outcome and performance data on behalf of mental health and substance use disorder consumers in North Carolina's publicly-funded system of services. The NC TOPPS system provides reliable information that is used to measure the impact of treatment and to improve services and manage quality throughout the service system.

Data issues/caveats that affect outcome measures::

Implementation of Raise the Age may affect the outcome measures.

Priority #: 7

Priority Area: PWWDC

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Access to quality SUD treatment for pregnant women and women of child bearing age with an opioid use disorder

Objective:

Strategies to attain the objective:

(1) Ensure all NC Perinatal & Maternal Substance Use and CASAWORKS for Families Residential Initiative programs provide or provide access to and coordination with opioid treatment programs and/or office-based buprenorphine providers.
(2) Work with the NC Plan of Safe Care Interagency Collaborative and other stakeholder groups to identify and address gaps and barriers to access SUD treatment services for this population.
(3) Development and dissemination of education materials for women seeking treatment services and healthcare and other professionals working with women who may be affected by the state Division of Social Services CAPTA Plan of Safe Care policies.
(4) Provision of training and technical assistance to SUD treatment providers, LME-MCOs, health care providers, hospitals social services including child welfare and other stakeholder on opioid and other substance use during pregnancy, access to gender responsive SUD services and Opioid treatment services and other related information.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of pregnant women and women of child bearing age with an opioid disorder participating in treatment

Baseline Measurement: During SFY 2019, 479 pregnant women and 6359 women of child bearing age, 18-45, accessed SUD treatment for an opioid use disorder.

First-year target/outcome measurement: Increase by 1% the number of pregnant women and women of child bearing age of child bearing age with an opioid use disorder receiving SUD treatment services

Second-year target/outcome measurement: : Increase by 1% the number of pregnant women and women of child bearing age of child bearing age with an opioid use disorder receiving SUD treatment services

Data Source:

NCTOPPS

Description of Data:

The NCTOPPS (Treatment Outcomes and Program Performance System) is a web-based program that gathers outcome and performance data on behalf of mental health and substance use disorder consumers in North Carolina's publicly-funded system of services. The NC TOPPS system provides reliable information that is used to measure the impact of treatment and to improve services and manage quality throughout the service system.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 8

Priority Area: PWWDC

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Access to gender responsive, family-centered SUD treatment services and supports for pregnant women and women with dependent children.

Objective:

Strategies to attain the objective:

(1) Maintain a dedicated Perinatal Substance Use Specialist position to ensure pregnant and parenting women receive appropriate screening and referral for SUD treatment and supports and prenatal care services through a toll-free hotline.
(2) Maintain and update the statewide capacity management database to identify available treatment slots in the NC Perinatal and Maternal Substance Use and CASAWORKS for Families Residential Initiatives.
(3) Increase awareness of substance use issues and available resources specific to pregnant and parenting women through collaboration with stakeholder and the provision of training and technical assistance.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of pregnant women and women with dependent children referred to gender-responsive SUD treatment through the toll-free hotline

Baseline Measurement: During SFY 2019, 514 pregnant women and women with dependent children received referrals (124 of the 514 women were pregnant.)

First-year target/outcome measurement: Increase the number of treatment referrals by 1%

Second-year target/outcome measurement: Increase the number of treatment referrals by 1%

Data Source:

Quarterly and annual Perinatal Substance Use Project reports for the toll-free hotline services.

Description of Data:

These reports include the number of pregnant and parenting women who call the hotline requesting treatment resources for a substance use disorder.

Data issues/caveats that affect outcome measures::

none anticipated.

Priority #: 9

Priority Area: PWWDC

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Access to SUD treatment services for individuals with a substantiated Child Protective Services (CPS) case.

Objective:

Strategies to attain the objective:

Maintain funding and accessibility to Qualified Professionals in Substance Abuse (QPSAs) statewide to conduct assessments with individuals referred by county CPS and offer appropriate SUD treatment referrals.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals with a substantiated CPS case or found in need of services due to substance use who are referred for a SUD assessment.

Baseline Measurement: During SFY 2019, a total of 943 individuals were referred by county CPS for a SUD assessment.

First-year target/outcome measurement: Increase the number of individuals referred for SUD assessment by 1%

Second-year target/outcome measurement: Increase the number of individuals referred for SUD assessment by 1%

Data Source:

Quarterly project reports for the WF/CPS Substance Use Initiative completed by the LME-MCOs.

Description of Data:

The data in this report include the number of individuals with a substantiated CPS case or found in need of services who were assessed.

Data issues/caveats that affect outcome measures::

None anticipated.

Priority #: 10

Priority Area: Youth Initiation and Tobacco Access

Priority Type: SAP

Population(s): PP, Other (Adolescents w/SA and/or MH, Students in College, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Decrease youth initiation to tobacco products.

Objective:

Overall objective is decrease youth access to tobacco products by increasing tobacco enforcement efforts in the state by 5%.

Strategies to attain the objective:

(1) Train prevention providers on merchant education and tobacco survey best practices. (2) Improve Synar survey protocols and procedures. (3) Work with the Department of Public Safety-Alcohol Law Enforcement (ALE) agency to increase the number of state compliance checks and conduct the annual Synar survey (4) Encourage prevention providers to partner with ALE to increase the number of statewide tobacco retailer trainings targeting local retailers. (5) Provide media training to prevention providers to increase the number of paid/earn media on tobacco prevention/enforcement campaigns. (6) Work with NCTTA and subcontractors with an evaluator to increase data collection at the state and local level related to tracking statewide tobacco prevention and enforcement.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The underage tobacco sales retail violation rate

Baseline Measurement: FY2019 20.8% of retail establishments sold tobacco to an underage person.

First-year target/outcome measurement: FY2020, will demonstrate a 10% decrease in the percentage of retail establishments that sold tobacco to an underage person.

Second-year target/outcome measurement: FY2021, will demonstrate an additional 5% decrease in the percentage of retail; establishments that sold tobacco to an underage person.

Data Source:

Annual Synar survey

Description of Data:

North Carolina measure their progress in reducing youth access to tobacco in annual, random, unannounced inspections which is analysis and reported in the annual Synar survey. The methodology requires approval from SAMHSA-CSAP.

Data issues/caveats that affect outcome measures::

FY2019 has an RVR of 20.8%.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
KODY H. KINSLEY • Deputy Secretary for Behavioral Health & IDD

October 21, 2019

RE: Special Terms of Award – North Carolina Substance Abuse Prevention and Treatment Block Grant (SABG)

I certify that the State and all sub-recipients will comply with the following NOA language:

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

DocuSigned by:
D7816E4CBA6F4A8...

Kody H. Kinsley
Deputy Secretary
Authorized Representative

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$71,070,396		$50,000,000	$38,478,949	$302,265,698	$0	$0
a. Pregnant Women and Women with Dependent Children**	$15,744,240		$0	$2,194,360	$20,265,698	$0	$0
b. All Other	$55,326,156		$50,000,000	$36,284,589	$282,000,000	$0	$0
2. Primary Prevention	$0		$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention	$17,994,598		$0	$2,470,207	$0	$0	$0
b. Mental Health Primary Prevention							
3. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
4. Tuberculosis Services	$0		$0	$0	$0	$0	$0
5. Early Intervention Services for HIV	$0		$0	$0	$0	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$908,000		$0	$0	$0	$0	$0
10. Total	**$89,972,994**	**$0**	**$50,000,000**	**$40,949,156**	**$302,265,698**	**$0**	**$0**

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Column D includes funds from the following SAMHSA grants: Treatment and recovery = SOR grant, SOR Supplement grant, MAT-PDOA grant and the PPW grant. Prevention = SPF-Rx and PFS.

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	10262	1137
2. Women with Dependent Children	22235	10723
3. Individuals with a co-occurring M/SUD	104923	28651
4. Persons who inject drugs	26238	13178
5. Persons experiencing homelessness	1183	3689

Please provide an explanation for any data cells for which the state does not have a data source.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

1. Pregnant Women aged 15-44 in NC estimated to have a SUD in 2018: 10,262.

Data sources:

• Pregnancy Rates. US DHHS, Center for Disease Control and Prevention, National Center for Health Statistics, 2010 Pregnancy Rates Among U.S. Women by Sally C. Curtin, M.A., and Joyce C. Abma, Ph.D., Division of Vital Statistics, NCHS; and Kathryn Kost, Ph.D., Guttmacher Institute, published December 2015.

Pregnancy rate for women aged 15-44 in the US (2010) = 98.7 per 1,000.

In 2010, 65.0% of pregnancies resulted in live births, 17.9% resulted in induced abortions, and 17.1% resulted in fetal losses.

In 2000, 63.1% of pregnancies resulted in live births, 20.4% resulted in induced abortions, and 16.6% resulted in fetal losses.

In 1990, 61.2% of pregnancies resulted in live births, 23.7% resulted in induced abortions, and 15.0% resulted in fetal losses.

Based on the above trend, in 2015 would estimate 66.0% of pregnancies to result in live births.

• Fertility Rates. US DHHS, Center for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics Reports,

Vol. 66, No. 1, January 5, 2017
Table 12. Birth rates, by age of mother: United States, each state and territory, 2015 Fertility rates reported are births per 1,000 women aged 15–44.
In the US = 62.5. In NC = 60.7.
Applying the 2015 estimated live birth rate of 66.0% of pregnancies resulting in a live birth to the 60.7 births per 1,000 women for NC in 2015, the expected pregnancy rate would = 92.0 pregnancies per 1,000 women aged 15-44.
• Population data. NC Office of State Budget and Management (NC OSBM), Population Estimates/Projections Data - Sex and Single Years of Age (2000-2038). https://www.osbm.nc.gov/demog/county-projections. Downloaded 6/26/19.
In NC as of July 2018, there were 2,065,687 women ages 15-44.
• Prevalence Rates. SAMHSA, Center for Behavioral Health Statistics and Quality, Results from the 2018 National Survey on Drug Use and Health: Detailed Tables, August 2019.
Table 5.5B Substance Use Disorder in Past Year among Persons Aged 12 or Older, by Age Group and Demographic Characteristics: Percentages, 2017 and 2018.
Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse.
State-specific rates for NC not published. Used US rates applied to NC population. Prevalence in 2018 for persons ages 12 and older with a SUD in the past year: Total 7.4%, Males 9.5%, Females 5.4%.
Calculations:
Applied the most current available national SUD prevalence rate for women (5.4% of women aged 12 and older) to the number of women in NC aged 15-44 years as of July 2018:
2,065,687 women x 5.4% = 111,547 women aged 15-44 in NC estimated to have a SUD.
Divided this number by 1,000 and multiplied by 92.0 pregnancies per 1,000 women aged 15-44 = 10,262 pregnant women in NC estimated to have a SUD in 2018.

2. Women in Poverty with Dependent Children in Need of SUD Treatment: 22,235.
Women with Dependent Children In SUD Treatment: 10,837 .
Data Sources:
• Number In Treatment. Per the North Carolina Treatment Outcomes and Program Performance System (NCTOPPS) as of 11/17/18, the number of women in the SUD population with dependent children in NC in SFY2018 = 10,837
• Women with Dependent Children. In researching women with dependent children, almost all internet searches pointed to federal and state programs targeting aid to women and families with dependent children in poverty and federal block grant requirements around maintenance of effort for this population. Therefore, I focused prevalence estimates on this population as well.
• Poverty Rate For Women. Per the North Carolina Justice Center Report titled, North Carolina's Greatest Challenge: Elevated Poverty Hampers Economic Opportunity for All By Tazra Mitchell Public Policy Analyst and Alexandra Sirota Director, BUDGET & TAX CENTER, 2016, the poverty rate for women in the NC was 17.8% in 2015 compared to 14.9% for men.
• Percent of Women In Poverty With Dependent Children. Per the Center For American Progress publication titled, The Straight Facts on Women in Poverty By Alexandra Cawthorne October 2008, which cited the U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement, 26% of all adult women (age 18 and older) with incomes below the poverty line are single mothers, 12%

are married with dependent children, 54% are single with no dependent children, and 8% are married with no dependent children.
• Prevalence Rates. SAMHSA, Center for Behavioral Health Statistics and Quality, Results from the 2018 National Survey on Drug Use and Health: Detailed Tables, August 2019.
Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse. State-specific rates for NC not published. Used US rates applied to NC population.
Table 5.8B Substance Use Disorder in Past Year among Persons Aged 12 or Older, by Age Group and Geographic and Socioeconomic Characteristics: Percentages, 2017 and 2018. Prevalence in 2018 for persons ages 18 and older with a SUD in the past year by poverty level: Less Than 100% = 10.3%
Table 5.5B Substance Use Disorder in Past Year among Persons Aged 12 or Older, by Age Group and Demographic Characteristics: Percentages, 2017 and 2018. Prevalence in 2018 for persons ages 18 and older with a SUD in the past year by gender: Total 7.4%, Males 9.5%, Females 5.4%.
• Population data. NC Office of State Budget and Management (NC OSBM), Population Estimates/Projections Data - Sex and Single Years of Age (2000-2038). https://www.osbm.nc.gov/demog/county-projections. Downloaded 6/26/19.
In NC as of July 2018, there are 4,217,028 women ages 18 and older.
Calculations:
Where NC-specific rates were not available, used US rates applied to NC population.
Using the Budget and Tax Center and NC OSBM data, 17.8% of women in NC in poverty (2016) x 4,217,028 women ages 18 and older in NC (July 2018) = 750,631 women in poverty.
Per the Census Bureau, 38% of women (age 18 and older in 2008) in the US with incomes below the poverty line have dependent children. Multiplying 38% x 750,631 women in poverty in NC (July 2018) = 285,240 women in poverty with dependent children in NC.
Per the NSDUH 2018 results, 10.3% of persons in the US less than 100% of poverty have a SUD. This is 39.2% higher than the 7.4% of persons ages 18+ in the US who have a SUD.
Per the NSDUH 2018 results, 5.6% of females ages 18+ in the US have a SUD. If the prevalence of women less than 100% of poverty with a SUD is 39.2% higher like it is for the total population, then one might expect 7.79% of females ages 18+ below 100% of poverty to have a SUD in the US.
Applying national rates to the NC population, one might expect 7.79% x 285,240 women in poverty with dependent children in NC = 22,235 to have a SUD.
3. Individuals with co-occurring MI/SUD in NC in 2018:
Adults Ages 18+ with Any MI + SUD 298,626
Adults Ages 18+ with SMI + SUD 104,923
Adolescents Ages 12-17 with MDE + SUD 12,160
Adolescents Ages 12-17 with MDE with severe impairment + SUD 9,728
Data Sources:
• Prevalence Rates. Substance Abuse and Mental Health Services Administration. (August 2019). Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP 19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

State-specific rates for NC not published. Used US rates applied to NC population.
AMI = Any Mental Illness
SMI = Serious Mental Illness
MDE = Major Depressive Episode
SUD = Substance Use Disorder
3.7% of Adults Ages 18+ have co-occurring AMI + SUD
1.3% of Adults Ages 18+ have co-occurring SMI + SUD
7.2% of Adults Ages 18-25 have co-occurring AMI + SUD
2.6% of Adults Ages 18-25 have co-occurring SMI + SUD
5.0% of Adults Ages 26-49 have co-occurring AMI + SUD
1.7% of Adults Ages 26-49 have co-occurring SMI + SUD
1.6% of Adults Ages 50+ have co-occurring AMI + SUD
0.5% of Adults Ages 50+ have co-occurring SMI + SUD
1.5% of adolescents ages 12-17 have co-occurring MDE + SUD
1.2% of adolescents ages 12-17 have co-occurring MDE with severe impairment + SUD
• Population data. NC Office of State Budget and Management (NC OSBM), Population Estimates/Projections Data - Sex and Single Years of Age (2000-2038). https://www.osbm.nc.gov/demog/county-projections. Downloaded 6/26/19.
In NC as of July 2018:
Total population (all ages) = 10,388,837.
Population ages 18+ = 8,070,965
Population ages 12-17 = 810,671
Calculations:
Applied the most current available national SUD prevalence rates for adults ages 18+ and adolescents ages 12-17 to the number of people in NC as of July 2018 in the relevant age group:
3.7% x 8,070,965 adults ages 18+ = 298,626 have co-occurring AMI + SUD
1.3% x 8,070,965 adults ages 18+ = 104,923 have co-occurring SMI + SUD
1.5% x 810,671 adolescents ages 12-17 = 12,160 have co-occurring MDE + SUD
1.2% x 810,671adolescents ages 12-17 = 9,728 have co-occurring MDE with severe impairment + SUD

4. Estimated persons aged 13+ who inject drugs in NC in 2018: 26,238 .
Data Sources:
• Prevalence. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, Atlanta, Georgia. Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis to Calculate National Rates of HIV and Hepatitis C Virus Infections. Authors: Amy Lansky, Teresa Finlayson, Christopher Johnson, Deborah Holtzman, Cyprian Wejnert, Andrew Mitsch, Deborah Gust, Robert Chen, Yuko Mizuno, and Nicole Crepaz. Published May 19, 2014. PLoS ONE 9(5): e97596. doi:10.1371/journal.pone.0097596.
This study estimated the proportion of persons who inject drugs (PWID) in the US population to calculate rates of HIV and HCV. The authors

conducted a meta-analysis using data from 4 national probability surveys (General Social Survey – GSS, National Health and Nutrition Examination Survey – NHANES, National Survey of Family Growth – NSFG, and National Survey of Drug Use and Health – NSDUH) that measured lifetime (3 surveys) or past-year (3 surveys) injection drug use over multiple years (1999 – 2008) to estimate the proportion of the United States population that has injected drugs.
- Lifetime PWID comprised 2.6% (95% confidence interval: 1.8%–3.3%) of the U.S. population aged 13 years or older.
- Past-year PWID was 0.30% (95% confidence interval: 0.19 %–0.41%) of the U.S. population aged 13 years or older.
• Prevalence. SAMHSA, Center for Behavioral Health Statistics and Quality, Results from the 2018 National Survey on Drug Use and Health: Detailed Tables, August 2019.
Table 1.97B Specific Hallucinogen, Inhalant, Needle, Heroin, and Other Drug Use in Lifetime among Persons Aged 12 or Older, by Age Group: Percentages, 2017 and 2018.
Needle Use (Heroin, Cocaine, Methamphetamine) Ages 12+ in the US population in 2018 = 1.6% (Lifetime).
• Population data. NC Office of State Budget and Management (NC OSBM), Population Estimates/Projections Data - Sex and Single Years of Age (2000-2038). https://www.osbm.nc.gov/demog/county-projections. Downloaded 6/26/19.
Population in NC as of July 2018: Ages 12+ = 8,881,636 Ages 13+ = 8,745,872
Calculations:
State-specific rates for NC not published. Used US rates applied to NC population.
Applying the CDC's Past-year PWID rate of 0.30% of the US population aged 13+ to the number of people in NC aged 13+ as of July 2018: 0.30% x 8,745,872 adolescents and adults aged 13+ = 26,238 estimated persons aged 13+ who inject drugs during the year in NC.
Depending on which source is used, the estimated number of persons who inject drugs during their lifetime is:
CDC: 2.6% x 8,631,991 adolescents and adults aged 13+ = 224,432 estimated persons aged 13+ who inject drugs during their lifetime in NC.
NSDUH: 1.6% x 8,881,636 adolescents and adults aged 12+ = 142,106 estimated persons aged 12+ who inject drugs during their lifetime in NC.

5. Persons experiencing homelessness in NC in 2019 that have a SUD: 1,183 .
Data Source:
• Homeless Count: NC Coalition to End Homelessness (NCCEH) January 2019 Point-In-Time (PIT) count, 8/11/2019. The NCCEH conducts a statewide count of homeless persons one night during the last week of January each year and publishes data on the web. (www.ncceh.org/datacenter/pitdata)
• Homeless Count: HUD Exchange website. Continuum of Care (CoC) Homeless Assistance Programs Homeless Populations and Subpopulations Reports: 2018 CoC Homeless Populations and Subpopulations Report – North Carolina.pdf, 11/13/2018. Based on PIT information provided to HUD by CoCs in the application for CoC Homeless Assistance Programs. (https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/?filter_Year=&filter_Scope=State&filter_State=NC&filter_CoC=&program=CoC&group=PopSub).
NC 2019 PIT Count: 9,314 people experienced homelessness. 17% were children ages 17 and younger = 1,583. 83% were adults ages 18+ = 7,731. The data provided on the NCCEH website did not include any information on the number or percent of homeless persons with SUD or SMI. 2019 data for NC is not yet available on the HUD Exchange website. Latest data posted was 2018. Looked at prior years data on persons with SUD to estimate the number for 2019.

NC 2016 PIT Count: 9,559 people experienced homelessness. 15% had a SUD. 17% had SMI. (Source: NCCEH)
NC 2017 PIT Count: 8,962 people experienced homelessness. The NCCEH infographic that year did not provide data on SUD and SMI. NCCEH provided a separate data table that year with counts of adults by community with SUD and SMI. SUD and SMI data for children was not provided. 1,102 (15.4%) adults had a SUD. 1,328 (18.5%) adults had SMI. The NC data posted on the HUD Exchange website for that year reported the same numbers with SUD and SMI but said nothing about the numbers representing adults only. It gave the impression the numbers represented all ages.
NC 2018 PIT Count: The NCCEH infographic does not include information about SUD and SMI. According to data for NC posted on the HUD Exchange website, 9,268 people (7,506 adults + 1,762 children) experienced homelessness. 993 had SUD, and 1,207 had SMI. If the percentages with SUD and SMI were based on homeless adults, the percentages would be 13.2% and 16.1%. If the percentages were based on total homeless persons, they would be 10.7% and 13.0% (lower than prior years). I asked NCCEH if the numbers reported to HUD with SUD and SMI were only for adults like in 2017. Andy Phillips at NCCEH (9/26/19) responded that the PIT count numbers reported with SUD and SMI include all homeless people and are not limited to adults. He said HUD guidance around SMI and SUD reporting doesn't make a distinction between adults and children. Everyone is asked for this information.
Calculations:
9,314 people experienced homelessness in NC in 2019.
Calculated a 3-year average rate for 2016, 2017, and 2018 (sum of homeless persons with SUD divided by the sum of total homeless persons) = 12.7%. Used this rate to estimate the number of homeless persons in 2019 with a SUD = 12.7% x 9,314 = 1,183 persons estimated to have a SUD.
If the 2018 rate of 10.7% were to be used to estimate the number of homeless persons with a SUD = 10.7% x 9,314 = 997 persons with SUD.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment*	$35,535,198
2 . Primary Substance Abuse Prevention	$8,997,299
3 . Early Intervention Services for HIV**	$0
4 . Tuberculosis Services	$0
5 . Administration (SSA Level Only)	$454,000
6. Total	**$44,986,497**

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered ?designated states? as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a ?designated state? in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state?s AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

A		B
Strategy	**IOM Target**	**FFY 2020 SA Block Grant Award**
1. Information Dissemination	Universal	$722,285
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$722,285**
2. Education	Universal	$1,083,428
	Selective	$632,000
	Indicated	$90,286
	Unspecified	$0
	Total	**$1,805,714**
3. Alternatives	Universal	$110,149
	Selective	$63,200
	Indicated	$7,222
	Unspecified	$0
	Total	**$180,571**
4. Problem Identification and Referral	Universal	
	Selective	$72,228
	Indicated	$168,533
	Unspecified	
	Total	**$240,761**
	Universal	$1,504,762

5. Community-Based Process	Selective	
	Indicated	
	Unspecified	
	Total	**$1,504,762**
6. Environmental	Universal	$1,564,952
	Selective	
	Indicated	
	Unspecified	
	Total	**$1,564,952**
7. Section 1926 Tobacco	Universal	$404,175
	Selective	
	Indicated	
	Unspecified	
	Total	**$404,175**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Expenditures		**$6,423,220**
Total SABG Award*		**$44,986,497**
Planned Primary Prevention Percentage		**14.28 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

Table 5a planned expenditures of $6,423,220 plus Table 6 planned expenditures of $2,574,079 equal the required 20% set aside amount of $8,997,299 reported in Table 4.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	$1,193,577
Universal Indirect	$4,196,174
Selective	$767,428
Indicated	$266,041
Column Total	**$6,423,220**
Total SABG Award*	**$44,986,497**
Planned Primary Prevention Percentage	**14.28 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Targeted Substances	
Alcohol	☑
Tobacco	☑
Marijuana	☑
Prescription Drugs	☑
Cocaine	☑
Heroin	☑
Inhalants	☑
Methamphetamine	☑
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☑
Targeted Populations	
Students in College	☑
Military Families	☑
LGBTQ	☑
American Indians/Alaska Natives	☑
African American	☑
Hispanic	☑
Homeless	☑
Native Hawaiian/Other Pacific Islanders	☑
Asian	☑
Rural	☑
Underserved Racial and Ethnic Minorities	☑

Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FY 2020 A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems	$411,806	$0	
2. Infrastructure Support	$2,080,150	$69,280	
3. Partnerships, community outreach, and needs assessment	$668,518	$638,221	
4. Planning Council Activities (MHBG required, SABG optional)	$0	$0	
5. Quality Assurance and Improvement	$495,643	$288,000	
6. Research and Evaluation	$691,865	$399,485	
7. Training and Education	$2,087,163	$1,179,093	
8. Total	**$6,435,145**	**$2,574,079**	**$0**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.
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Footnotes:

Includes contracts with 21 agencies for the activities listed above.

Table 5a planned expenditures of $6,423,220 plus Table 6 planned expenditures of $2,574,079 equal the required 20% set aside amount of $8,997,299 reported in Table 4.

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds.
The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

Although not a Medicaid expansion state, in October 2018, CMS approved North Carolina's 1115 Demonstration Waiver application, which is effective 10.01.19 through 10.31.24. This waiver will allow DHHS to implement Medicaid managed care and phase certain populations into managed care over time. Under this waiver, North Carolina has the authority to incorporate several innovative features which will further the state's commitment to improving the well-being of individuals through a well-coordinated system of care that addresses both medical and non-medical drivers of health.

Additionally, North Carolina submitted and was approved for an 1115 SUD Demonstration Waiver that will expand SUD benefits to offer the complete ASAM continuum, waive the IMD exclusion for SUD services, ensure providers and services meet evidence-based program and licensure standards, build SUD provider capacity, strengthen care coordination and care management for the SUD population and improve the Prescription drug monitoring program.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

The state provides services and supports towards integrated care for individuals and families with co-occurring mental and substance use disorders through federal funds (i.e., Medicaid, Block Grant, and Discretionary Grants) and state funds. Clinical Coverage Policy 8-C requires that all comprehensive clinical assessments include information on an individual's chronological general and medical health history and current issues, as well as current medications for physical conditions. These assessment requirements are applicable for all consumers and adherence is reviewed and monitored annually through block grant monitoring reviews. Additionally, Evaluation and Management codes have been approved by the Division that allow for various levels and types of health screening for many years.
On a smaller scale, the Division has been piloting a program in three FQHCs located across North Carolina to initiate individuals on naltrexone for an opioid use disorder, while also meeting their physical and medical needs through services provided at the FQHC.
North Carolina was also recently awarded a PIPBHC (Promoting Integration of Primary and Behavioral Health Care) grant that will focus on integrating medical care for individuals with primary mental health, but also co-occurring substance use disorders.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered ○ Yes ◉ No

through QHPs?

b) and Medicaid? (●) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

The seven LME-MCOs that manage public behavioral health funds for all 100 counties in NC are responsible for monitoring access to SUD services.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? (●) Yes ( ) No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education (●) Yes ( ) No

b) Health risks such as

ii) heart disease (●) Yes ( ) No

iii) hypertension (●) Yes ( ) No

iv) high cholesterol (●) Yes ( ) No

v) diabetes (●) Yes ( ) No

c) Recovery supports (●) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? (●) Yes ( ) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ( ) Yes (●) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

The major issues or problems related to the implementation and enforcement of parity provisions that the state is facing are related to (1) the absence or inadequacy of information about parity provisions, and (2) the stigma related to mental health and substance use disorders that prevent many people from seeking treatment or help for their problems.

10. Does the state have any activities related to this section that you would like to highlight?

DHHS received CMS approval to implement within Medicaid managed care an innovative Healthy Opportunities pilot program in two to four regions to improve health and reduce health care costs. Recognizing that overall health is driven by many factors beyond the four walls of a hospital or clinic, these pilots, working with the managed care plans in their regions, will identify the most cost-effective ways to deliver care. The pilots will support and strengthen work already underway in communities and at the state level to maximize efficiencies and effectiveness within the managed care program, focusing on housing, food, transportation, employment and interpersonal safety. North Carolina is the first state to receive approval to comprehensively pilot these innovations, making it a national leader in promoting value and improving health through its managed care program.

Please indicate areas of technical assistance needed related to this section

None at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for **Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	○ Yes ○ No
b) Ethnicity	○ Yes ○ No
c) Gender	○ Yes ○ No
d) Sexual orientation	○ Yes ○ No
e) Gender identity	○ Yes ○ No
f) Age	○ Yes ○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ○ Yes ○ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ○ Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ○ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ○ Yes ○ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ○ Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ○ Yes ○ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focus on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

The Program Integrity procedures for NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) are incorporated into the Service System Integrity plan. It is the purpose of the Service System Integrity Plan to support compliance, proper expenditure and accountability within DMH/DD/SAS programs by ensuring that State and Block Grant dollars are utilized appropriately, in accordance with statutory and regulatory framework, and in support of programmatic goals.
The Service System Integrity Plan promotes the following principles:
1. Promote a cost efficient and effective behavioral health care system.
2. Ensure adherence to statutory and regulatory standards and practices.
3. Develop and monitor communication methods, training and technical assistance regarding service system integrity.
4. Support appropriate strategies and approaches to carrying out effective Service System Integrity efforts.
5. Proactively recognize areas of risk that may adversely affect Service System Integrity and proactively address vulnerabilities.
6. Fair and reasonable enforcement of system integrity monitoring. Failure to comply with system integrity efforts may result in technical assistance, plans of correction or other actions.

Please indicate areas of technical assistance needed related to this section

None at this time.

Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state?s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- [x] Children (under age 12)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [x] Adults (ages 27-54)
- [x] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [x] Sexual/gender minorities
- [x] Rural communities
- [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [x] Archival indicators (Please list)

NC Report Card, NC Courts, NC Detect, DPH Alcohol Data Dashboard, DPH Opioid Dashboard, DMH Drug Control Unit (opioid prescribing rates), FDA, NC Department of Motor Vehicles

- [ ] National survey on Drug Use and Health (NSDUH)
- [ ] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] State - developed survey instrument
- [x] Others (please list)

Youth Tobacco Survey

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

Prevention block grant providers are asked to complete an assessment, determine local level priorities and to utilize this information to select and conduct evidence-based prevention strategies.

If no, (please explain) how SABG funds are allocated:

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe

We apply and receive credit for prevention certification from the NC training and standards accreditation board. We also offer trainings and webinars to assist prevention providers in becoming licensed/certified.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe mechanism used

Yes, we contract with the North Carolina Training and Technical Assistance Center and Community Impact NC to provide training and TA to substance abuse prevention block grant providers and coalitions on evidence-based strategies, the SPF planning process and Synar-related activities.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

If yes, please describe mechanism used

Yes, we work with the North Carolina Training and Technical Assistance Center and Wake Forest University to assess community readiness as part of the bi-annual needs assessment process.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ○ Yes ○ No ◉ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☐ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** ☐ Timelines
- **c)** ☐ Roles and responsibilities
- **d)** ☐ Process indicators
- **e)** ☐ Outcome indicators
- **f)** ☐ Cultural competence component
- **g)** ☐ Sustainability component
- **h)** ☐ Other (please list):
- **i)** ☑ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ◉ Yes ○ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ◉ Yes ○ No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The criteria used include outcomes associated with a reduction of use and/or intentions to use ATOD, and/or information published in a peer reviewed journal

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☑ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Clearinghouse/information resource centers, Resource directories, Brochures and other printed material, Speaking engagements/community presentations, Health Fairs, Information lines/hot lines, prevention focused websites, email blasts and newsletters

b) Education:

Strengthening Families, Life Skills Training, Media Detective, Media Ready, All Stars, Project Alert, Too Good for Drugs, Unique You, Project Towards No Drug Abuse, Reconnecting Youth, Project Venture

c) Alternatives:

Drug free dances and parties, Lead and Seed, YES, Youth Move, Community service activities, Outward Bound, Recreation Activities

d) Problem Identification and Referral:

Employee Assistance Program, Student Assistance Program

e) Community-Based Processes:

Community and Volunteer training, Strategic Plan, Town Hall Meetings, Coalition/Task Force/Collaborative Meetings,

Communities Mobilizing for Change on Alcohol, Sustainability Planning/Leveraging Resources

f) Environmental:

Synar, Establishing, Reviewing or changing school, community and/or workplace ATOD policies, Youth Environmental Management strategies, Responsible Alcohol Sales training, Alcohol Purchase Surveys, Safe Stores, Safe Homes, Safer Prescriber training, PDMP registration/utilization, Lockbox/locking cabinet installation, chemical medicine disposal, Take Back events, Lock Your Meds campaign, Social Norms campaigns

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

If yes, please describe

We meet regularly with contractors, providers and LMEs to discuss allowable activities and meet monthly with our state budget office to discuss expenditures.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [ ] Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** [x] Establishes a process for providing timely evaluation information to stakeholders
- **e)** [x] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** [ ] Other (please list:)
- **g)** [ ] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** [x] Numbers served
- **b)** [x] Implementation fidelity
- **c)** [x] Participant satisfaction
- **d)** [x] Number of evidence based programs/practices/policies implemented
- **e)** [x] Attendance
- **f)** [x] Demographic information
- **g)** [ ] Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

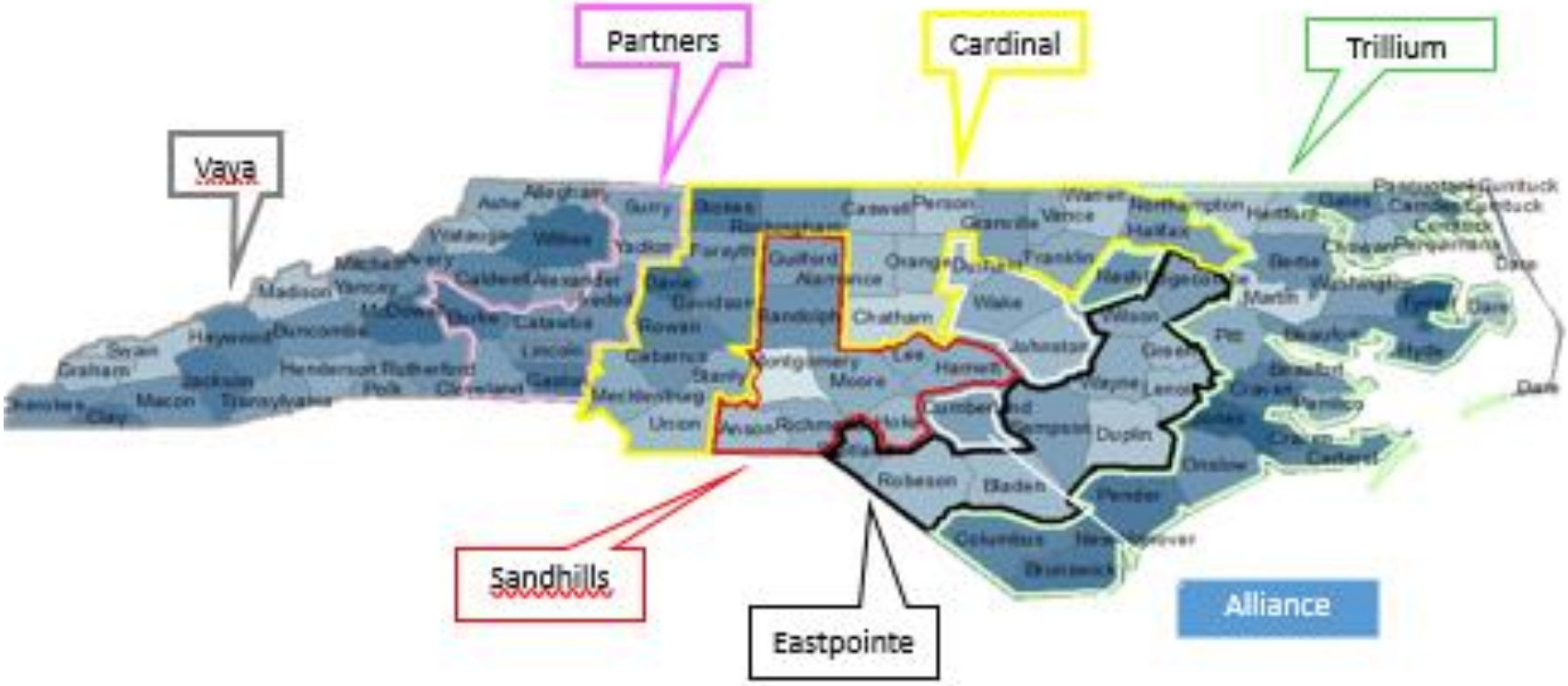
- **a)** [x] 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** [ ] Heavy use
- [x] Binge use
- [x] Perception of harm
- **c)** [x] Disapproval of use

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

Footnotes:

North Carolina Substance Abuse Prevention Block Grant Baseline Evaluation



October 31, 2018

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Disclaimer

The views, opinions, and content of this publication are those of the authors and do not necessarily reflect the views, opinions, or policies of the NCDHHS.

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Table of Contents

EXECUTIVE SUMMARY

Introduction

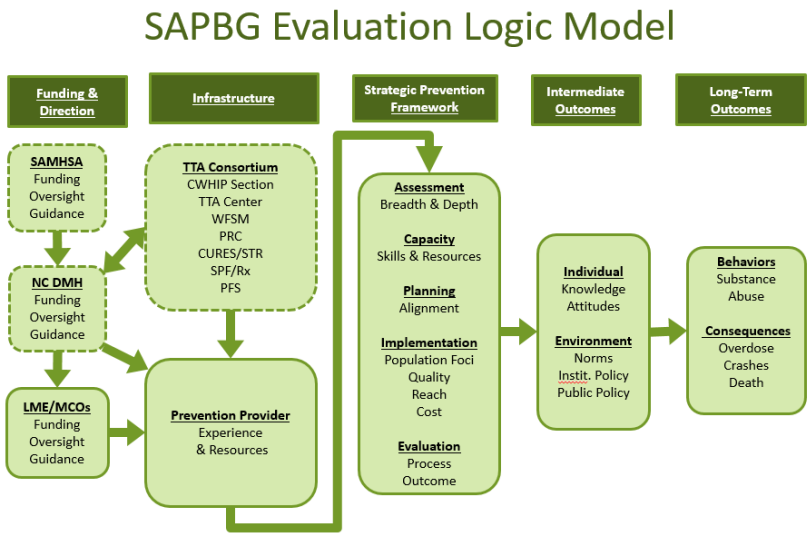
The North Carolina Department of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) is the Single State Agency responsible for administering the North Carolina Substance Abuse Prevention and Treatment Block Grant (SAPTBG). The SAPTBG is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The SAPTBG provides North Carolina approximately $45 million per year for substance abuse prevention, early intervention, treatment, and recovery support, about $9 million of which is for the prevention of substance abuse.

Our evaluation team at Wake Forest School of Medicine (WFSM) was commissioned to evaluate the prevention component of the SAPTBG (abbreviated as SAPBG for the purposes of this report) by the Community Wellness, Health Integration, and Prevention Section of DMH/DD/SAS. The evaluation is designed to be both *formative* ("evaluative activities undertaken to furnish information that will guide program improvement") and *summative* ("evaluative activities undertaken to render a summary judgement on certain critical aspects of the program's performance") (see Rossi et al., 1999).

The structure of this Executive Summary follows that of the report: *Introduction*, *Methods*, *Results*, *SAPBG System Strengths and Opportunities*, and *Next Steps*.

Methods

The evaluation is organized around a logic model. The logic model was developed by the Evaluation Team at WFSM, in collaboration with staff of the DMH/DD/SAS and the North Carolina Training and Technical Assistance Consortium. The logic model shown below) includes five major components: **funding and direction** for the program (provided by SAMHSA, DMH/DD/SAS (abbreviated in the model as "NC DMH"), and seven regional Local Management Entities/Managed Care Organizations (LME/MCOs) responsible for overseeing contracts to prevention providers.



The second major component of the logic model is

infrastructure, which includes the NC Training and Technical Assistance Consortium (an informal advisory body made up of DMH/DD/SAS staff and representatives from each of the organizations coordinating DMH/DD/SAS substance abuse prevention initiatives) as well as the 22 Prevention Provider Agencies, which receive funding and direction from the LME/MCOs.

The third major component is the **Strategic Prevention Framework** (SPF). The SPF is SAMHSA's recommended process for planning substance abuse prevention efforts. It consists of five steps (Assessment, Capacity Building, Planning, Implementation, and Evaluation) and two guiding principles (Cultural Competence and Sustainability) (SAMHSA, 2017).

The fourth major component is **intermediate outcomes**, which may include both individual-level changes (such as changes in knowledge and attitudes related to substance abuse), as well as changes in community environments (such as changes in community norms, institutional policy, and public policy).

The fifth major component of the model is **long-term outcomes**. Achieving these outcomes is the ultimate goal of the SAPBG. They consist of changes in behaviors (such as age of substance abuse initiation and substance abuse), as well as negative consequences related to substance abuse (such as overdoses, motor vehicle crashes, and deaths).

The evaluation has six goals:

1. Assess the NC SAPBG **infrastructure** for supporting the use of rigorous, evidence-based prevention strategies.
2. Assess Local Management Entity/Management Care Organization (LME/MCO) and prevention provider capacity to **implement the Strategic Prevention Framework**, including capacity to implement rigorous, evidence-based prevention strategies.
3. Assess **intermediate outcomes**, such as individual knowledge and attitudes and environmental changes.
4. Assess **long-term outcomes**, such as substance abuse and its consequences.
5. Identify **characteristics** of the infrastructure and SPF Implementation associated with positive **changes in intermediate and long-term outcomes.**
6. Identify current strengths of the SAPBG system and make **recommendations** to further strengthen the effectiveness and efficiency of the NC SAPTBG.

Because this is the baseline report, our focus is on Evaluation Goals No. 1 (assessing infrastructure), No. 2 (assessing SPF implementation), and, based upon findings from No 1 and 2, No. 6 (recommendations). Future reports will be able to exploit follow-up data, enabling assessment of No. 3 (intermediate outcomes), No. 4 (long-term outcomes), and No. 5 (infrastructure and SPF characteristics associated with positive changes in intermediate and long-term outcomes).

This report relies on secondary data compiled from a number of sources. Data on *Infrastructure* come from SAPTBG Compliance Reports provided to the state by the LME/MCOs. Data on implementation of the *SPF* also come from SAPTBG Compliance Reports. Data on *Intermediate Outcomes* come from the Drug Control Unit of DMH/DD/SAS (e.g., data on opioid prescribing rates), the Food and Drug Administration (data on tobacco retailer compliance with relevant laws and

regulations), and the Synar Survey (data on tobacco retailer compliance with the tobacco minimum age of sale law). Data on *Long-Term Outcomes* come from the CDC's Youth Risk Behavior Survey and the NC Youth Tobacco Survey (e.g., state-level data on youth alcohol, tobacco, and drug use), the NC Department of Public Health (e.g., data on drug overdoses, emergency department visits, and hospitalizations), and the NC Division of Motor Vehicles (e.g., alcohol-involved fatal crashes).

Results

As in the body of the report, results are presented here organized by the categories of the logic model: *Funding and Direction*, *Infrastructure*, *Strategic Prevention Framework*, *Intermediate Outcomes*, and *Long-Term Outcomes*.

Funding and Direction

Each state receiving the SAPBG is expected to implement the six Center for Substance Abuse Prevention (CSAP, a component of SAMHSA) strategies: *community-based process*, *environmental strategies*, *prevention education*, *information dissemination*, *alternative activities*, and *problem identification and referral*. Following SAMHSA guidance, in 2016 DMH/DD/SAS established benchmarks intended to move the NC system from one that focused primarily on individual-strategies to one focused primarily on the "core" strategies of community-based process and environmental strategies. The benchmarks set a target of LME/MCOs' expending at least 51% of their allocated SAPBG funds on community-based process and environmental strategies, and no more than 30% of their SAPBG funds on prevention education, 12% on information dissemination, 3% on alternative activities, and 4% on problem identification and referral. DMH/DD/SAS has continued to encourage this transition through its communications with LME/MCOs and by providing a number of resources , such as a model scope of work that LME/MCOs could use with their prevention providers, as well as guidelines for planning and implementing core strategies. LME/MCOs in turn provide funding, oversight, and guidance to their networks of prevention providers.

Infrastructure

This section describes the Training and Technical Assistance Consortium (TTAC), which is an informal advisory group of DMH/DD/SAS CWHIP staff, the Parent Resource Center, The TTA Center, SAMHSA prevention discretionary grant leads, and WFSM.

The key component of the infrastructure is the network of prevention provider agencies that deliver prevention services within communities. The report includes a number of findings related to this key component of the state's infrastructure for prevention, which are briefly summarized, below.

Funding Level and Concentration of SAPBG Staff: As a group, ***the LME/MCOs show stable funding*** between FY 2017 and FY 2018 (as measured by LME/MCO's allocation per person in their service area). In addition, to there is ***favorable movement towards greater full time equivalence of staff working on prevention***.

Certification and Experience of the Prevention Workforce: ***The SAPBG workforce is relatively inexperienced*** (over half are

early career, defined as five or fewer years of experience in prevention), and ***only about 1/4 are certified as prevention specialists***.

Strategic Prevention Framework

Focus on Community-Based Process and Environmental Strategies: ***LME/MCOs are meeting the benchmarks earlier than anticipated.*** Statewide, LME/MCOs expended 64% of their SAPBG funds on community based process and environmental strategies in FY 2018, compared with 42% in FY 2017. In FY 2018, all but one of the LME/MCOs met the benchmarks. Comparable movement was seen between FY 2017 and FY 2018 in increasing use of universal indirect strategies (using the Institute of Medicine category scheme for prevention).

Prevention Education Strategies: ***Prevention providers have transitioned to greater utilization of universal youth prevention education.*** With this shift, positive movement was also observed in the numbers of individuals completing an entire curriculum, as well as reductions in small, less than optimal class sizes.

Synar Related Activities: ***LME/MCOs increased time and coverage for Synar activities most directly related to Synar goals.*** These include substantial increases in the percentage of Synar hours spent on tobacco merchant education, as well as coverage of merchants.

Intermediate Outcomes

Because this is a baseline evaluation report, data on *Intermediate Outcomes* are presented in order to (1) describe the level of substance abuse and related problems in North Carolina, and (2) illustrate the data that we will be able to use in subsequent reports to examine intermediate and long-term outcomes. Data reported here include North Carolina-specific trends in prescribing of opioid analgesics (showing reductions over time, following the pattern of the U.S. as a whole), and on tobacco retailer compliance with the state minimum age-of-sale law (age 18) and FDA advertising and labelling regulations (where patterns are mixed, depending on the source of data used).

Long-Term Outcomes

Data are presented on long-term outcomes related to nonmedical use of prescription drugs, alcohol use, and tobacco use. As mentioned above, for this baseline evaluation report, data are presented in order to describe the level of substance abuse and related problems in North Carolina and to illustrate the data that we will be available to use in subsequent reports to examine long-term outcomes. Of particular note here are increasing rates of fatal overdoses, emergency department visits, and hospitalizations resulting from use of illicitly produced opioids (such as fentanyl) and heroin.

SAPBG System Strengths and Opportunities

Strengths

The baseline evaluation identified a number of important strengths in the North Carolina SAPBG system. These include the following:

1. Substantial progress has been made in transitioning from a system focused largely on individual behavior change to one that focuses on population-based substance abuse prevention strategies. Evidence for this includes our finding that 42.4% of SAPBG program funds were spent on community-based process and environmental strategies in FY 2017, increasing to 63.7% in FY 2018.
2. Prevention providers are shifting their Synar time to activities that are most likely to make a meaningful difference in the retail violation rate, such as merchant education; they are also reaching more merchants across more counties in their Synar efforts.
3. Encouraging trends are in evidence in North Carolina—as is true nationally—in continuing reductions in rates of prescribing of opioid analgesics.

Opportunities

As is often the case, some of the identified strengths in the system suggest that there are opportunities for continuing improvements. These include:

1. An important opportunity for the system is ensuring that community-based process and environmental strategies are implemented effectively, and are aligned with actual needs in communities. While this evaluation report does not include data that bear directly on this question, it is widely recognized that effective planning and implementation of strategies such as these can be challenging. To this end, the WFSM evaluation team has developed several products that may be useful in encouraging effective planning and implementation of these Core strategies. These include a literature review on the effectiveness of various environmental strategies (Wagoner et al., 2018), a guide to implementing and supporting policies (Wagoner et al., 2018), and a guide to developing and implementing effective substance use prevention communication campaigns (Ross et al., 2018). In addition to dissemination of these materials, there may be opportunities for the TTA Center and the TTA Consortium to develop and implement a coordinated effort to stimulate effective planning and implementation of community-based process and environmental strategies.
2. Continuing development of the prevention workforce in the state is an important opportunity. There is a high proportion of early career prevention providers, as well as a high proportion who are not certified or registered to be certified as a substance abuse prevention specialist. Concern about this is somewhat mitigated by our impression that inexperienced prevention providers are supported by a cadre of experienced prevention professionals within every LME/MCO. Nonetheless, there may be opportunities in the coming year for DMH/DD/SAS to encourage LME/MCOs and prevention provider agencies to increase hiring of certified prevention professionals and to offer opportunities to current staff to become certified.
3. While progress has been made in the state in reducing rates of prescribing opioid analgesics, there is mounting concern about the dramatic increases in overdoses related to illicitly manufactured synthetic and semi-synthetic opioids and heroin. Unfortunately, there is little evidence on which, if any, prevention strategies related to use of these substances is effective. If it would be useful, the WFSM Evaluation Team could conduct a national environmental scan to identify

promising primary prevention strategies being implemented in states and communities to address the evolving nature of the opioid epidemic.

4. There may be opportunities to build on recent system improvements in Synar-related activities. This fiscal year (FY 2019), the WFSM Evaluation Team will be conducting an in-depth assessment of Synar activities in each LME/MCO, and the extent to which these activities, as well as other factors, are associated with rates of retailer compliance with the tobacco age-of-sale law. The results of this assessment could inform efforts by DMH/DD/SAS, the TTA Consortium, LME/MCOs, and prevention providers to continue strengthening the state response to youth tobacco use and Synar compliance.
5. There are a number of important gaps in data systems that could inform prevention efforts—including the statewide evaluation. These include the following.
   a. Data on the implementation of SPF is only available at the LME/MCO and prevention provider level, not county level, and currently only address the implementation phase of the SPF. Indicators of quality of implementation are largely absent. WFSM will be conducting an in depth review of communication campaign implementation using strategic action plan and process evaluation data, with the intent of addressing quality to the extent possible, but also identifying gaps and making recommendations for implementation quality assessments. This will be a first step in addressing this gap, and if desired WFSM Evaluation Team can extend this analysis to other strategies.
   b. There are some data quality problems, particularly with respect to counting reach, that limit the usefulness of some of the measures of implementation. WFSM Evaluation Team will be conducting a training on counting reach, and will also be analyzing SAPTG reporting data to identify problems, develop automated screening tools and other processes to more rapidly identify and correct reporting errors.
   c. Individual-level data on knowledge, attitudes, and behaviors are highly limited (the only data available are for a single year, limited to youth, and are only available at the LME/MCO level).

It is recommended that the data related gaps be brought to the North Carolina State Epidemiological Outcomes Workgroup for consideration. As a multi-departmental, state level working group, they may be able to work within and across systems to increase data resources for multiple sectors.

Next Steps

The proposed next steps for the evaluation include the following:

1. Meet with DMH/DD/SAS staff to discuss the findings and recommendations of this baseline evaluation report and identify appropriate follow-up actions.
2. Meet with DMH/DD/SAS and the TTA Consortium to discuss uses of other recent deliverables, including the literature review on the effectiveness of various environmental strategies (Wagoner et al., 2018), guide to implementing and supporting policies (Wagoner et al., 2018), and guide to

developing and implementing effective substance use prevention communication campaigns (Ross et al., 2018). In addition to potential dissemination of these materials, there may be opportunities for the TTA Center and the TTA Consortium to collaborate on the development and implementation of a coordinated effort to stimulate effective planning and implementation of community-based process and environmental strategies.

3. Conduct an in-depth assessment of Synar activities in each LME/MCO, including an assessment of the extent to which these activities, as well as other factors, are associated with rates of retailer compliance with the tobacco age-of-sale law. The results of this assessment could inform efforts by DMH/DD/SAS, the TTA Consortium, LME/MCOs, and prevention providers to continue strengthening the state response to youth tobacco use and Synar compliance.
4. Meet with DMH/DD/SAS staff and the SEOWG to identify and explore possible approaches to addressing gaps in current data systems.
5. Conduct interviews with staff from each of the seven LME/MCOs to assess their attitudes, capacity, and direction of prevention efforts.
6. Compile updated data on each of the components of the evaluation logic model, as these data come available. Having these data will enable us to report, in the 2nd Annual Report, continuing changes in infrastructure, SPF implementation, intermediate outcomes, and long-term outcomes. This will include a quasi-experimental analysis of the impact of measures of SPF implementation on both intermediate and long-term outcomes (see measures included in Table 3.1). As an example, we will be able to assess, at the LME level, the extent to which shifts from individual-focused to core strategies are associated with reductions in key outcomes, including retailer compliance with tobacco age-of-sale laws and opioid overdose and hospitalization rates.

INTRODUCTION

The North Carolina Department of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) is the Single State Agency responsible for administering the North Carolina Substance Abuse Prevention and Treatment Block Grant (SAPTBG). The SAPTBG is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The SAPTBG provides North Carolina approximately $45 million per year for substance abuse prevention, early intervention, treatment, and recovery support, about $9 million of which is for the prevention of substance abuse. North Carolina's SAPTBG is administered through seven regional Local Management Entities/Managed Care Organizations (LME/MCOs). LME/MCOs contract with community-level providers to service the LME/MCOs' catchment areas, which ranges from 4 to 26 counties each.

Our evaluation team at Wake Forest School of Medicine (WFSM) was been commissioned to evaluate the prevention component of the SAPTBG (abbreviated as SAPBG for the purposes of this report) by the Community Wellness, Health Integration, and Prevention Section (CWHIP) of DMH/DD/SAS. This is a baseline report, from what is expected to be a multi-year evaluation. The report presents data mainly at the state level and at the LME/MCO level, as these entities are responsible for carrying out DMH/DD/SAS directives in relation to the SAPBG. Implementation of prevention strategies at the community level is handled by each of the LME/MCO's prevention provider network. There are currently 22 prevention providers, four of which have contracts under multiple LME/MCOs.

Following direction of SAMHSA, NC DMH/DD/SAS has worked to transition the SAPBG from a system primarily focused on individual-based substance abuse prevention strategies for high risk youth to one that focuses on population-based substance abuse prevention strategies for universal audiences, which can reach more people in more sustainable ways. Thus, an important focus for this evaluation is an assessment of progress, achievements, and challenges related to this transition.

A second important focus for this evaluation report is examining Synar related activities. The Synar Amendment requires states to maintain a tobacco age-of-sale retail violation rate (RVR) under 20%, or risk losing up to 40% of the SAPTBG. In recent years, North Carolina's violation rate has come close to violating this standard, risking $17 million in SAPTBG funds for the state. DMH/DD/SAS has been working in a variety of ways to increase Synar compliance.

The evaluation is designed to be both *formative* ("evaluative activities undertaken to furnish information that will guide program improvement") and *summative* ("evaluative activities undertaken to render a summary judgement on certain critical aspects of the program's performance") (see Rossi et al., 1999). Recommendations based on our baseline evaluation assessment are provided at the end of this report.

METHODS

Logic model

Development of a logic model is a critical component of program evaluation, as it brings the underlying logic of a program to the surface, thereby enabling assessment of each of the components of the program, and of their relationships to the other components. The logic model presented below was developed by the Evaluation Team at WFSM, in collaboration with staff of the NC DMH/DD/SAS and the NC Training and Technical Assistance Consortium (TTAC; described below). A draft version of the logic model was presented to the TTAC on April 23, 2018. Based on feedback obtained at that meeting, and subsequently from NC DMH/DD/SAS staff, revisions to the model were made, resulting in the model presented below.

As can be seen in Figure 3.1, the logic model includes five major components. The first is **funding and direction** for the program, which is provided by SAMHSA, NC DMH/DD/SAS (abbreviated in the model as "NC DMH"), and the seven regional LME/MCOs responsible for overseeing prevention provider contracts.

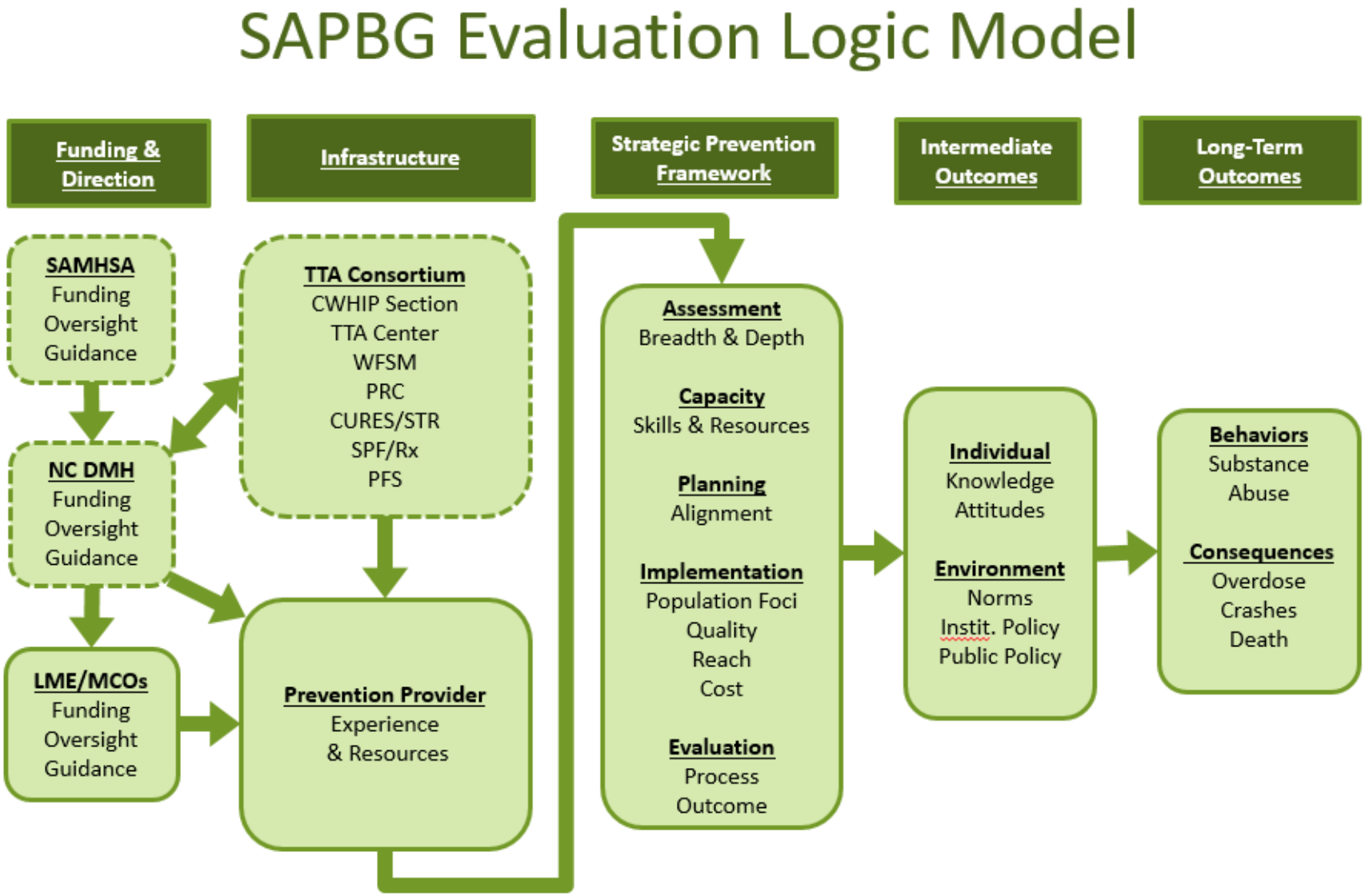
The second major component of the logic model is **infrastructure**. This infrastructure includes the NC Training and Technical Assistance Consortium, which is an informal advisory body made up of DMH/DD/SAS staff and representatives from each of the organizations coordinating DMH/DD/SAS substance abuse prevention initiatives, including the 21st Century Cures Act and the State Targeted Response to the Opioid Crisis program; the Strategic Prevention Framework for Prescription Drugs initiative; the Strategic Prevention Framework – Partnerships for Success initiative, training and technical assistance efforts, and evaluation and support for the SAPTBG. A second critical aspect of the infrastructure is the 22 Prevention Provider Agencies, which receive funding and direction from the LME/MCOs.

The third major component is the **Strategic Prevention Framework** (SPF). The SPF is SAMHSA's recommended process for planning substance abuse prevention efforts. It consists of five steps (Assessment, Capacity Building, Planning, Implementation, and Evaluation) and two guiding principles (Cultural Competence and Sustainability) (SAMHSA, 2017).

The fourth major component is **intermediate outcomes**. These may include both individual-level changes (such as changes in knowledge and attitudes related to substance abuse), as well as changes in community environments (such as changes in community norms, institutional policy, and public policy).

The fifth major component of the model is **long-term outcomes**. Achieving these outcomes is the ultimate goal of the SAPBG. They consist of changes in behaviors (such as age of substance abuse initiation and substance abuse), as well as negative consequences related to substance abuse (such as overdoses, motor vehicle crashes, and deaths).

Figure 3.1. SAPBG Evaluation Logic model.



Evaluation Goals

In line with the SAPBG evaluation logic model, the overall goals of this multi-year evaluation are to:

7. Assess the NC SAPBG **infrastructure** for supporting the use of rigorous, evidence-based prevention strategies.
8. Assess Local Management Entity/Management Care Organization (LME/MCO) and prevention provider capacity to **implement the Strategic Prevention Framework**, including capacity to implement rigorous, evidence-based prevention strategies.
9. Assess **intermediate outcomes**, such as individual knowledge and attitudes and environmental changes.
10. Assess **long-term outcomes**, such as substance abuse and its consequences.
11. Identify **characteristics** of the infrastructure and SPF Implementation associated with positive **changes in intermediate and long-term outcomes.**
12. Identify current strengths of the SAPBG system and make **recommendations** to further strengthen the effectiveness and efficiency of the NC SAPTBG.

Because this is the baseline report, our focus is on Evaluation Goals No. 1 (assessing infrastructure), No. 2 (assessing SPF implementation), and, based upon findings from No 1 and 2, No. 6 (recommendations). Future reports will be able to exploit follow-up data, enabling assessment of No. 3 (intermediate outcomes), No. 4 (long-term outcomes), and No. 5 (infrastructure and SPF characteristics associated with positive changes in intermediate and long-term outcomes).

Data Collection and Analyses

This baseline evaluation report relied on secondary data compiled from a number of sources. Table 3.1 provides documentation of the type of data used, as well as its source, organized by the logic model component which the data is intended to address. The baseline evaluation report solely utilizes descriptive statistics. LME/MCOs identities are masked for infrastructure and SPF implementation related measures to protect confidentiality. As it may influence some of the results that are reported. LME/MCOs with special projects that go beyond the normal mandate of the SAPBG, such as responsibility for a statewide initiative or an initiative for special populations, are noted with an asterisk.

As in most, if not all state systems in the U.S., there are gaps in the existence or availability of data, which create some challenges for evaluation. In the case of the NC prevention system, the three most important gaps include the following:

- Data on the implementation of SPF is only available at the LME/MCO and prevention provider level, not county level, and currently only address the implementation phase of the SPF.
- There are some data quality problems, particularly with respect to counting reach, that limit the usefulness of some of the measures of implementation.
- Individual-level data on knowledge, attitudes, and behaviors are highly limited (the only data available are for a single year, limited to youth, and are only available at the LME/MCO level).

Table 3.1. Sources of Data Used in this Report

Logic Model Component	Measure	Source	Smallest Unit	Years Available
Infrastructure				
Resources	SAPBG Dollars Allocated	SAPTBG Compliance Reports	Prevention Provider	FY 2017&18
	SAPBG Staff FTEs	SAPTBG Compliance Reports	Prevention Provider	FY 2017&18
Experience	SAPBG Staff NCSAPPB Certification	SAPTBG Compliance Reports	Prevention Provider	FY 2017&18
	SAPBG Staff experience	SAPTBG Compliance Reports	Prevention Provider	FY 2017&18
Strategic Prevention Framework				
SAPBG Expenditures	Expenditures by CSAP Strategy	SAPTBG Compliance Reports	Prevention Provider	FY 2017&18
	Expenditures by IOM Target	SAPTBG Compliance Reports	Prevention Provider	FY 2017&18
Prevention Education	Curriculum, dates, provider agency, host agency, county, and number enrolled and completed	SAPTBG Compliance Reports	County	FY 2017&18
Synar	Tobacco age of sale retail violation rate reduction strategies	SAPTBG Compliance Reports	Prevention Provider	FY 2017&18
	Merchant education stores by county, city, street address and dates	SAPTBG Compliance Reports	Stores	FY 2017&18
Intermediate Outcomes				
Environment	Opioid Prescribing Rates (prescriptions per 100 residents) By County, CDC: N.C. Residents, 2006-2016	DMH/DD/SAS, Drug Control Unit	County	2006-2016
	Percent of Patients with Average Daily Dose >90 MME* By County, CSRS: N.C. Residents, 2011-2016	DMH/DD/SAS, Drug Control Unit	County	2011-2016
	Retail compliance with tobacco advertising and labeling laws	FDA	County	2012-2017
	Compliance with retail tobacco age of sales laws	FDA	County	2012-2017

Table 3.1. Sources of Data Used in this Report (Continued)

Logic Model Component	Measure	Source	Smallest Unit	Years Available
Intermediate Outcomes				
Environment	Retail compliance with advertising and labeling laws	DMH/DD/SAS, Synar Survey	County	2014-2017
	Compliance with retail tobacco age of sales laws	DMH/DD/SAS, Synar Survey	County	2014-2017
Long-Term Outcomes: Behaviors				
Alcohol	Currently drank alcohol (at least one drink of alcohol, on at least 1 day during the 30 days before the survey)	CDC YRBS High School	State	2003-2017
Tobacco	Current smoking (During the past 30 days, on how many days did you smoke cigarettes?)	CDC YRBS High School	State	2003-2017
	Current smoking (During the past 30 days, on how many days did you smoke cigarettes?)	NC DPH, Youth Tobacco Survey	State	2003-2017
	Currently Used An Electronic Vapor Product (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on at least 1 day during the 30 days before the survey)	CDC YRBS High School	State	2015-2017
Prescription Drugs	All Intents Poisoning Deaths by County: N.C. Residents, 1999-2016	NC DPH, Injury & Violence Prevention	County	1999-2016
	All Intents Commonly Prescribed Opioid Medication Poisoning Deaths by County: N.C. Residents, 1999-2016	NC DPH, Injury & Violence Prevention	County	1999-2016
	All Intents Other Synthetic Opioid Poisoning Deaths by County: N.C. Residents, 1999-2016	NC DPH, Injury & Violence Prevention	County	1999-2016
	All Intents Cocaine Poisoning Deaths by County: N.C. Residents, 1999-2016	NC DPH, Injury & Violence Prevention	County	1999-2016

Table 3.1. Sources of Data Used in this Report (Continued)

Logic Model Component	Measure	Source	Smallest Unit	Years Available
Long-Term Outcomes: Consequences				
Prescription Drugs	All Intents Poisoning ED Visits by County: N.C. Residents, 2008-2016	NC DPH, Injury & Violence Prevention	County	2008-2016
	All Intents Commonly Prescribed Opioid Medication Poisoning ED Visits by County: N.C. Residents, 2008-2016	NC DPH, Injury & Violence Prevention	County	2008-2016
	All Intents Heroin Poisoning ED Visits by County: N.C. Residents, 2008-2016	NC DPH, Injury & Violence Prevention	County	2008-2016
	All Intents Cocaine Poisoning ED Visits by County: N.C. Residents, 2008-2016	NC DPH, Injury & Violence Prevention	County	2008-2016
	All Intents Poisoning Hospitalizations by County: N.C. Residents, 2004-2016	NC DPH, Injury & Violence Prevention	County	2004-2016
	All Intents Commonly Prescribed Opioid Medication Poisoning Hospitalizations by County: N.C. Residents, 2004-2016	NC DPH, Injury & Violence Prevention	County	2004-2016
	All Intents Heroin Poisoning Hospitalizations by County: N.C. Residents, 2004-2016	NC DPH, Injury & Violence Prevention	County	2004-2016
Alcohol	Alcohol-Related ED visits for ages 12-25	NC DPH, NC Injury & Violence Prevention Branch	County	2013-2017
	Alcohol-involved fatal crashes	North Carolina Division of Motor Vehicles	County	2013-2017

RESULTS

Funding and Direction

SAMHSA is the federal agency responsible for administering the Substance Abuse Prevention and Treatment Block Grant. It provides funding for substance abuse prevention, early intervention, treatment, and recovery support to every state in the nation. It includes a 20% set-aside for the primary prevention of substance use, which is the focus of this baseline evaluation report.

By statue, each state must implement each of six primary substance abuse prevention strategies, commonly referred to as the six CSAP strategies, named after the branch of SAMHSA responsible for overseeing prevention portion of the block grant, the Center for Substance Abuse Prevention (SAMHSA, 2017). The definition of each of the six strategies is provided below.

- **Community-Based Processes "**provide for ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning."
- **Environmental Strategies** "establish or change written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population."
- **Prevention Education "**builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental abilities. There is more interaction between facilitators and participants than in the information strategy."
- **Information Dissemination** "provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two."
- **Alternative Activities "**provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities, and to discourage the use of alcohol and drugs through these activities.
- **Problem Identification and Referral** "aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education." This does not include assessing whether an individual is in need of treatment.

Also by statute, substance abuse prevention strategies are classified using the Institute of Medicine (IOM) population

targets of universal, selective, and indicated. They are defined below.

- **Universal** strategies are "targeted to the general public or a whole population group that has not been identified on the basis of individual risk." Universal strategies can be direct, working with individuals, or indirect, working with populations.
- **Selective** strategies are "targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average."
- **Indicated** strategies are **"**targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels."

SAMHSA provides oversight in monitoring compliance with SAPBG regulations through three formal mechanisms. The first is the annual SAPTBG plan, in which states indicate what they are planning to do. It is a structured report requiring anticipated expenditures by CSAP strategy and IOM target, target substances and populations, specific interventions to be utilized, and, every other year, a detailed assessment of substance abuse prevention needs and gaps, an analysis of health disparities and a plan to address them, a workforce development plan, and the establishment of state priorities. The current SAPBG priorities focus on prescription drug abuse due to the rapidly rising overdose death rate, and tobacco use, including reducing the retail violation rate (RVR).

Second, SAMHSA provides oversight by way of review of an annual report required of each state. This report enables SAMHSA to monitor expenditures and people served by CSAP strategy and IOM target, target substances and populations, and the number of evidenced-based interventions utilized by IOM target.

The third formal mechanism SAMHSA uses to fulfill its oversight responsibilities are site visits. Site visits may be programmatic, financial or both. SAMHSA conducted a programmatic site visit of North Carolina in 2014 and a programmatic and financial site visit in 2017. The 2014 site visit concluded that North Carolina was not reaching a sufficient proportion of the population due to its focus on individual-based programs for selective and indicated populations. It required that the state receive technical assistance and develop a plan to transition the system to reach a more substantial proportion of the population using population-based strategies, including community-based processes and environmental strategies. SAMHSA's site visit report also noted significant deficiencies in reporting accuracy and completeness and mandated improvements to address these deficiencies. The 2017 site visit formal report is not yet available, but it is our understanding that it is expected to include important findings related to Synar-related activities. First, due to a deficiency in state statutes not providing authorization for North Carolina Alcohol Law Enforcement (ALE) to conduct inspections for compliance with the tobacco age-of-sale law, there was a lack of statewide enforcement of this law. Second, as identified by the annual Synar Survey (a clustered random sample of tobacco age-of-sale retail compliance inspections), the retail violation rate (RVR) was very close to exceeding the 20% non-compliance threshold. If exceeded, the state risks losing up to 40% of SAPTBG funds ($17

million dollars in NC).

SAMHSA provides guidance on the SAPBG through requested and mandated technical assistance, assistance in interpreting regulations, and support from the SAMHSA project officer. Mandated technical assistance originates from site visit reports, such as the mandate from the 2014 site visit to get technical assistance in transitioning to a system focusing on population-based substance abuse prevention strategies. SAMHSA provides assistance in interpreting regulations as needed, such as providing guidance on counting population-based strategies or in classifying difficult-to-categorize interventions. Finally, in North Carolina's case, SAMHSA provides guidance with regular calls between the SAMHSA Project Officer and the state National Prevention Network (NPN) contact.

DMH/DD/SAS (specifically the CWHIP section) is the state-level entity responsible for administering the SAPBG. It allocates funding to each of the seven regional LME/MCOs. In FY 2014 and in subsequent years, the allocation is based on a specified amount per person in the LME/MCO's service area. DMH/DD/SAS also provide contracts to develop resources across the state for the SAPBG, such as contracts to the Training and Technical Assistance Center, Parent Resource Center, Governor's Institute on Substance Abuse, Alcohol Drug Council, and Wake Forest School of Medicine.

DMH/DD/SAS has two primary mechanisms for providing oversight in meeting SAPBG requirements: LME/MCO SAPBG compliance reporting and LME/MCO SAPBG audits. SAPBG compliance reports are due twice a year, in January and July, with each report covering the preceding six months. The compliance report includes 13 sections, reported by prevention provider agency and aggregated to the LME/MCO level. The sections include expenditures by CSAP strategy and IOM target; other substance abuse prevention funds received; risk groups targeted; CSAP strategies utilized, their associated service types, and hours spent on each; people reached by CSAP strategy, IOM target, and demographic characteristics; prevention provider agency staff, their title, NCSAPPB Prevention Specialist certification status, SAPBG FTE, and the counties they service; a strategic prevention plan; substance abuse prevention curricula implemented, including the facilitating staff, location, and the numbers enrolled and completing the curriculum by IOM target; how their Synar time was spent by month; and Synar merchant education locations. Only prevention education and Synar merchant education are reported by county.

DMH/DD/SAS also provides oversight by way of LME/MCO audits. Audits are conducted each spring, with the exception of spring 2018, when prevention providers were transitioning to a new reporting system. Audits are of the LME/MCO, but prevention provider agency staff are expected to be present with documentation for the services they provided. The audits are based on standards, as well as rules for acceptable documentation, for each of the six CSAP strategies (DMH/DD/SAS, 2017).

DMH/DD/SAS provides guidance in implementing the SAPBG in a variety of ways. First, it provides direction to the Training and Technical Assistance (TTA) Center regarding workforce development plans. The TTA Center submits a plan outlining specific trainings to be conducted, how many times, in what

format, and whether it's required or optional, which DMH/DD/SAS approves. This includes foundational trainings which set standards for how specific strategies are implemented, as well as content focused trainings.

DMH/DD/SAS also conducts regional networking meetings, as a way to share important updates on the SAPBG program, provide reporting training, and provide an opportunity for prevention providers to network with one another. Historically these meetings were conducted at two or three locations across the state, but beginning in FY17, they were conducted at the offices of each of the seven LME/MCOs to provide an opportunity to interact with LME/MCO staff.

Relatedly, DMH/DD/SAS provides LME/MCOs with analyses based on their SAPBG compliance reports, and discusses potential opportunities for improvement. These analyses examine staffing patterns, spending and persons served by CSAP strategy and IOM target, by provider where possible. The analyses also identify potential data quality issues, as well as requests for corrections. These reports also examine whether the LME/MCOs, and individual providers (in cases where data is available), are meeting their benchmarks (as described below).

Benchmarks were established and communicated to the LME/MCOs via a September 2016 memorandum (DMH/DD/SAS, 2016). The benchmarks were established in response to SAMHSA's mandate that the state transition to a greater focus on population-based strategies. The benchmarks set a target of LME/MCOs' expending at least 51% of their allocated SAPBG funds on community-based process and environmental strategies, and no more than 30% of their SAPBG funds on prevention education, 12% on information dissemination, 3% on alternative activities, and 4% on problem identification and referral. Community-based process and environmental strategies were designated as *core* prevention strategies required of all LME/MCOs, and the remaining three as *support* prevention strategies, which are optional for LME/MCOs. The benchmarks further specified that at least 60% of prevention education funds be spent on programs targeting a universal audience, and that no more than 35% and 5% of the prevention education funds be spent on programs targeting selective and indicated audiences, respectively. Recognizing that different LME/MCOs were in different places regarding the benchmarks, and that it was important to not undermine relationships built within communities, no firm timeline was set for meeting the benchmarks. All that was specified was that LME/MCOs show progress in transitioning to the benchmarks. Our understanding is that DMH/DD/SAS envisioned that complete compliance with the benchmarks would require a process of up to five years.

To support LME/MCOs in working towards meeting the benchmarks, DMH/DD/SAS developed a model scope of work that the LME/MCOs could use in contracting with their prevention providers. The model scope of work incorporated elements of the benchmarks, including specifying definitions for each of the six CSAP strategies and a percentage of expenditures assigned for each. It also included specifications related to reporting quality and qualifications of prevention provider staff, including a preference for certified Substance Abuse Prevention Specialists, as encouraged by SAMHSA, or minimally graduation from college in a human service and/or related experience.

Finally, DMH/DD/SAS provides guidance in the form of formal guidelines. Guidelines provide background information for specific strategies and set standards for their implementation. Currently guidelines exist for public policy, communication campaigns, youth prevention education, and parent prevention education. The first two address strategies that environmental strategies funds can be used for, while the latter represent strategies that prevention education funds can be used for.

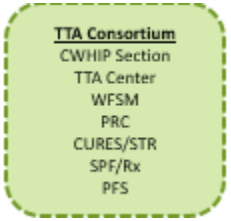
LME/MCOs provide funding, oversight and guidance to their contracted prevention provider agencies. They are responsible for fulfilling DMH/DD/SAS mandates, including recruiting and maintaining a prevention provider network, including funding each prevention provider agency to provide substance abuse prevention services to specific counties.

LME/MCOS are all required to develop contracts with their prevention provider agencies and provide oversight in compliance with contract terms. The LME/MCOs have discretion in how they do this, including the level of contract detail, whether or not they require review and approval of prevention strategies, whether they conduct pre-audits, and whether they have contractual requirements over and above those required by DMH/DD/SAS. LME/MCOs are required to collect SAPBG compliance report data from their prevention provider agencies, and aggregate data for submission to DMH/DD/SAS. The benchmarks are a requirement for grant leads, and Wake Forest School of Medicine, which provides evaluation and support services.

LME/MCOs to meet, but they must provide oversight of their prevention provider agencies to ensure they are making progress in transitioning to the benchmarks. The LME/MCOs again have discretion in how this is done, and they may choose, for example, to require all prevention providers to meet the benchmarks, identify specific prevention provider agencies to implement specific CSAP strategies, or specify prevention provider agency transition goals based upon where each prevention provider agency was when the benchmarks were adopted.

Finally, LME/MCOs are responsible for providing guidance to their prevention providers. They have considerable discretion in how they do this, and may vary from a very collaborative process where they work with prevention providers to determine how to meet DMH/DD/SAS mandates, to a more directive approach, specifying deliverables and how prevention providers can comply with them.

Infrastructure



The Training and Technical Assistance Consortium (TTAC) is an informal advisory group of DMH/DD/SAS CWHIP staff, the Parent Resource Center, The TTA Center, SAMHSA prevention discretionary grant leads, and WFSM.

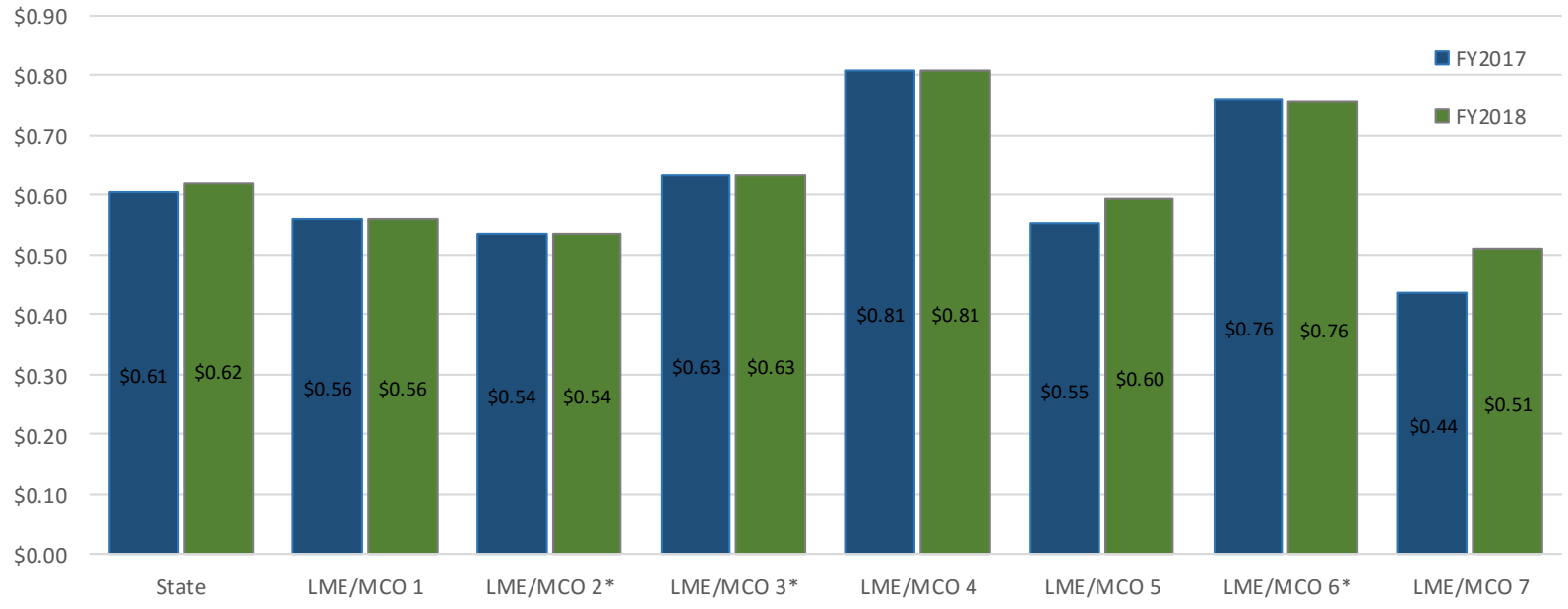
Prevention Provider
Experience
& Resources

Funding Level and Concentration of SAPBG Staff

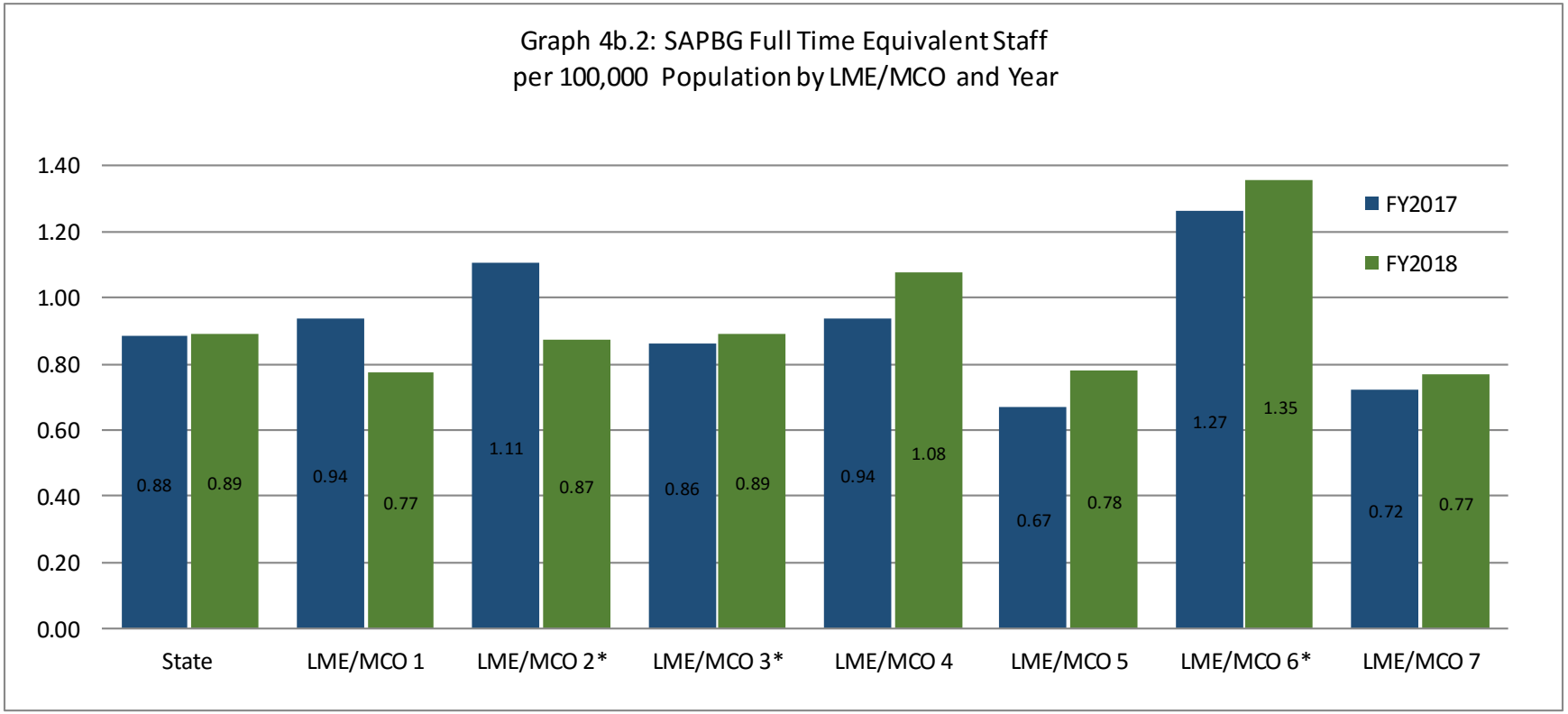
Stable funding and movement towards greater full time equivalence of staff working on prevention

In FY 2014 and in subsequent years, the allocation of prevention funds was set as a specified amount per person in the LME/MCO's service area. This established the level of resources available to prevention providers for working in each county across the state. In FY 2018, LME/MCOs were allocated $5.9 million, averaging $0.62 per person. This was relatively unchanged from FY 2017, although the per person allocation varied across the LME/MCOs. Part, but not all, of the variation by LME/MCO can be explained by special projects in LME/MCO 3 and 6. With the exception of LME/MCO 5 and 7, whose increases brought them closer to the average SAPBG allocation per person, the SAPBG allocation per person was stable from FY 2017 to 2018.

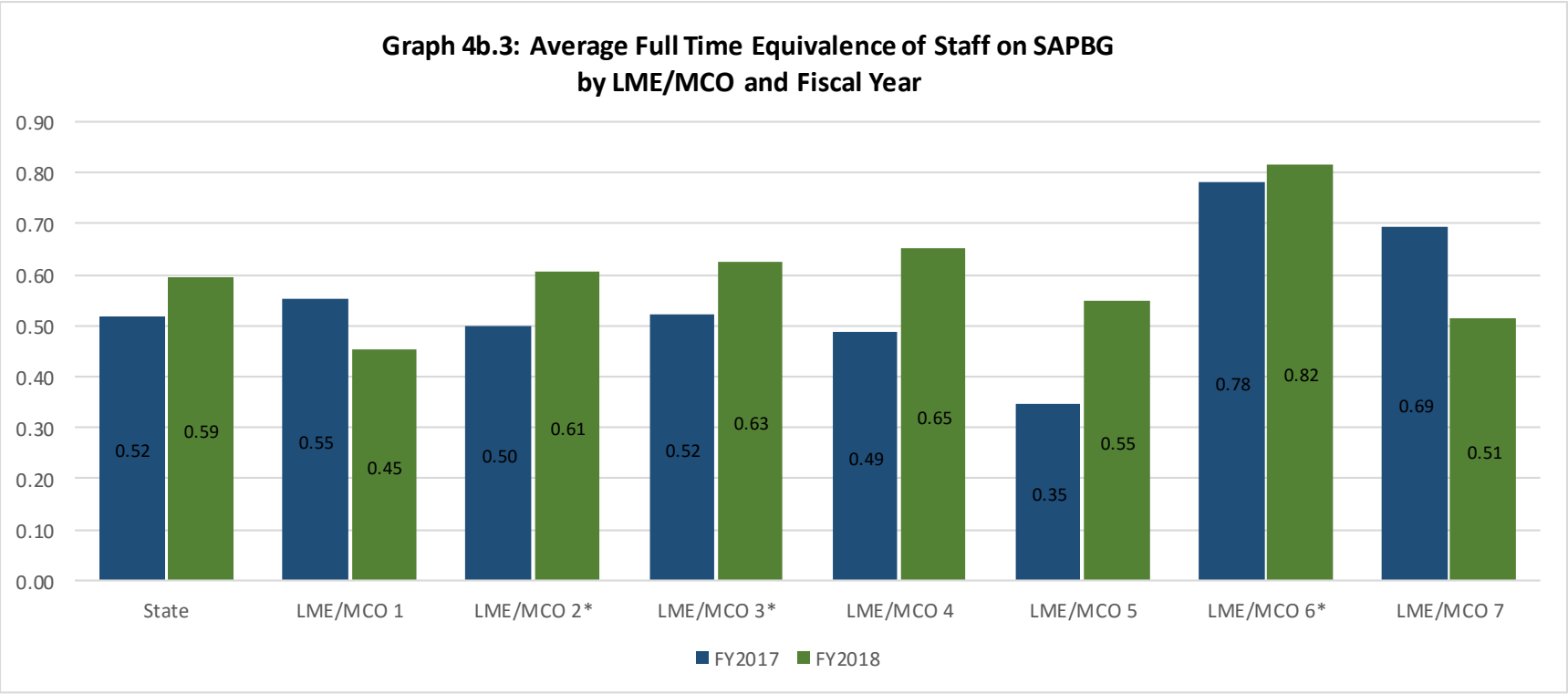
Graph 4b.1: SAPBG Dollars Allocated Per Person by LME/MCO and Year



SAPBG expenditures are predominately for personnel. In FY 2018, the state had 159 SAPBG staff making up 85.1 FTEs. This averaged .89 SAPBG full-time equivalent staff per 100,000 population. This was relatively unchanged from FY 2017. Thus, a large urban county could have several SAPBG staff available to support the county, while a small rural county would only have a small proportion of one staff person if funds were evenly allocated per person across LME/MCOs and the prevention providers in their network. SAPBG full-time equivalent staff per 100,000 population varied both by LME/MCO and fiscal year. The variation in SAPBG full-time equivalent staffing by LME/MCO is similar to the variation found in the SAPBG dollars allocated per person by LME/MCO. Based upon compliance report data, variation within LME/MCOs appears to be at least partially due to employee turnover.



It us our understanding that there was concern regarding the dispersion of staff that was shared with LME/MCOs. This concern was especially great for prevention provider agencies with a large number of staff with small percentage time commitments, as across the SAPBG there are large number of strategies implemented, each requiring different skills and expertise that are difficult to master if you only have a small proportion of your time dedicated to master them. Across the state, prevention provider agency staff worked an average .59 full time equivalence on SAPBG in FY 2018. This was a slight increase over FY 2017 when the concern over staff dispersion was shared with LME/MCOs. There was considerable variation across LME/MCOs in the full-time equivalent hours their staff spent on SAPBG, from a low of .35 in LME/MCO 5 in FY 2017 to a high of .82 in LME/MCO 6 in FY 2018. With the exception of LME 1 and 7, the average full-time equivalence of staff time spent on SAPBG increased from FY 2017 to FY 2018. This increase in staff full time equivalence may allow for a greater focus of staff on SAPBG goals.



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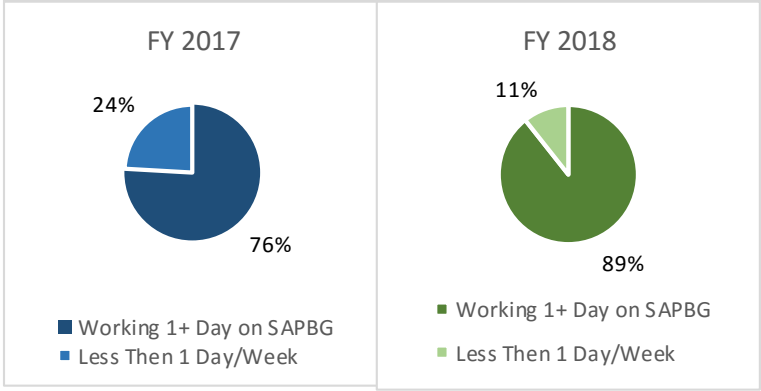
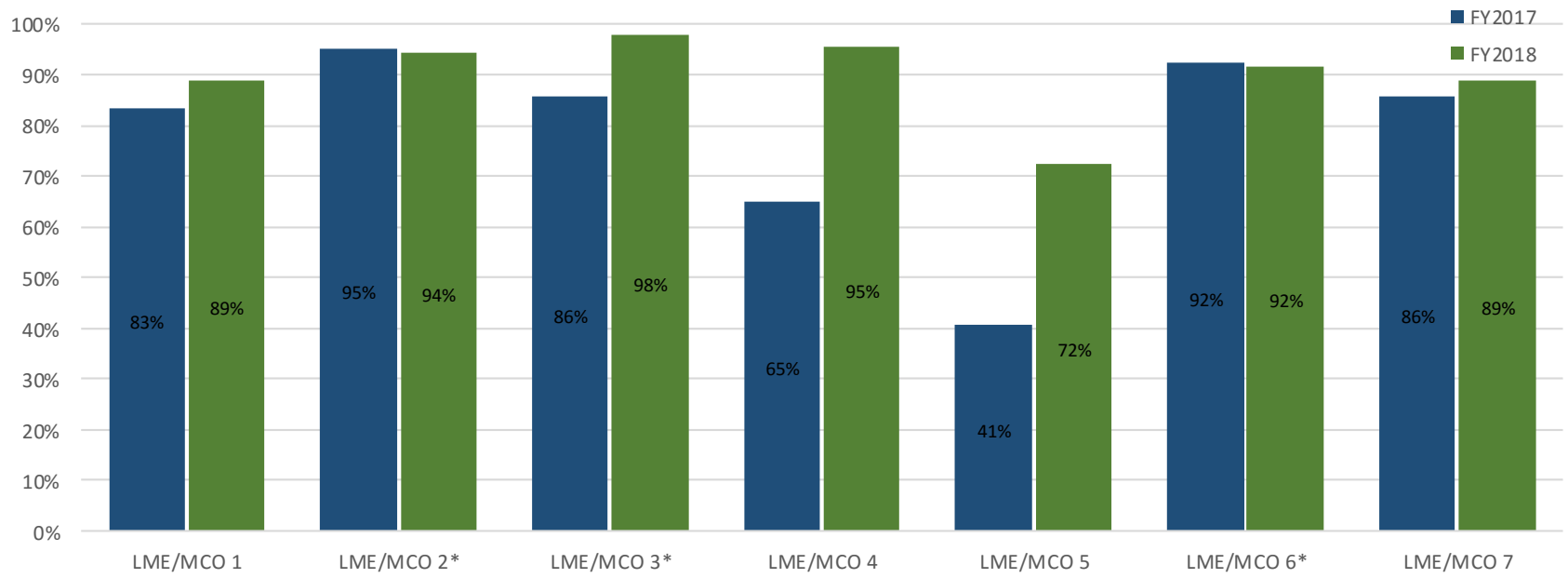
Across North Carolina, 89% of prevention provider agency staff worked at least one day per week on SAPBG in FY 2018. This is another metric to look at staff dispersion, which had decreased over FY 2017 when this was raised as a concern with LME/MCOs. There was considerable variation across LME/MCOs in the proportion of staff working at least one day per week on SAPBG in FY 2017, from a low of .41 in LME/MCO 5 in FY 2017 to a high of 95% in LME/MCO 2, which came close to leveling out in FY 2018. With the exception of LME 2, which maintained an already high proportion of staff working at least one day per week in FY 2017, the percentage of staff working at least one day per week on SAPBG activities increased from FY 2017 to 2018.

Graph 4b.4: Staff Working at Least One Day Per Week on SAPBG by Year



Graph 4b.5: Percent of Staff Working One Day or More on the SAPBG by LME/MCO and Year



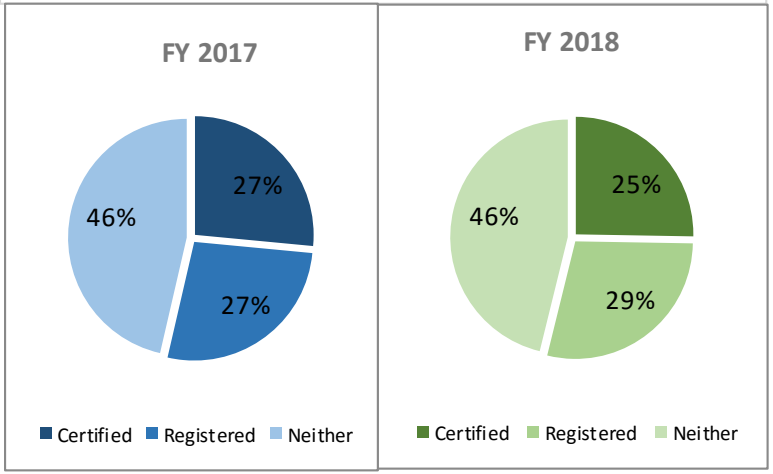
Prevention Provider Experience & Resources

Certification and Experience of the Prevention Workforce

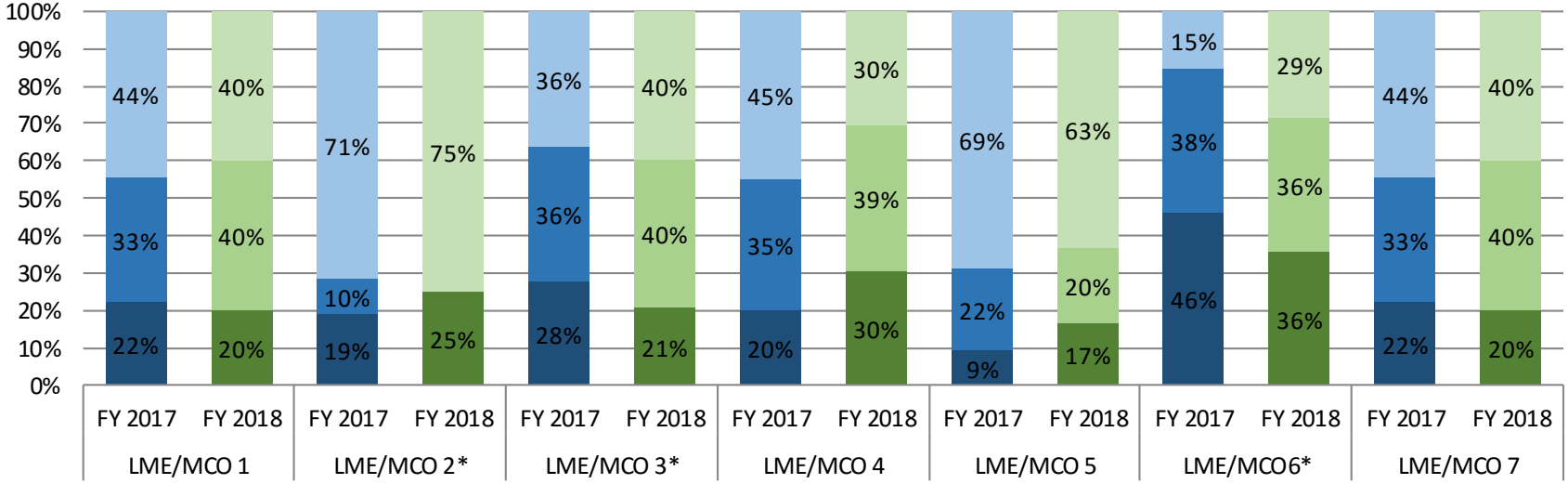
The SAPBG workforce is relatively inexperienced, with only ¼ certified as prevention specialists

It is our understanding that SAMHSA encourages certification of prevention specialists, which was also encouraged by DMH/DD/SAS using the model scope of work disseminated to LME/MCOs, to increase the professionalism of the field. Across the state, 25% of SAPBG staff were certified as a NCSAPPB Prevention specialist, 29% were registered for certification, and 46% were neither certified nor registered in FY 2018. This was relatively unchanged from FY 2017. The proportion of staff either certified or registered as a NCSAPPB Prevention Specialist varied considerably across the LME/MCOs, from a low of 25% in LME/MCO 2 in FY 2018 to a high of 85% in LME/MCO 6 in FY 2017.

Graph 4b.6: NCSAPPB Prevention Specialist Status by Year

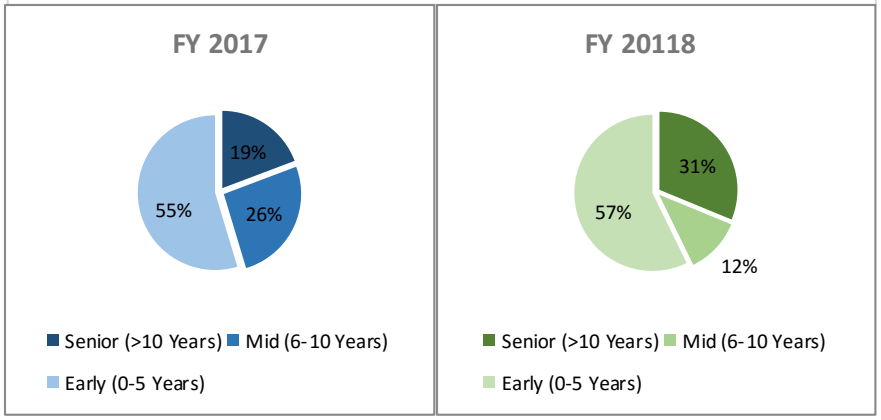


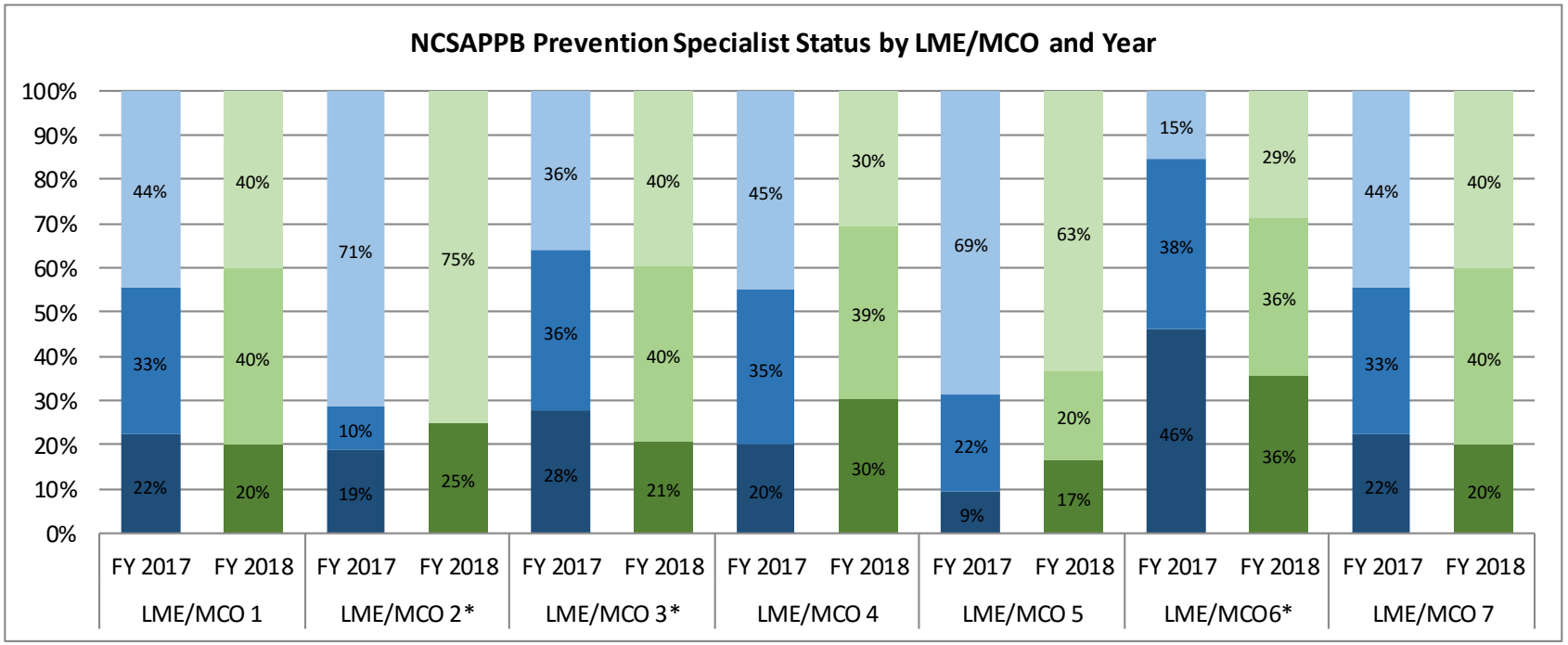
Graph 4b.7: NCSAPPB Prevention Specialist Status by LME/MCO and Year



Across the state, the majority of the SAPBG workforce were early in their career, with 57% of SAPBG staff with five or fewer years of experience in FY 2018. This is another metric for professionalism which may impact capacity to implement SAPBG strategies. This was relatively unchanged from FY 2017, though it varied from a low of 23% of staff early in their career in LME/MCO 6 to a high of 80% in LME/MCO 5 in FY 2018. While the proportion of early career SAPBG staff was stable across years, more than half of the mid-career professionals in FY 2017 moved to senior career professionals in FY 2018. This change was especially pronounced in LME/MCOs 2, 4, and 5.

Graph 4b.8: Career Status by Year





Implementation
Population Foci
Quality
Reach
Cost

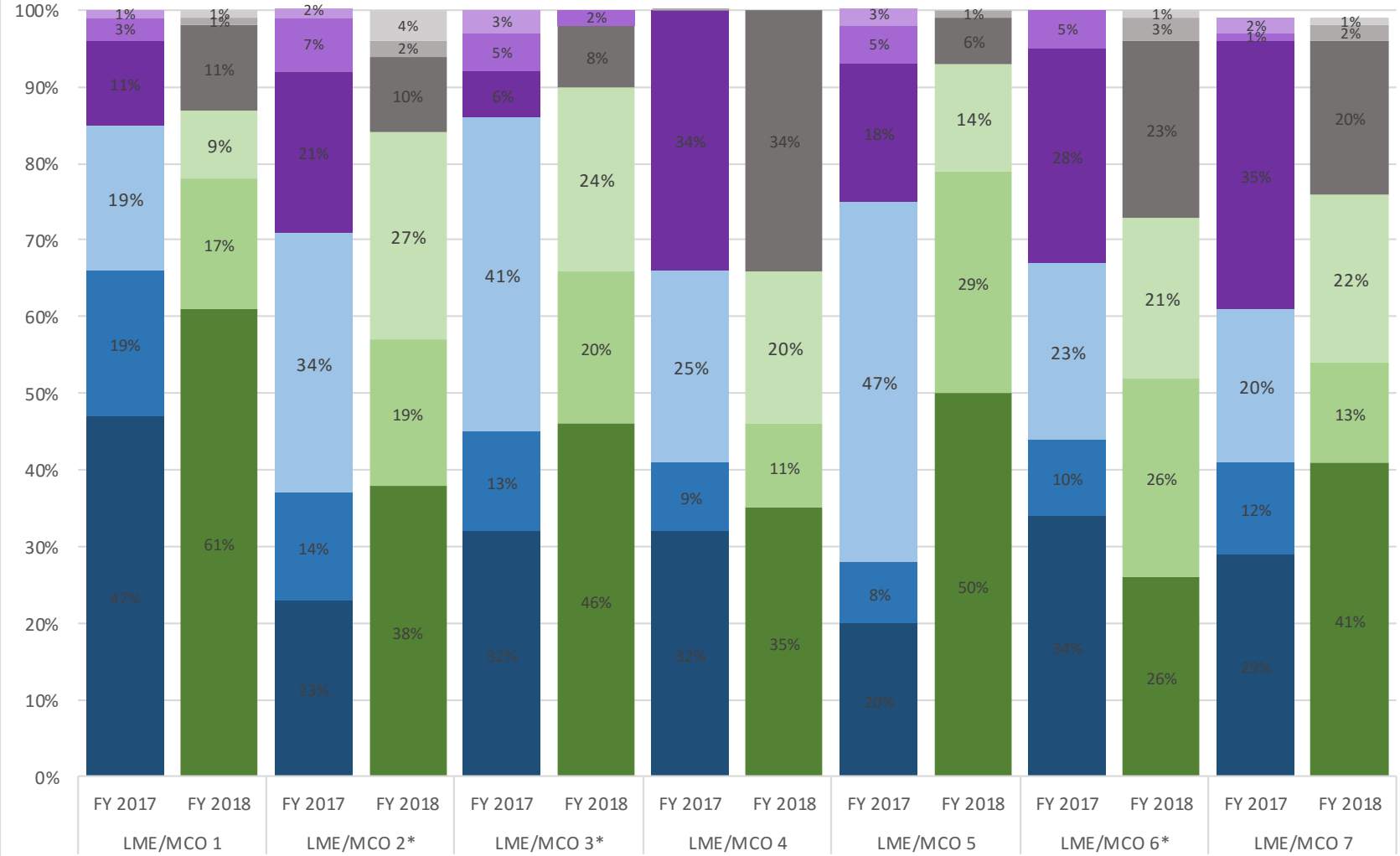
Focus on Community-Based Process and Environmental Strategies

LME/MCOs are meeting the benchmarks earlier than anticipated

In September 2016 DMH/DD/SAS announced benchmarks for SAPBG expenditures, requiring LME/MCOs to transition toward spending at least 51% of their SAPBG funds community-based process and environmental strategies and no more than 30% on prevention education, collectively representing the CORE prevention strategies. In FY 2018, LME/MCOs in the state expended 64% of their SAPBG funds on community based-process and environmental strategies and 20% of their funds on prevention education, meeting the benchmarks. This was a substantial change compared to FY 2017, when the benchmarks were first introduced. While the state transitioned to meeting the benchmarks, there was considerable variation by LME/MCO, both in comparison to other LME/MCOs and over time. In FY 2017 only LME/MCO 1 had met the CORE strategy benchmarks. By FY 2018, all but LME/MCO 4 had met the CORE strategies benchmarks

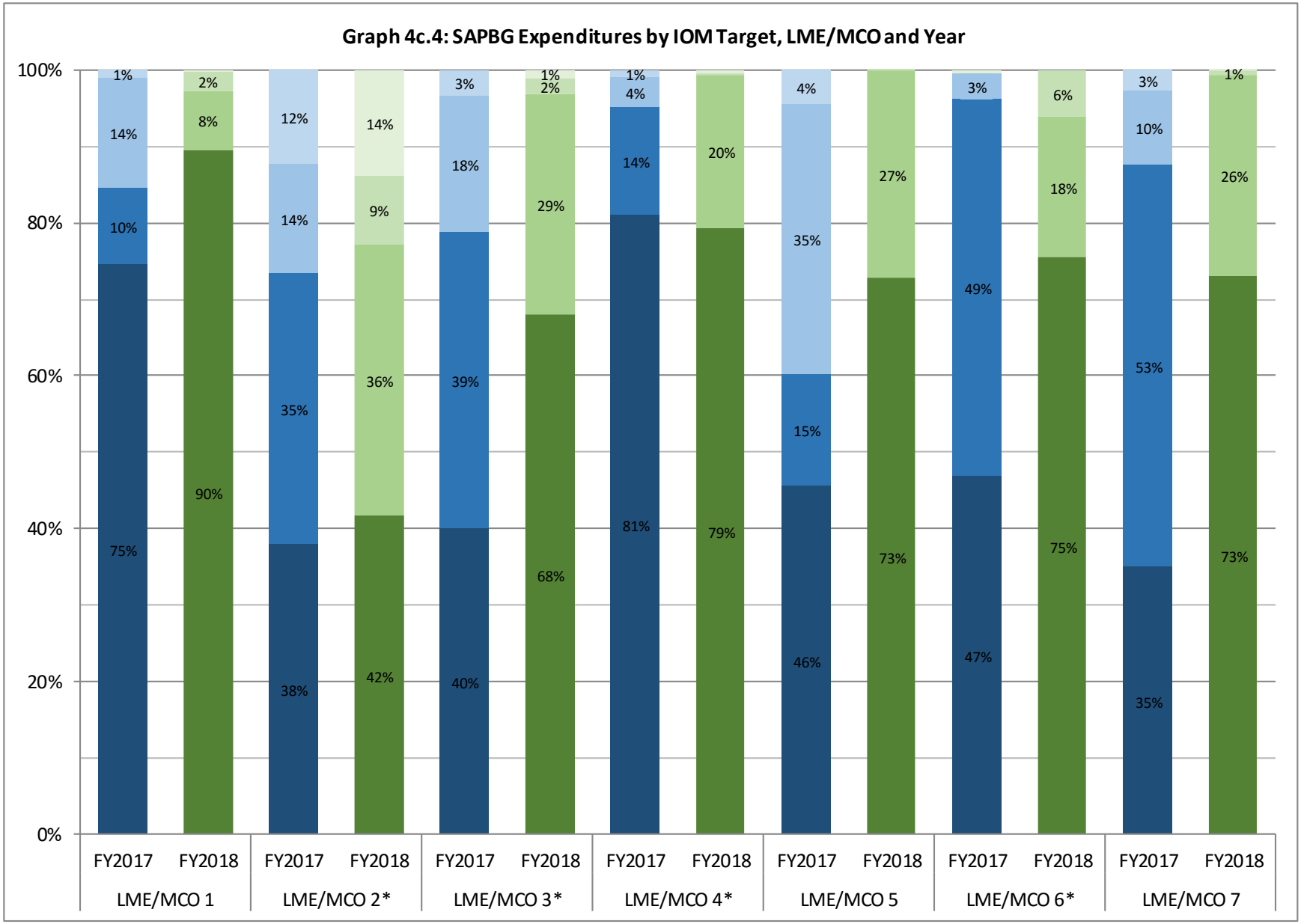
Graph 4c.1: Percent SAPBG Expenditures by CSAP Strategy and Year

Graph 4c.2: SAPBG Expenditures by CSAP Strategy, LME/MCO and Year



Community-based process and environmental strategies are considered universal indirect strategies. As a result, when utilization of community-based processes and environmental strategies increased, so did utilization of universal indirect strategies. Across the state, 72% of SAPBG expenditures were for strategies targeting a universal indirect audience in FY 2018. This represented a substantial increase over FY 2017. Expenditures for universal, selective, and indicated prevention strategies all decreased FY 2017 to 2018, although the decrease was most pronounced for selective strategies. There was significant variation by LME/MCO, both in FY 2017, and in the degree to which each LME/MCO shifted its resources towards universal indirect strategies in FY 2018. LME/MCO 1 had an already high proportion of SAPBG expenditures in universal indirect strategies in FY 2017 and increased this proportion in FY 2018. LME/MCO 3, 5, 6, and 7 all started out dedicating less than 50% of their SAPBG resources to universal indirect prevention strategies in FY 2017, and all increased these expenditures to more than two thirds of their SAPBG funds in FY 2018. LME/MCO 2 and 4 devoted a fairly consistent proportion of their SAPBG resources to universal indirect strategies, with these LME/MCOs spending a lower than average proportion of their SAPBG funds on universal indirect strategies and a higher than average proportion of their SAPBG funds on universal indirect strategies in FY 2017 and 2018

Graph 4c.3: SAPBG Expenditures by IOM Target and Year



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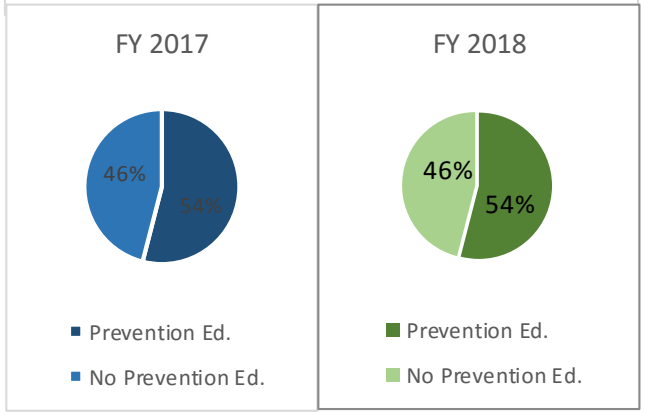
Implementation
Population Foci
Quality
Reach
Cost

Prevention Education Strategies

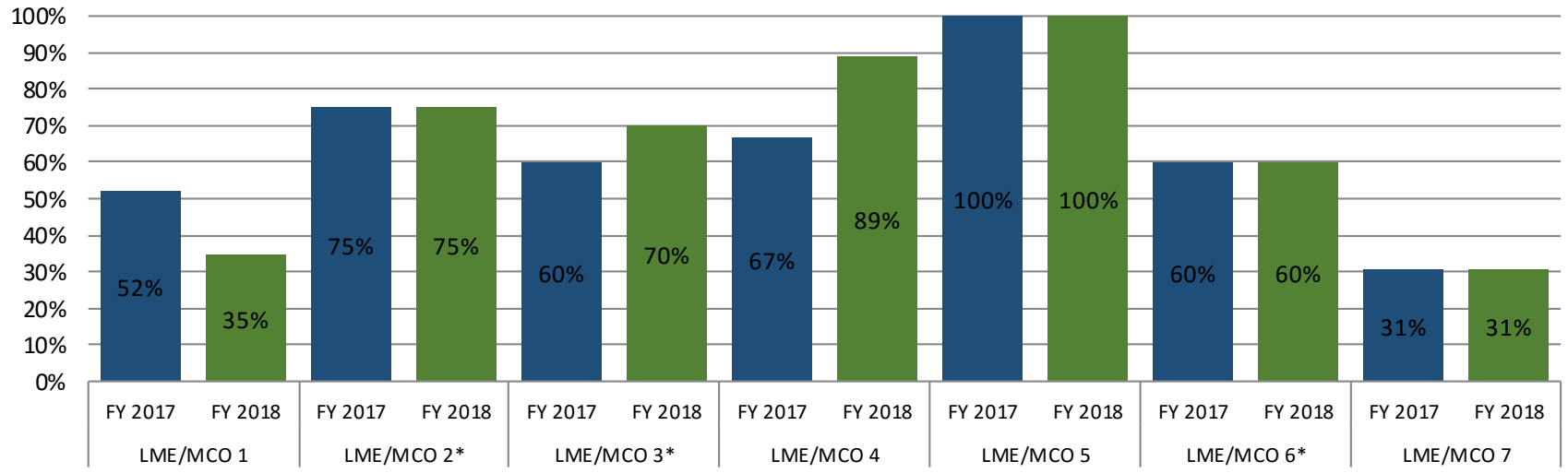
Prevention providers have transitioned to greater utilization of universal youth prevention education

Across the state, 54% of counties received prevention education in FY 2018. There is no gold standard for what proportion of counties should receive prevention education, which is resource intensive to implement. That said, locations should be selected based upon both need and capacity, working to build capacity in high need counties with limited capacity. At the state level, this remained stable from FY 2017, though there was variation within and across LME/MCOs from year to year, from a low of 31% of counties in LME/MCO 7 to a high of 100% of counties in LME/MCO 5. It is not clear from available data if counties with prevention education have greater need, capacity, or both.

Graph 4c.5: Percent of Counties Receiving Prevention Education by Year

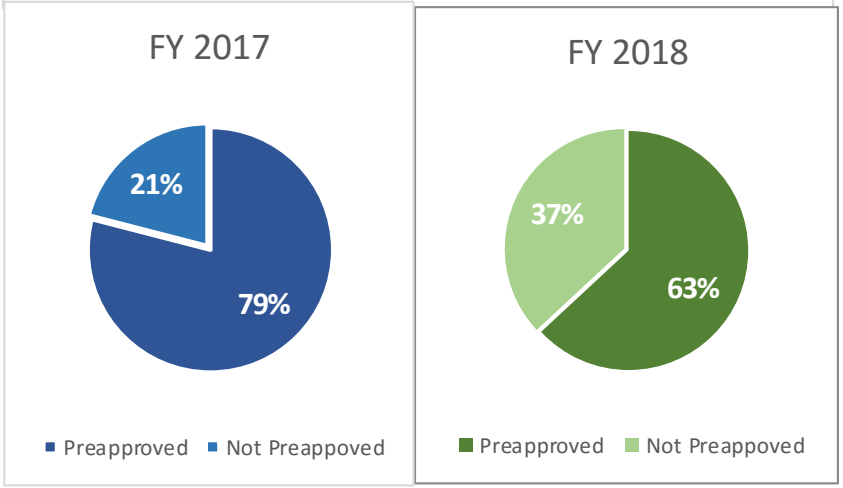


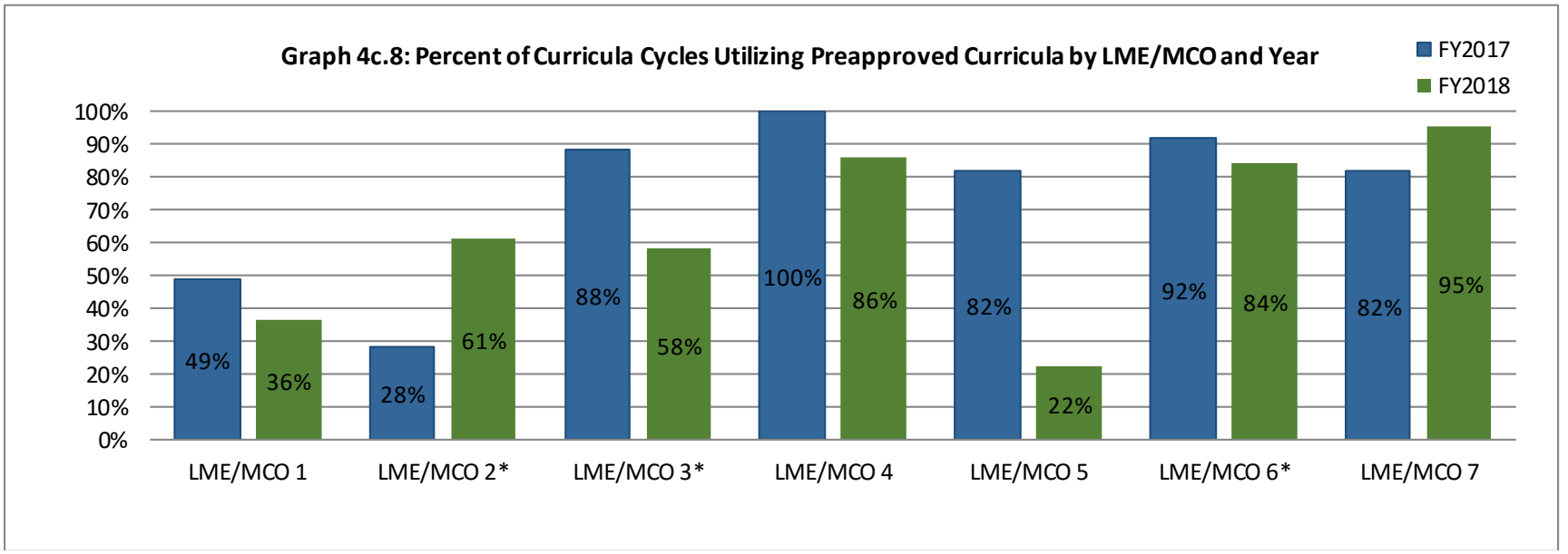
Graph 4c.6: Percent of Counties Receiving Prevention Education by LME/MCO and Year



DMH/DD/SAS has published guidelines specifying preapproved youth and parent/family prevention education programs. Preapproved curricula have been selected to ensure they have outcomes on substance use and/or its precursors and are supported by the state with curricular training and materials. Overall, 63% of curricula cycles were implemented utilizing preapproved curricula in FY 2018. This reflected a decrease from FY 2017. Our review of Block Grant Compliance Reports suggests that this decrease in utilization of preapproved curricula was predominately driven by newly utilizing of Second Steps and Life Skills Training curricula, which have proven to be effective at reducing precursors to substance abuse, but have not been tested for their effectiveness on substance abuse prevention outcomes. There was considerable variation in the percentage of curricula cycles utilizing preapproved curricula across and within LME/MCOs and from year to year, with the utilization of preapproved curricula escalating in LME/MCOs 2 and 7, and declining in LME/MCOs 1, 3, 4, 5, and 6.

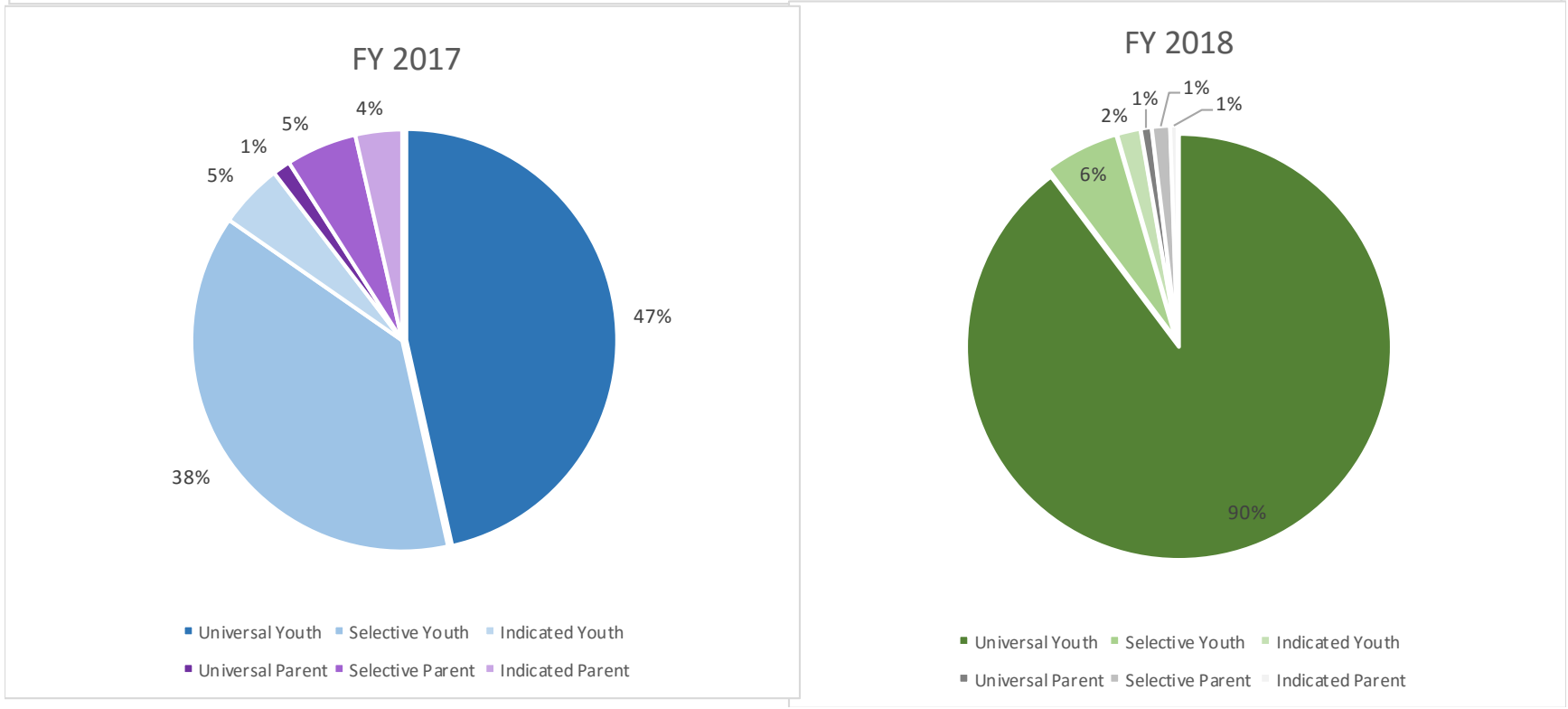
Graph 4c.7: Percent of Curricula Cycles Implemented with Pre-Approved Curricula by Year

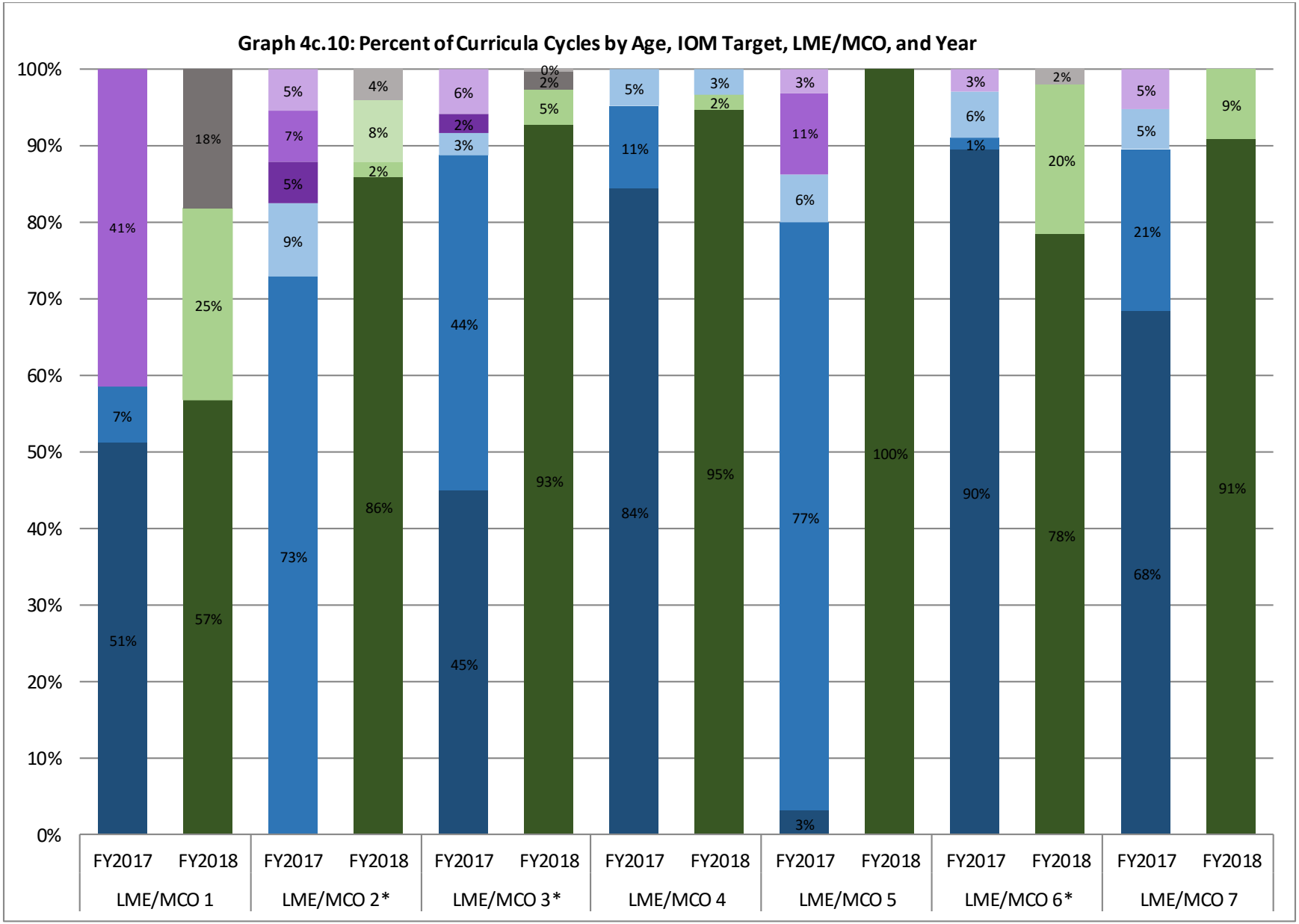




Prevention providers across the state moved from 47% of their curricula cycles utilizing universal youth prevention education curricula in FY 2017 to 90% in FY 2018, in line with The benchmarks. To achieve this increase in universal youth prevention education curricula, a reduced proportion of prevention education cycles were seen for selective and indicated youth, as well as selective and indicated parents, although the reductions in proportion of cycles was most pronounced for selective youth prevention education. This transition to a greater proportion of curricula cycles targeting universal youth prevention education happened in all but LME/MCO 6, which was already implementing a high proportion of curricula cycles targeting universal youth prevention education. The transition was most pronounced in LME/MCOs 2 and 5, which were implementing fewer than 5% of their prevention education curricula cycles targeting universal youth, moving to implementing more than 80% of their prevention education cycles with universal populations of youth. Among the LME/MCOs implementing parent prevention education in FY 2019 (1, 3, 5, 6, and 7), all reduced the proportion of curricula cycles targeting parents.

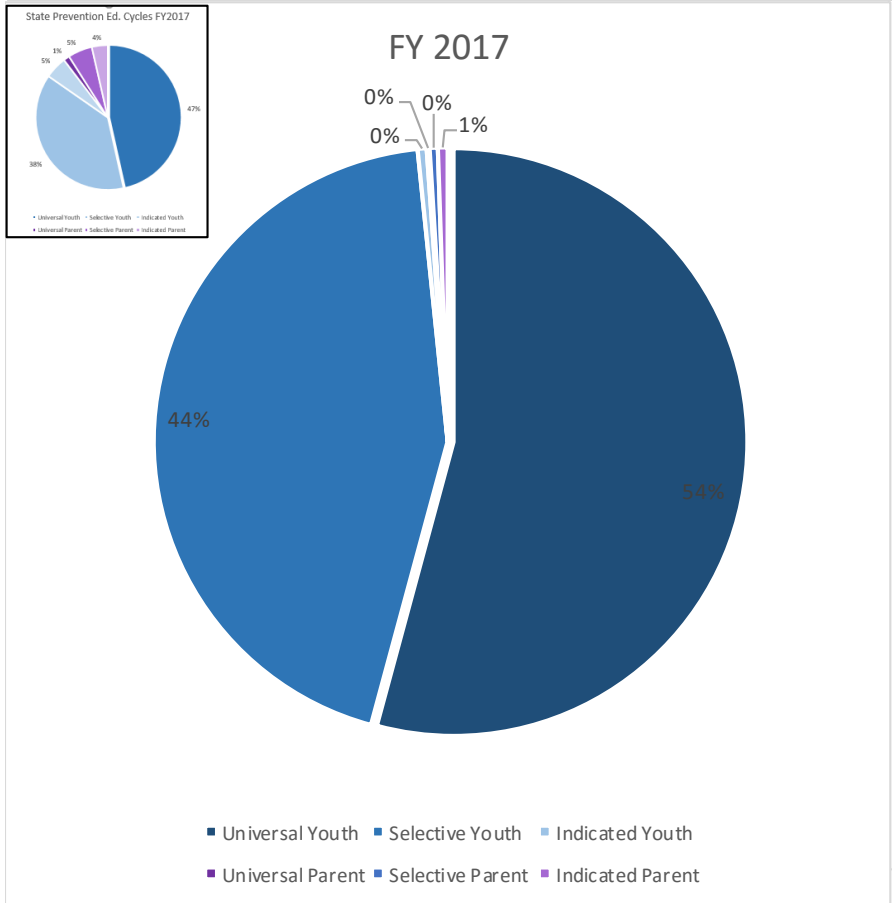
Graph 4c.9: Percent of Curricula Cycles Implemented by Age Group, IOM Target by Year

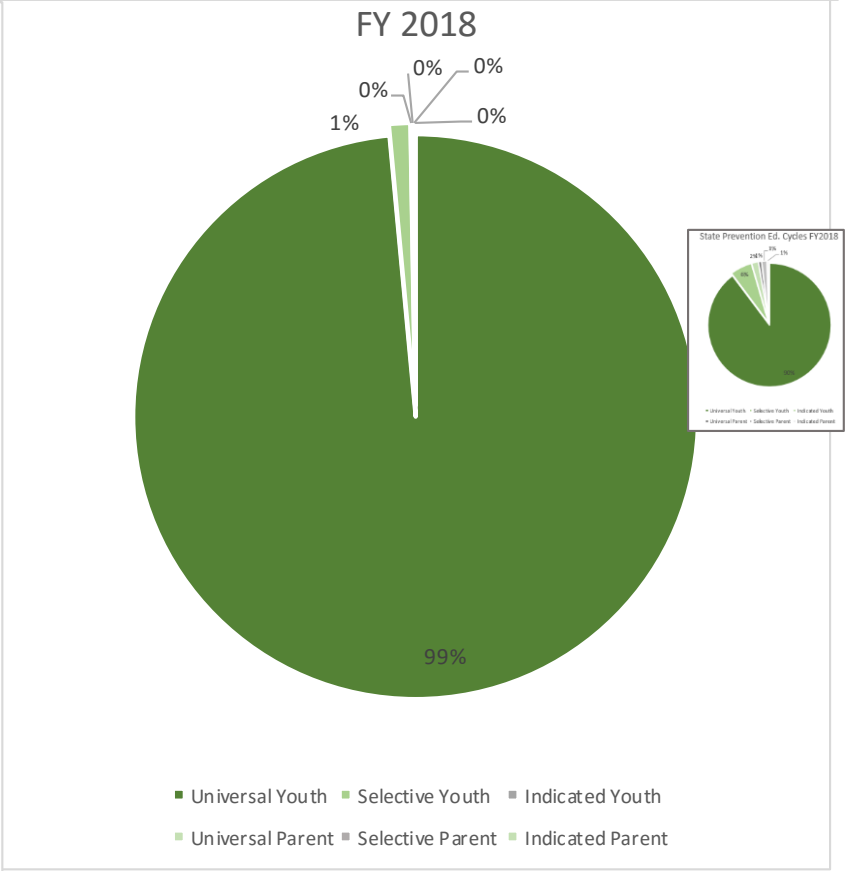



Graph 4c.10: Percent of Curricula Cycles by Age, IOM Target, LME/MCO, and Year
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
41%
7%
51%
18%
25%
57%
5%
7%
5%
9%
73%
4%
8%
2%
86%
6%
2%
3%
44%
45%
0%
2%
5%
93%
5%
11%
84%
3%
2%
95%
3%
11%
6%
3%
77%
100%
3%
6%
1%
90%
2%
20%
78%
5%
5%
21%
68%
9%
91%
FY2017
FY2018
LME/MCO 1
LME/MCO 2*
LME/MCO 3*
LME/MCO 4
LME/MCO 5
LME/MCO 6*
LME/MCO 7

When prevention providers implement universal youth prevention education curricula, they reach a greater proportion of consumers with fewer cycles, which was mandated by SAMHSA in the 2014 site visit. This is especially true when it comes to youth prevention education curricula for indicated youth and all forms of parent prevention education curricula, which are resource intensive. This was true for all LME/MCOs.

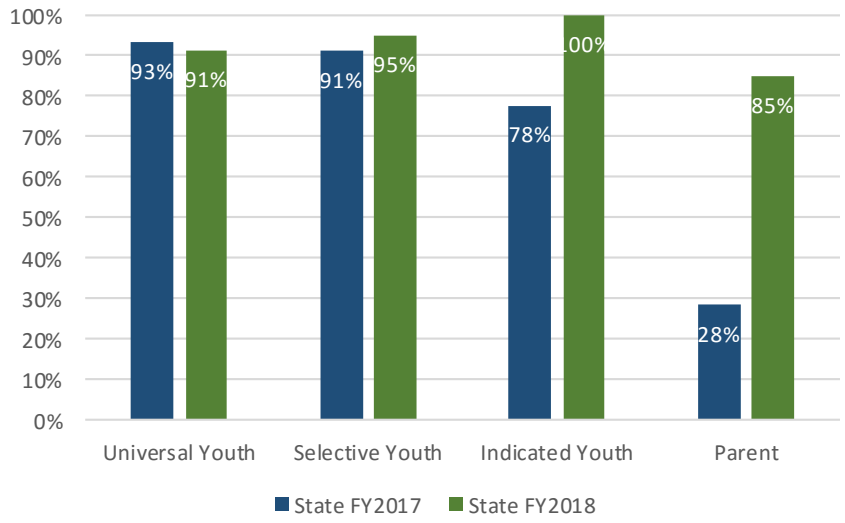
Graph 4c.11: Percent of Consumers Enrolled by Age Group, IOM Target by Year



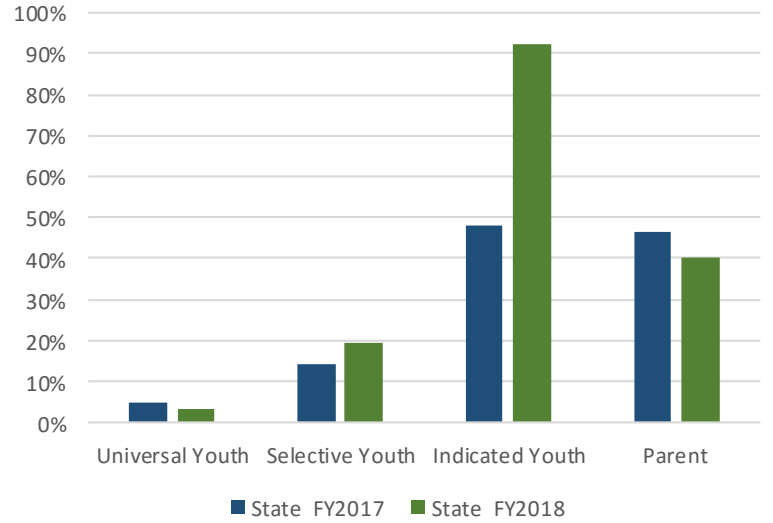


Across the state, the vast majority of prevention education cycles for universal and selective groups of youth ended with at least 80% of consumers completing the curricula in both FY 2017 and 2018. It was very rare for these cycles to end with fewer than 7 participants. These are both important metrics, as the state requires that 80% of participants complete at least 80% of curricula lessons to ensure sufficient dosage to produce behavioral change. In addition, most curriculum developers recommend against groups with fewer than 7 participants, as it changes the dynamics of the group in a manner that is not conducive to the goals of the curriculum. There was a more variable curriculum completion rate for prevention education cycles with indicated youth, with less than 80% of cycles with at least 80% of participants completing the curricula in FY 2017, but 100% of curricula cycles were completed with at least 80% of participants completing the curricula cycle in FY 2018. It is noteworthy that in FY 2018, when 100% of youth prevention education cycles for indicated youth were completed with at least 80% of the enrollees, more than 90% of prevention education cycles for indicated youth had fewer than 7 participants. Completion ratios for parent prevention education cycles were considerably higher in FY 2018 compared to FY 2017. Two things happened that may have contributed to the increase in completion rations for parent prevention education. First, new parent education guidelines were issued requiring a minimum enrollment 10 participants, as well as a participant retention, with the intention of decreasing both non-compliance and very small group size. Second, fewer cycles of prevention education were implemented with parents in FY 2018, with providers that had had difficulty meeting new parent education guidelines potentially opting out of parent-focused prevention education.

Graph 4c.12: Percent of Curricula Cycles Ending With At Least 80% of Consumers Completing the Curricula by Age, IOM Target, and Year



Graph 4c.13: Percent of Curricula Cycles Ending With Fewer Than 7 participants by Age, IOM Target, LME/MCO, and Year



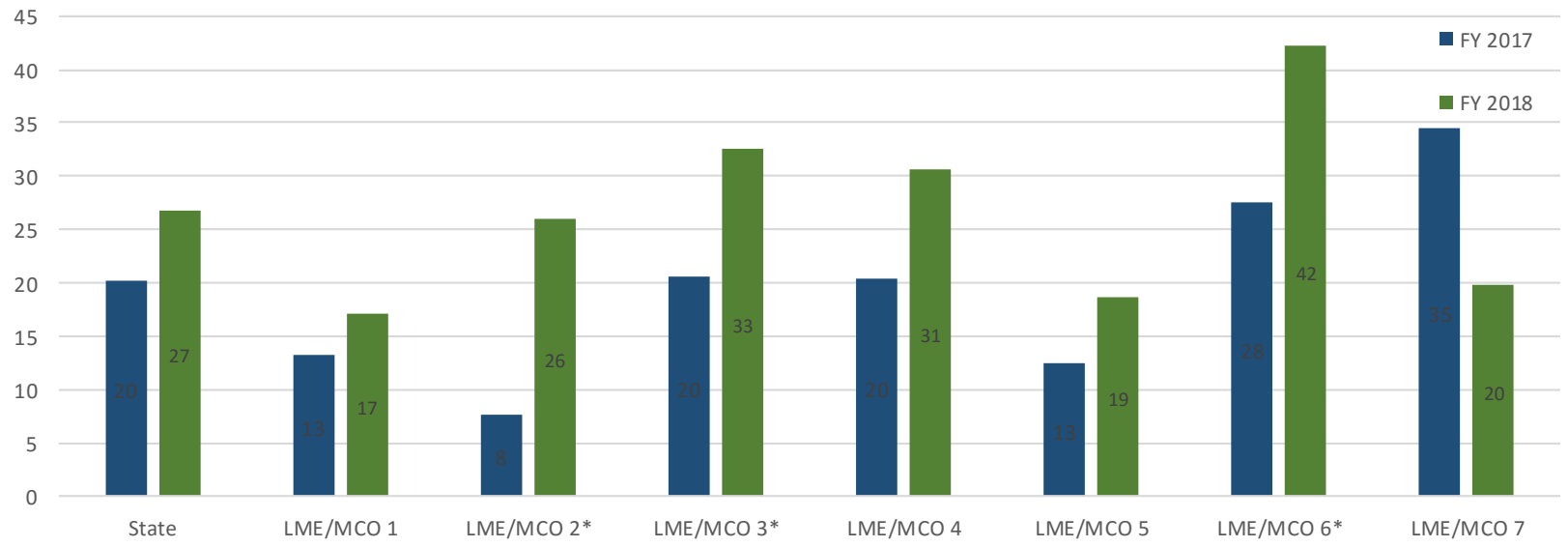
Implementation
Population Foci
Quality
Reach
Cost

Synar Related Activities

LME/MCOs increased time and coverage for Synar activities most directly related to goals for compliance

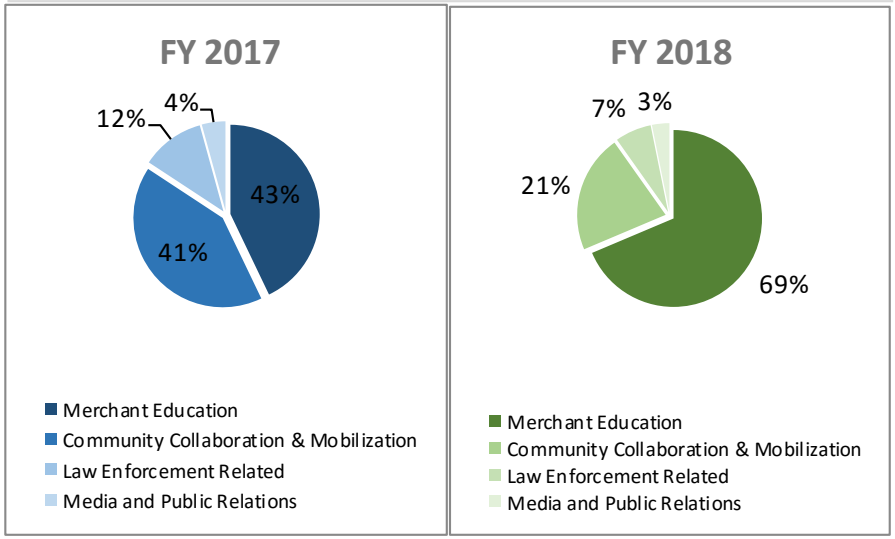
LME/MCOs averaged 27 Synar merchant education hours per 100 tobacco retailers in FY 2018. This is up from FY 2017, indicating that providers are focusing on more targeted Synar activities than they had been in FY 2017. There is variation across and within LME/MCOs, with all but LME/MCO 7 increasing merchant education time per retailer.

Graph 4c.15: Synar Merchant Education Hours Per 100 Tobacco Retailers by LME/MCO and Year

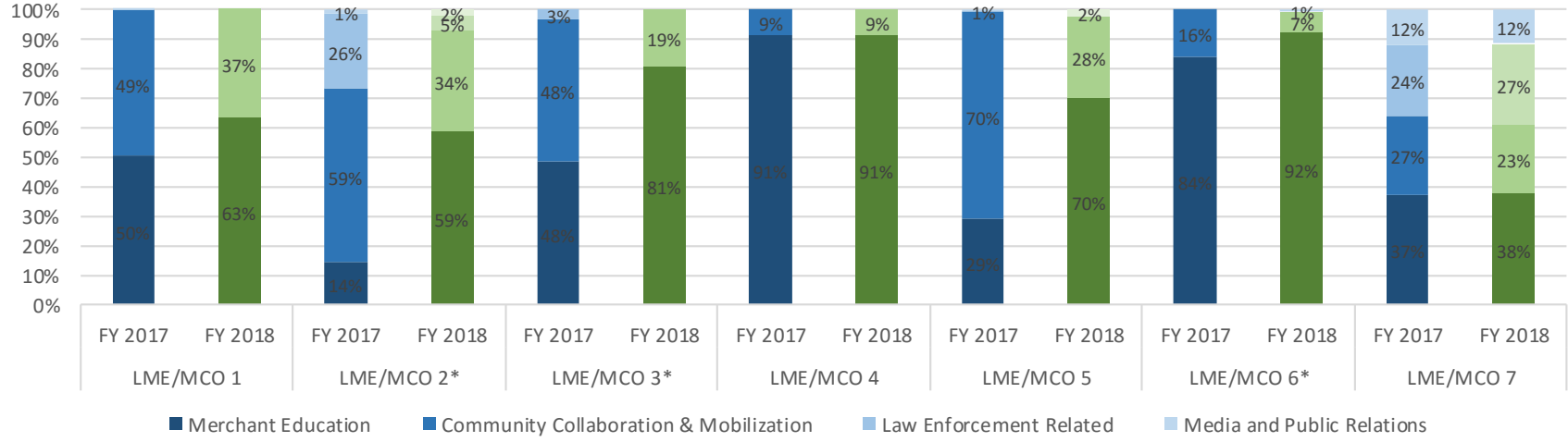


Across the state, prevention providers spent a higher proportion of their Synar time on merchant education in FY 2018 than in FY 2017. This was consistent with state recommendations, which had announced that it was eliminating some community-collaboration and mobilizing activities in FY2019 and that it was narrowing the definitions of others to ensure better alignment to goals related to Synar compliance. There was substantial variation across LME/MCOs in how they spend their Synar hours, and in the degree of change seen from FY 2017 to 2018, with merchant education ranging from 14% of their Synar time in LME/MCO 1 to 91% in LME/MCO 4. All but LME/MCOs 4 and 7 increased their Synar time on merchant education. Conversely, all LME/MCOs decreased the percentage of their Synar time spent on community collaboration & mobilization.

Graph 4c.15: Synar Hours by Type of Activity and Year

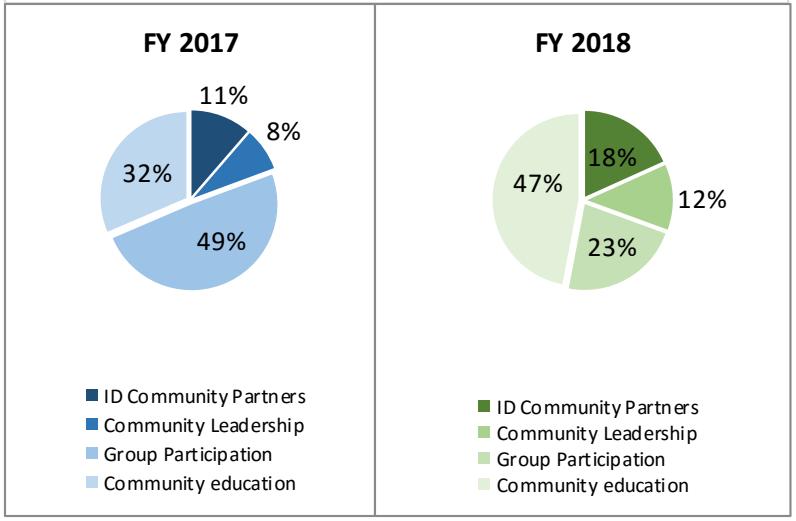


Graph 4c.17: Percent of Synar Hours by Type of Synar Activity LME/MCO and Year

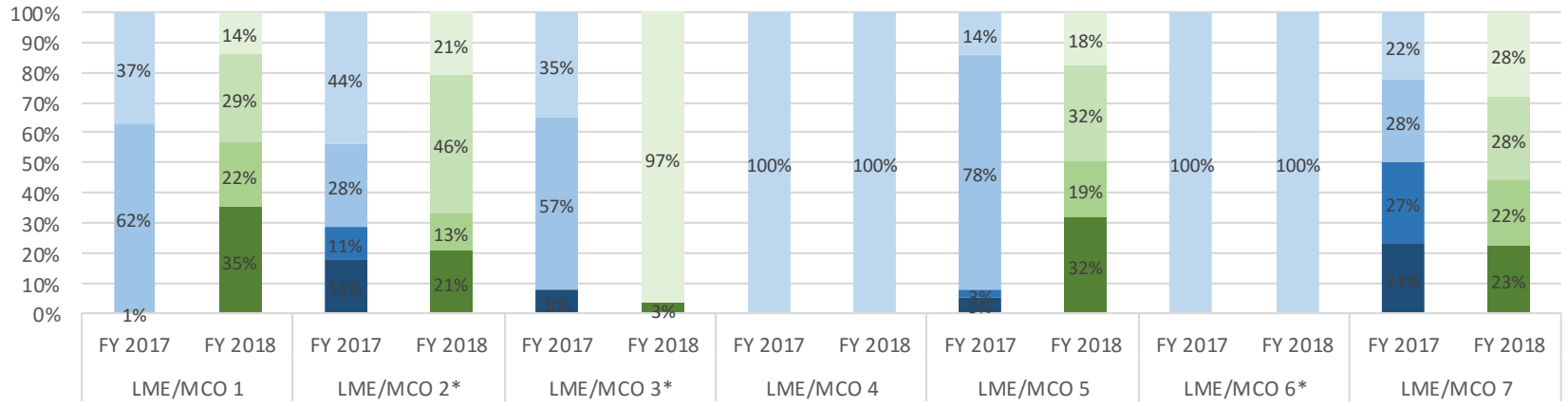


Across the state, prevention providers not only reduced time spent on community collaboration and mobilization for Synar, but also shifted how that time was used per DMH/DD/SAS direction, as there was significant concern that those hours may not have been used specifically to reduce the tobacco age of sale retail violation rate. For example, many providers reported group participation, which is defined as coalition participation, but there are very few coalitions in the state focused exclusively on tobacco, and none are known to exclusively focus on retailer compliance with the tobacco age of sale law. In FY 2018, 23% of community collaboration and mobilization Synar time was spent on group participation, down from FY 2017. How Synar time was spent within community collaboration and mobilization varied considerably by LME/MCO, but most LME/MCOs showed reductions in time spent on group participation and increases on time spent on community education.

Graph 4c.17: Synar Community Collaboration and Mobilization by Hours by Type of Activity and Year

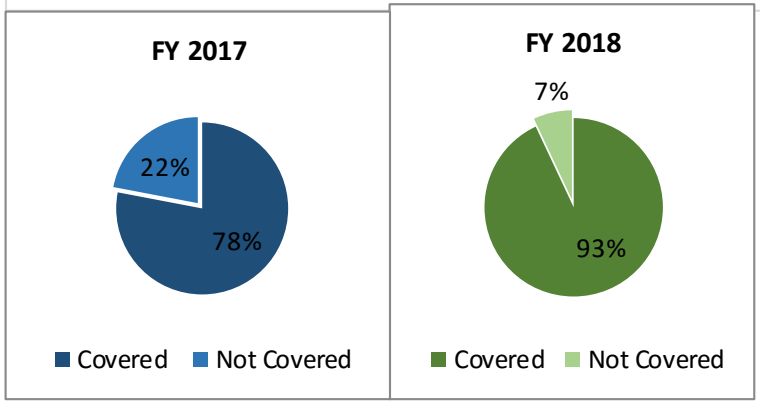


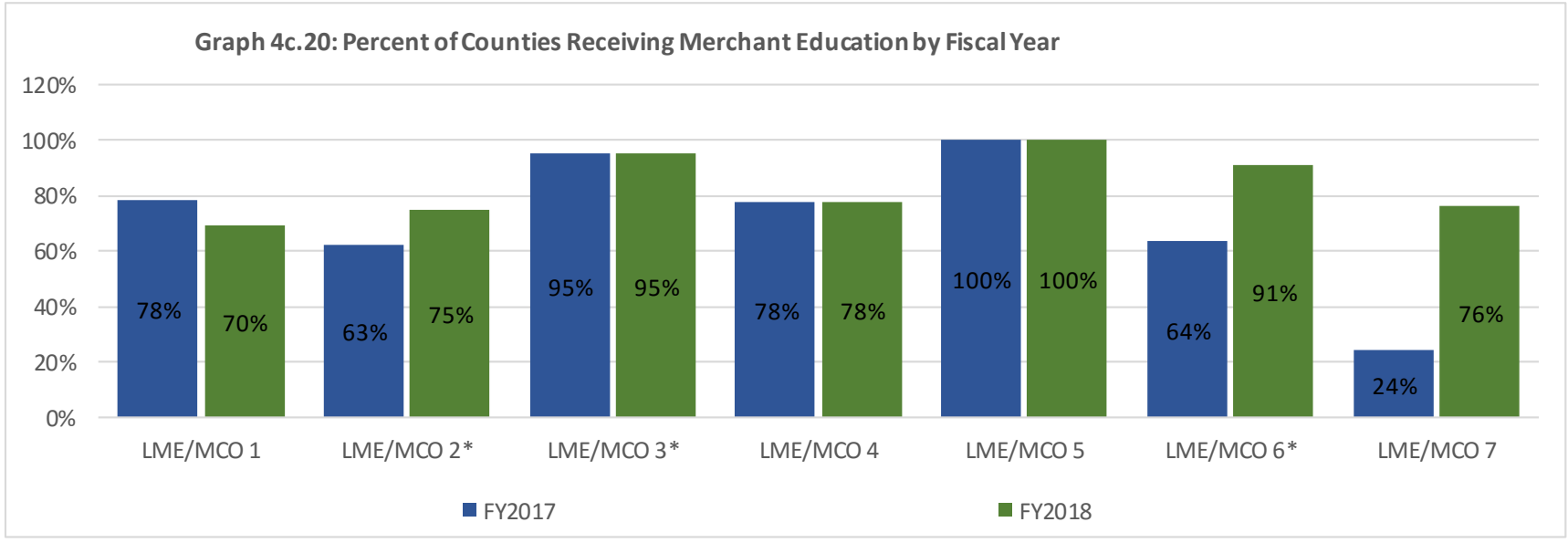
Graph 4c.19: Percent of Synar Community Collaboration and Mobilization Hours by Type of Activity, LME/MCO and Year



Across the state, prevention providers increased Synar merchant education coverage to 93% of their counties covered in FY 2018. This is critical in light of the RVR, which is hovering close to the 20% threshold at which the state may lost up to 40% of the block grant (up to $17 million). This varied across LME/MCOs, from a low of 24% of counties in LME/MCO 7 in FY 2017 to a high of 100% of counties in LME/MCO 5 in FY 2017 and 2018. The increase in the percentage of counties statewide receiving Synar merchant education was due to increases in county coverage in LME/MCOs 2, 6, and 7.

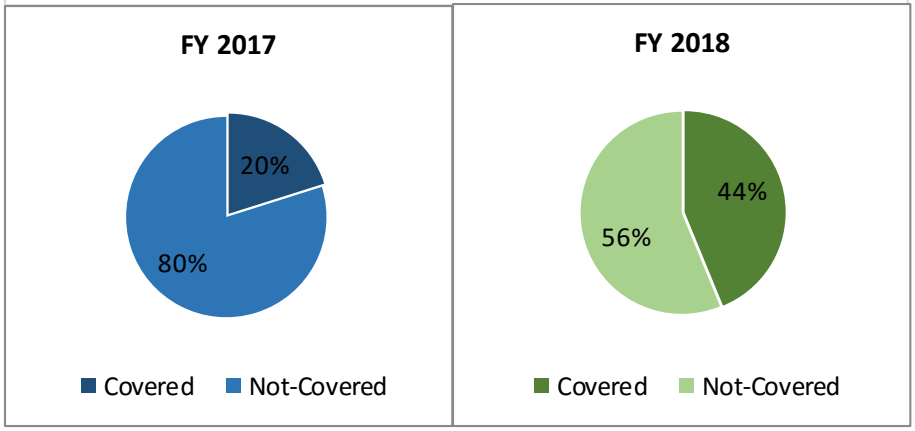
Graph 4c.19: Percent of Counties Receiving Synar Merchant Education by Fiscal Year



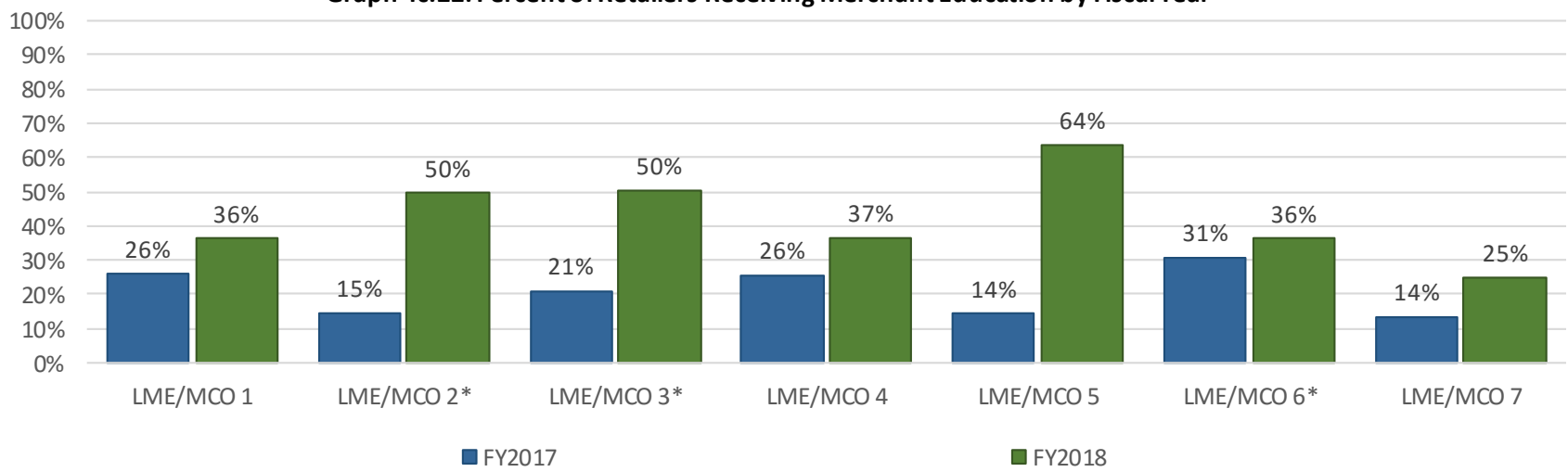


While most counties were reached via Synar merchant education, the same is not true of the proportion of retailers receiving merchant education, although providers more doubled the proportion of merchants receiving Synar merchant education in FY 2018 compared to FY 2017. Again, this is critical in light of the RVR. In FY 2018, the proportion of tobacco retailers receiving merchant education grew to 44%, although there was considerable variation among LME/MCOs, both in the proportion of tobacco retailers receiving Synar merchant education and in the proportion of merchants receiving Synar merchant education.

Graph 4c.21: Percent of Retailers Receiving Synar Merchant Education by Year



Graph 4c.22: Percent of Retailers Receiving Merchant Education by Fiscal Year



Intermediate Outcomes

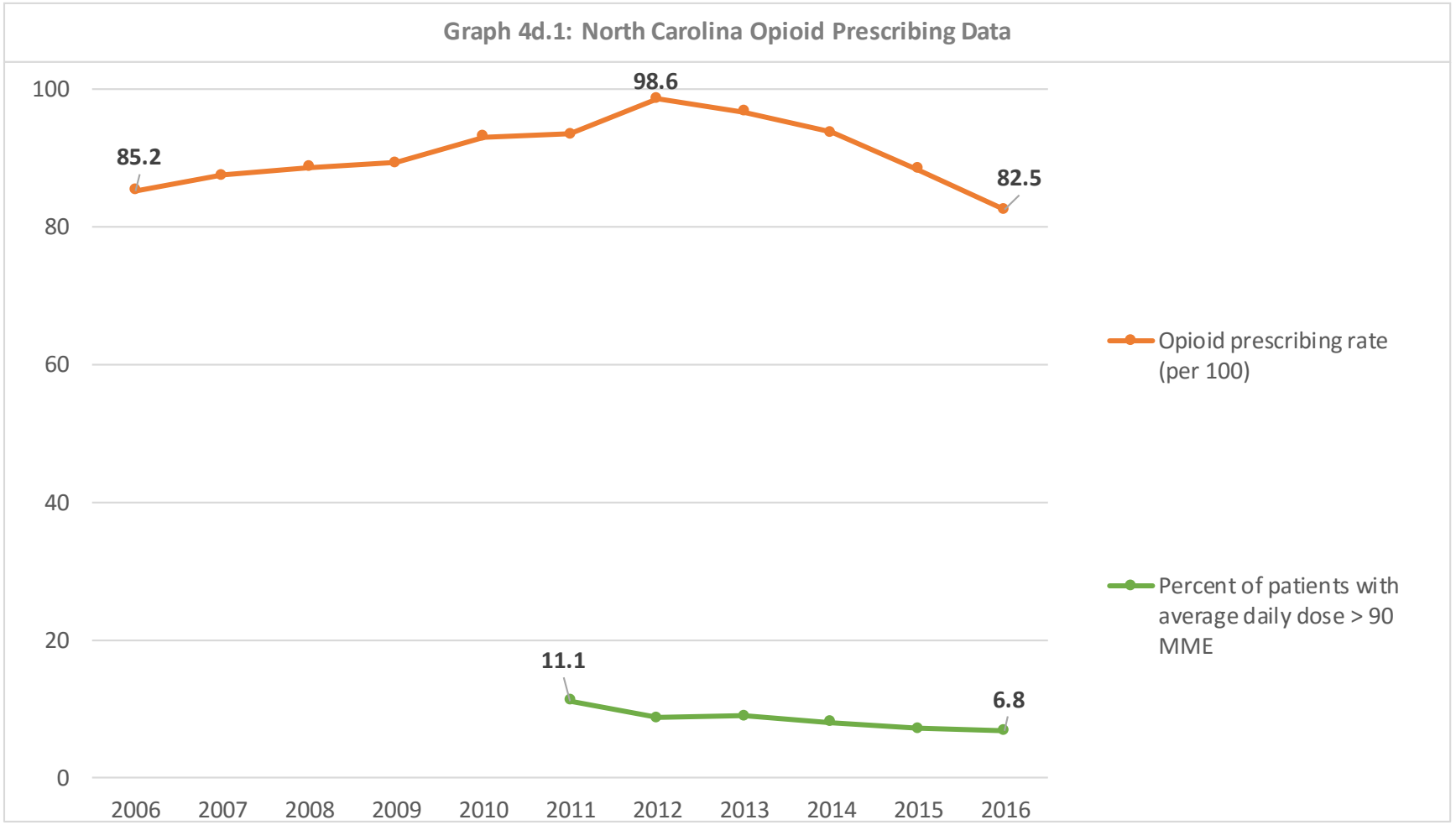
The fourth major component of the evaluation logic model is intermediate outcomes. As mentioned in the *Methods* section of this report, intermediate outcomes may include both individual-level changes (such as changes in knowledge and attitudes related to substance use and abuse) as well as changes in community environments (such as changes in community norms, institutional policies, and public policies).

For the purposes of this report, we present data on North Carolina-specific trends in prescribing of opioid analgesics and on tobacco retailer compliance with the state minimum age-of-sale law (age 18) and FDA advertising and labelling regulations. Each of these intermediate outcomes may be influenced by the implementation of prevention strategies by prevention providers. For example, prescriber education is a strategy that is intended to reduce over-prescribing or other inappropriate prescribing of opioid analgesics, and tobacco retailer education is a strategy that is intended to increase compliance with the tobacco minimum age-of-sale law. While neither of these outcomes is an end in itself, they are seen as intermediate outcomes on the path to reduced opioid overdoses and reduced prevalence of youth tobacco use.

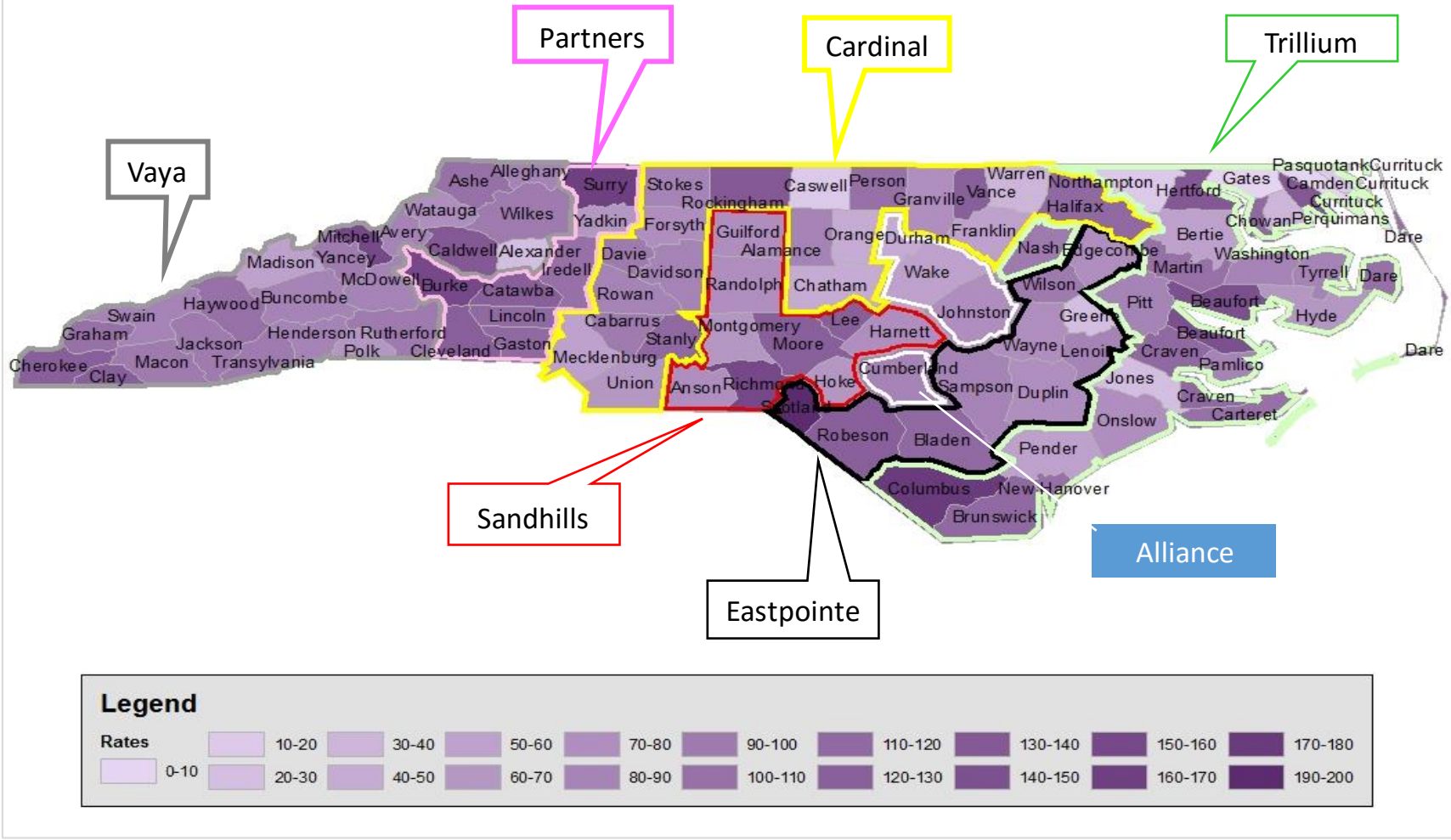
As discussed in *Evaluation Goals* in the *Methods Section* of this report, this baseline report focuses primarily on Evaluation Goal No. 1 (assessing infrastructure), No. 2 (assessing capacity), and, to a limited extent, No. 6 (recommendations). Future reports will be able to exploit follow-up data, which will enable assessment of intermediate outcomes (Evaluation Goal No. 3 (intermediate outcomes), No. 4 (long-term outcomes), and No. 5 (characteristics of infrastructure and implementation associated with positive changes in intermediate and long-term outcomes).

We report on intermediate and long-term outcomes here in order to (1) describe the level of substance abuse and related problems in North Carolina, and (2) illustrate the data that we will be able to use in subsequent reports to examine intermediate and long-term outcomes.

Opioid Prescribing Rate – Roughly following national trends (Guy et al., 2017), the state-level opioid prescribing rate in NC increased from 85.2 per 100 persons in 2006 to 98.6 per 100 persons in 2012, and then steadily decreased to 82.5 per 100 persons in 2016. The percentage of individuals with high doses of opioid analgesics (average daily dose >90 morphine milligram equivalents [MME]) decreased from 11.1% in 2011 to 6.8% in 2016 (see Graph 4d.1). The opioid prescribing rate was generally highest in the western and central-south counties compared to counties in in other parts of (see Graph 4d.2)


Graph 4d.1: North Carolina Opioid Prescribing Data
100
80
60
40
20
0
98.6
85.2
82.5
11.1
6.8
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
Opioid prescribing rate (per 100)
Percent of patients with average daily dose > 90 MME

Graph 4d.2: North Carolina Opioid Prescribing Rate by County and LME (2016)



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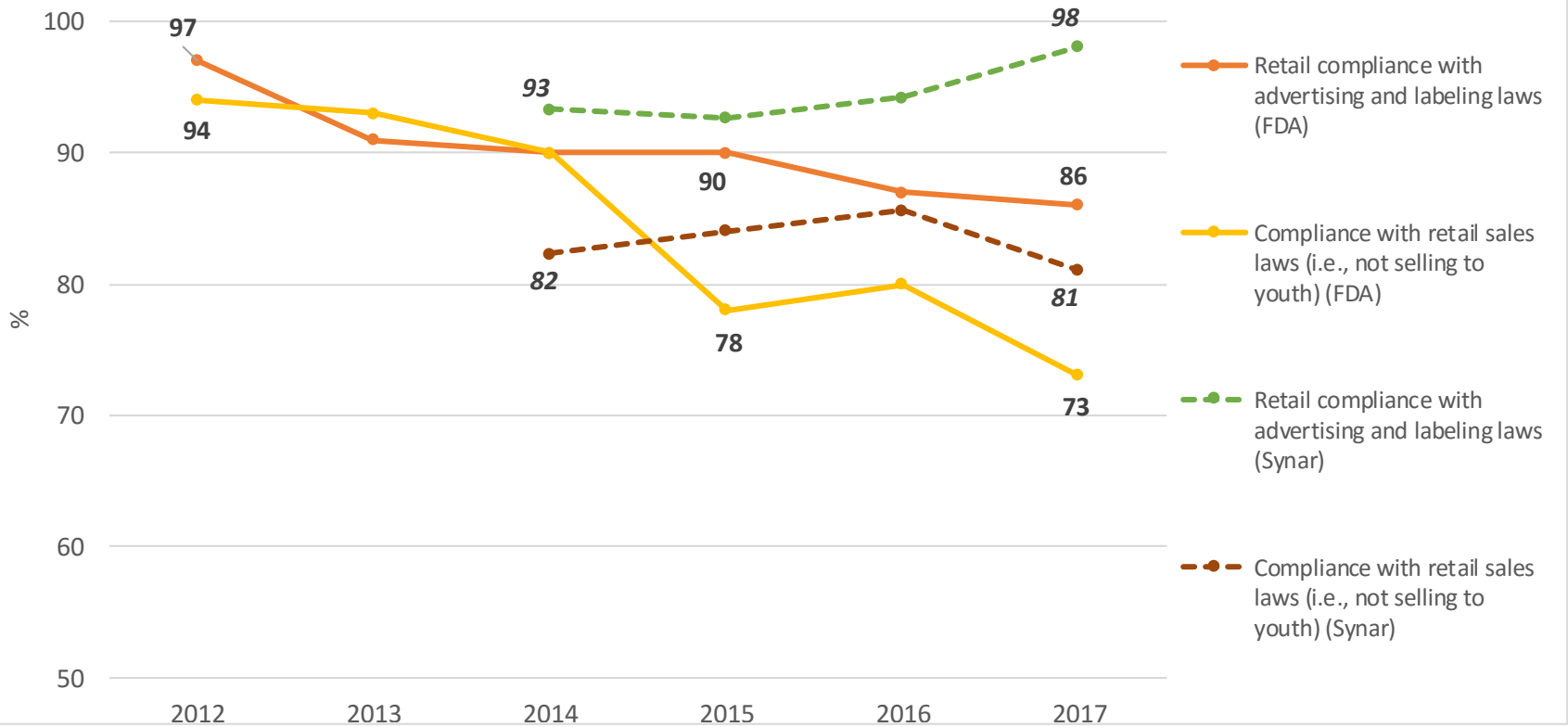
Tobacco – Graph 4d.3 shows trends in the outcomes of Food and Drug Administration (FDA) and Synar compliance checks and inspections of tobacco retailer compliance with North Carolina's minimum age of sale law (18) and advertising and labeling regulations. FDA age of sale compliance checks showed dramatic decreases in rates of compliance, from 94% in 2012 to 73% in 2017. On the other hand, Synar age of sale compliance checks showed moderate fluctuation in compliance rates, from 82% in 2014 to 81% in 2017. Synar inspections showed high rates of compliance with advertising and labeling requirements (93% in 2014, increasing to 98% in 2017), and FDA inspections showed high rates of compliance with these laws, but reductions over time (from 97% in 2012 to 86% in 2017).

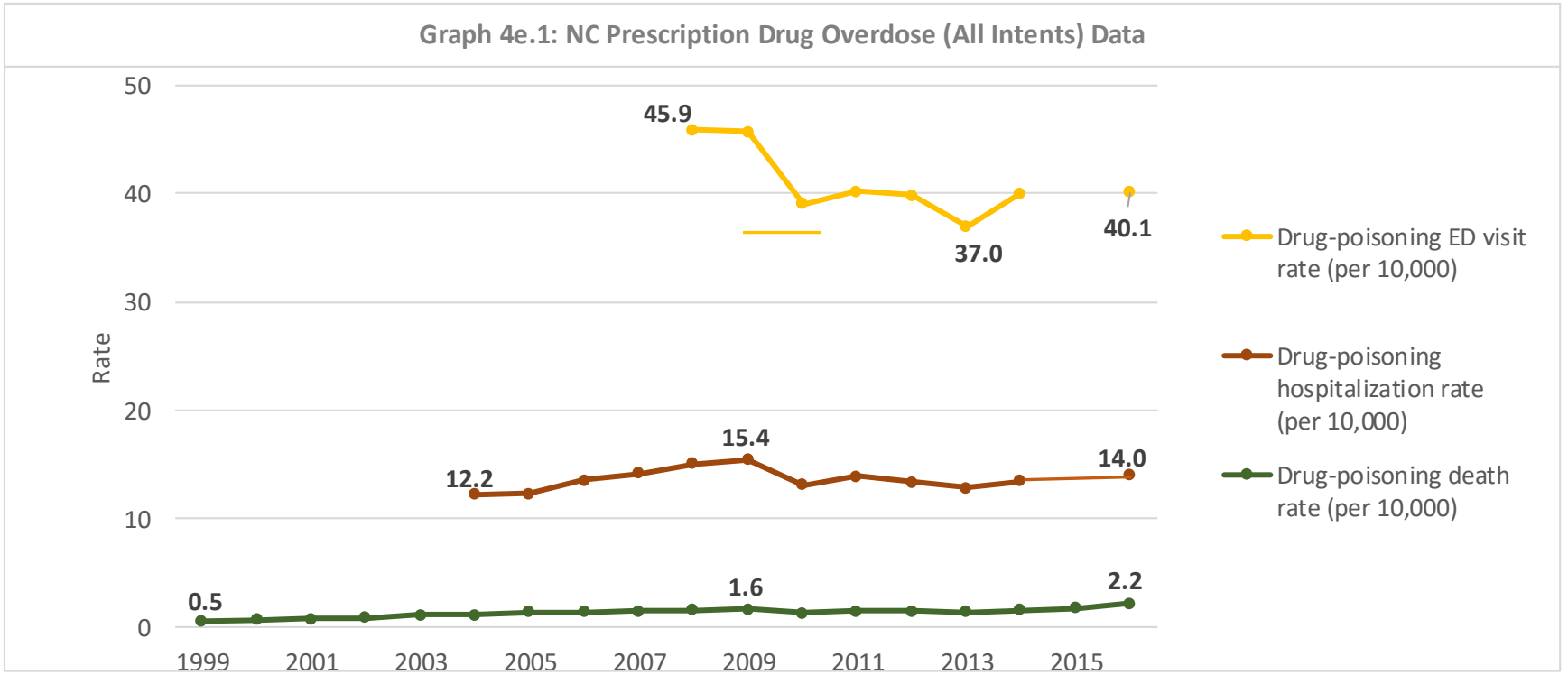
Graph 4d.3: Results of FDA and Synar Compliance Checks and Inspections of Tobacco Product Retailers in North Carolina



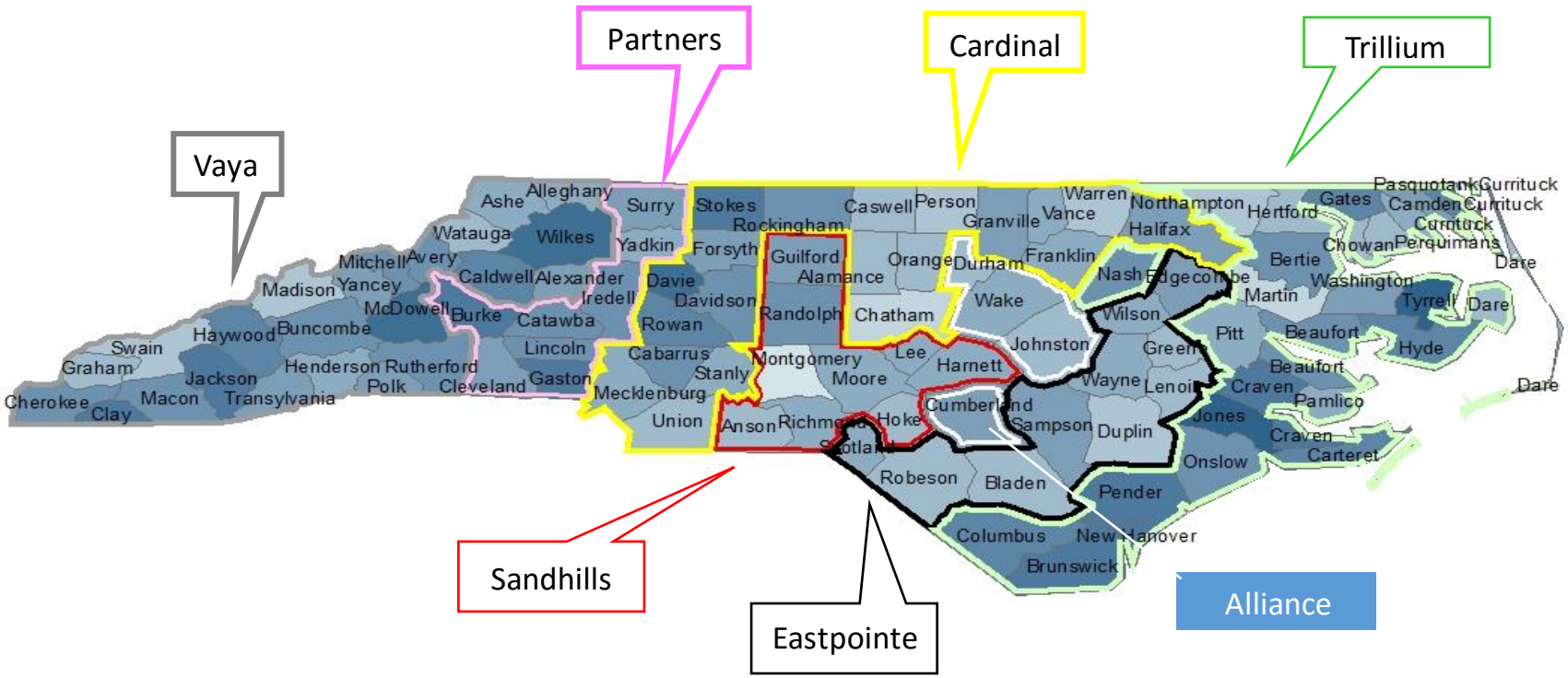
Long-Term Outcomes

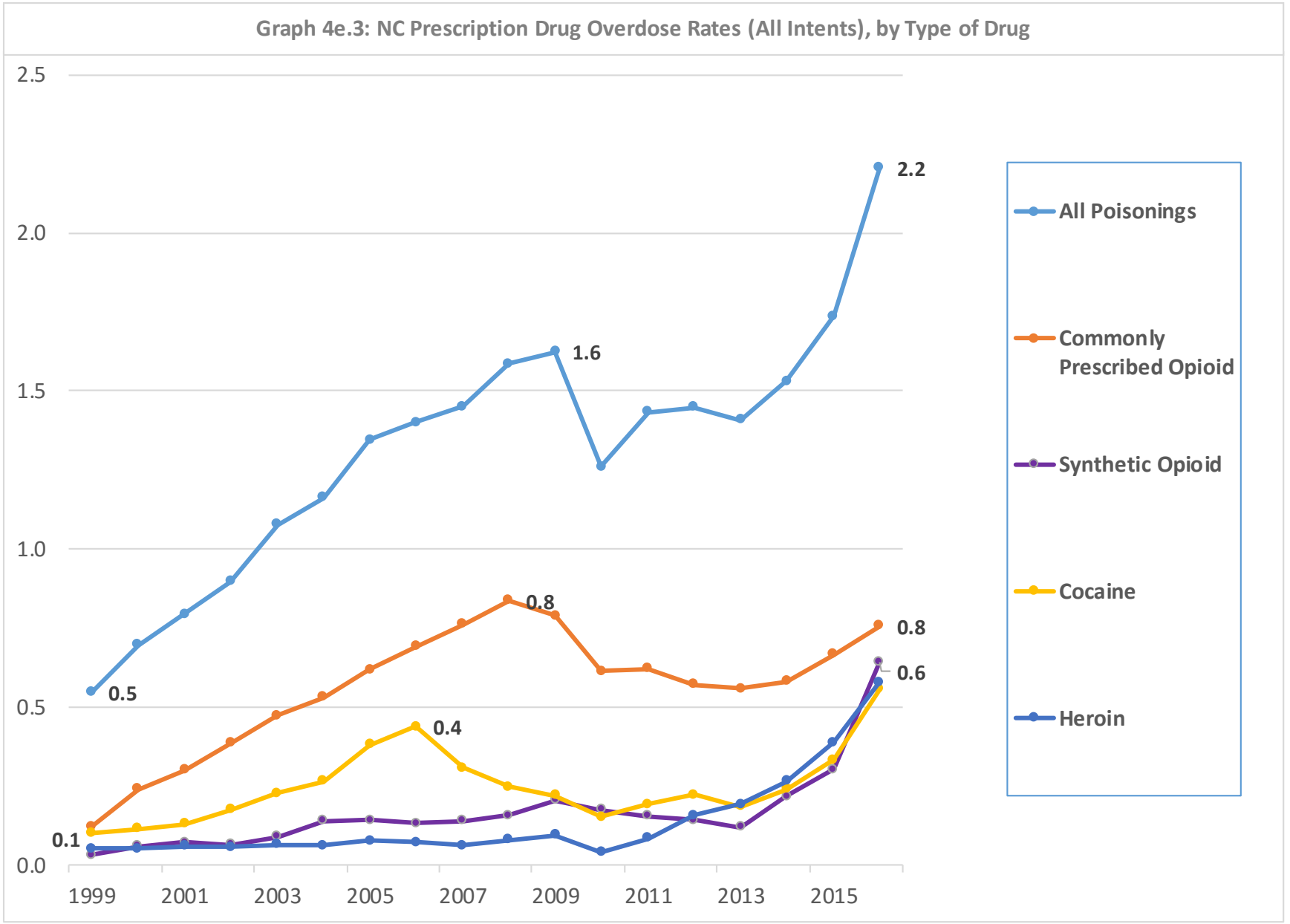
The fifth major component of the evaluation logic model is long-term outcomes. As mentioned in the *Methods* section of this report, achieving these outcomes is the ultimate goal of the SAPBG. They consist of changes in behaviors (such as age of substance abuse initiation and current substance use), as well as negative consequences related to substance use and abuse (such as overdoses , motor vehicle crashes, and deaths). For the purposes of this report, we present data on outcomes related to prescription drug use (including opioid use), alcohol use, and tobacco use in North Carolina.

Prescription Drugs – Overall, the drug-poisoning death rate increased more than four-fold from 1999 to 2016. Drug-poisoning hospitalizations stayed at about the same rate over time, while the emergency department visit rate decreased about 5% over the years (see Graph 4e.1). Overall, the drug-poisoning death rate was highest in counties in the western and eastern-coastal counties (see Graph 4e.2). Detailed data by specific drug types are presented in Graph4e.3-5.

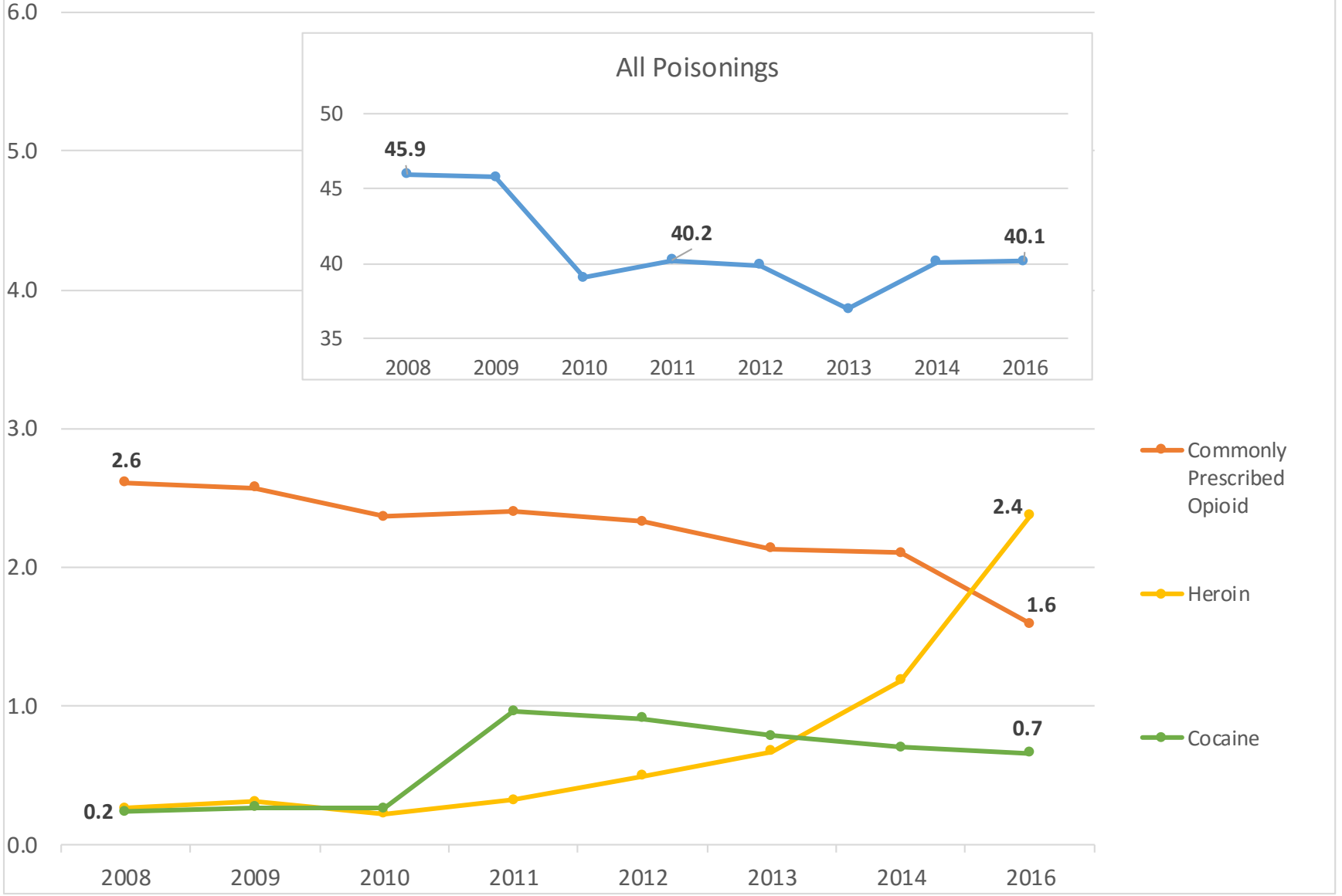


Graph 4e.2: NC Prescription Drug Overdose (All Intents) by County and LME (2016)





Graph 4e.4: North Carolina Prescription Drug Emergency Department Visits Rates, by Type of Drug



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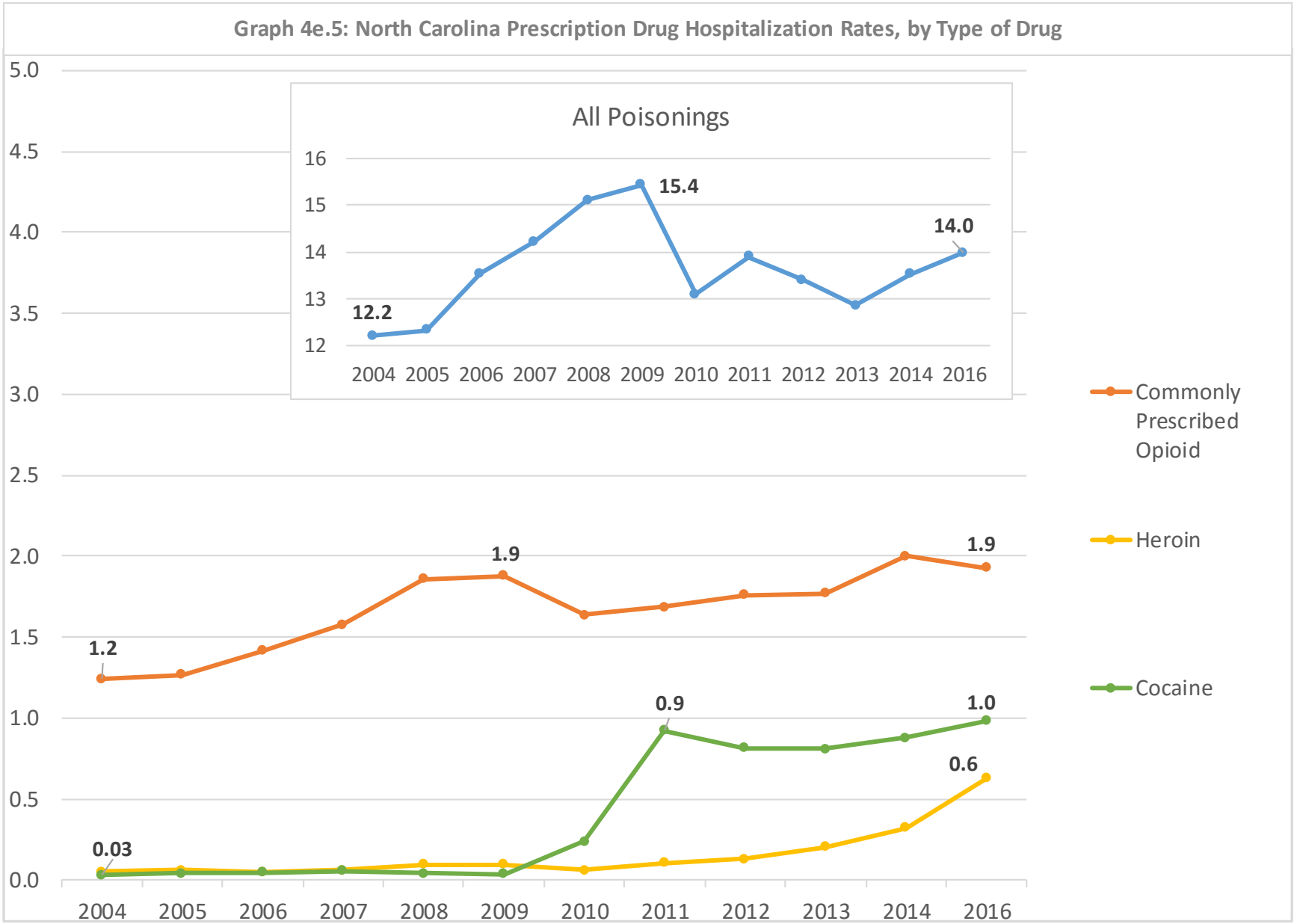

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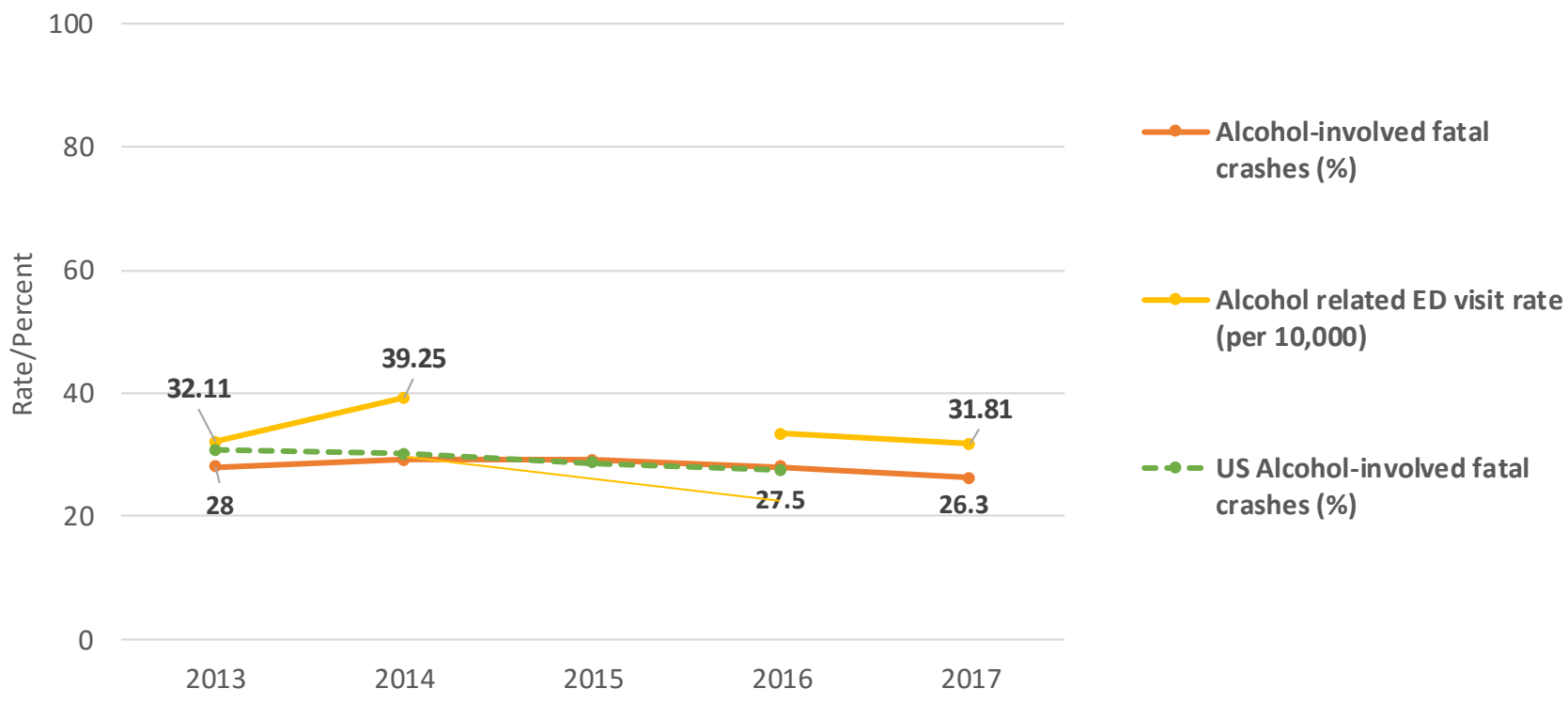
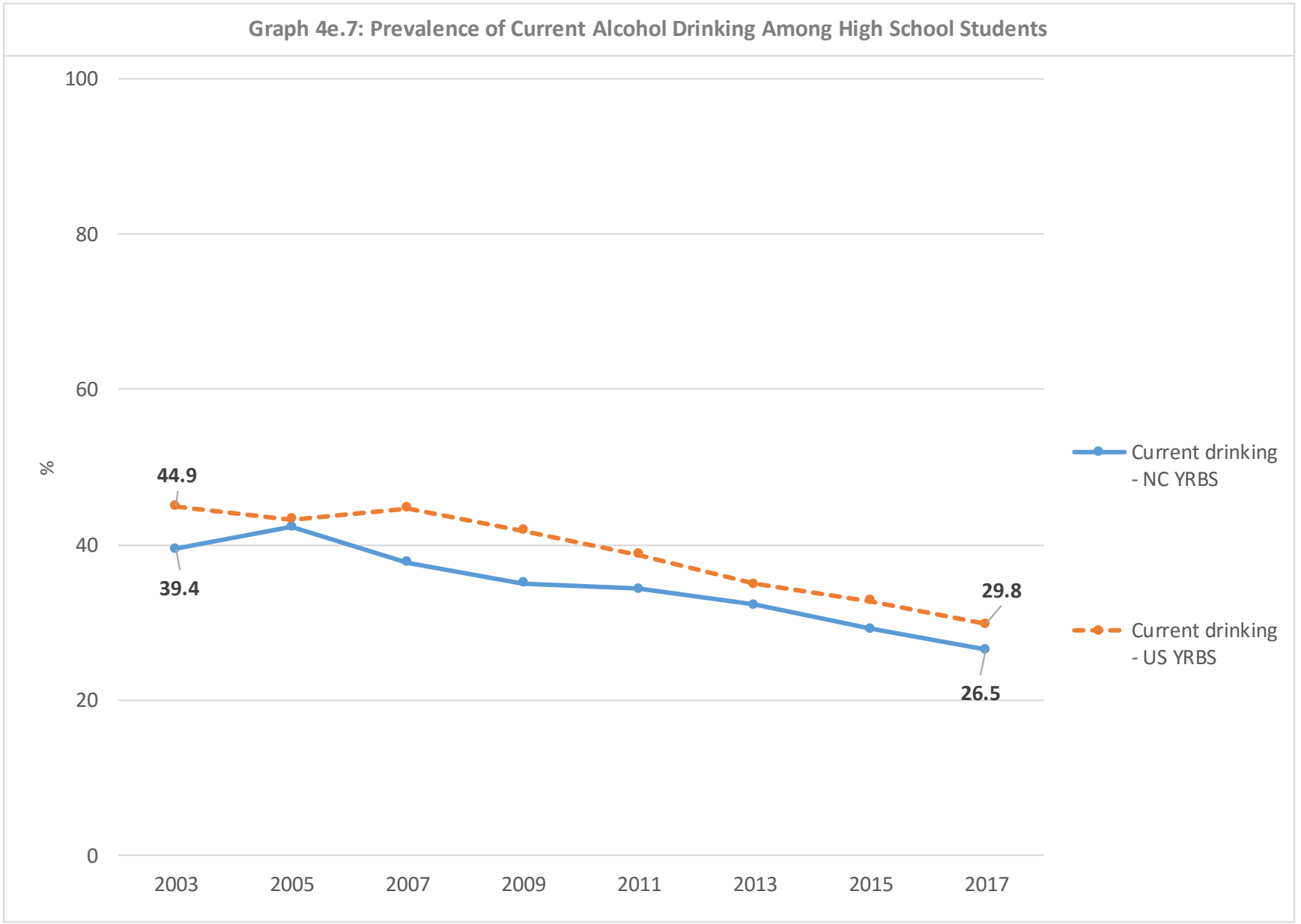
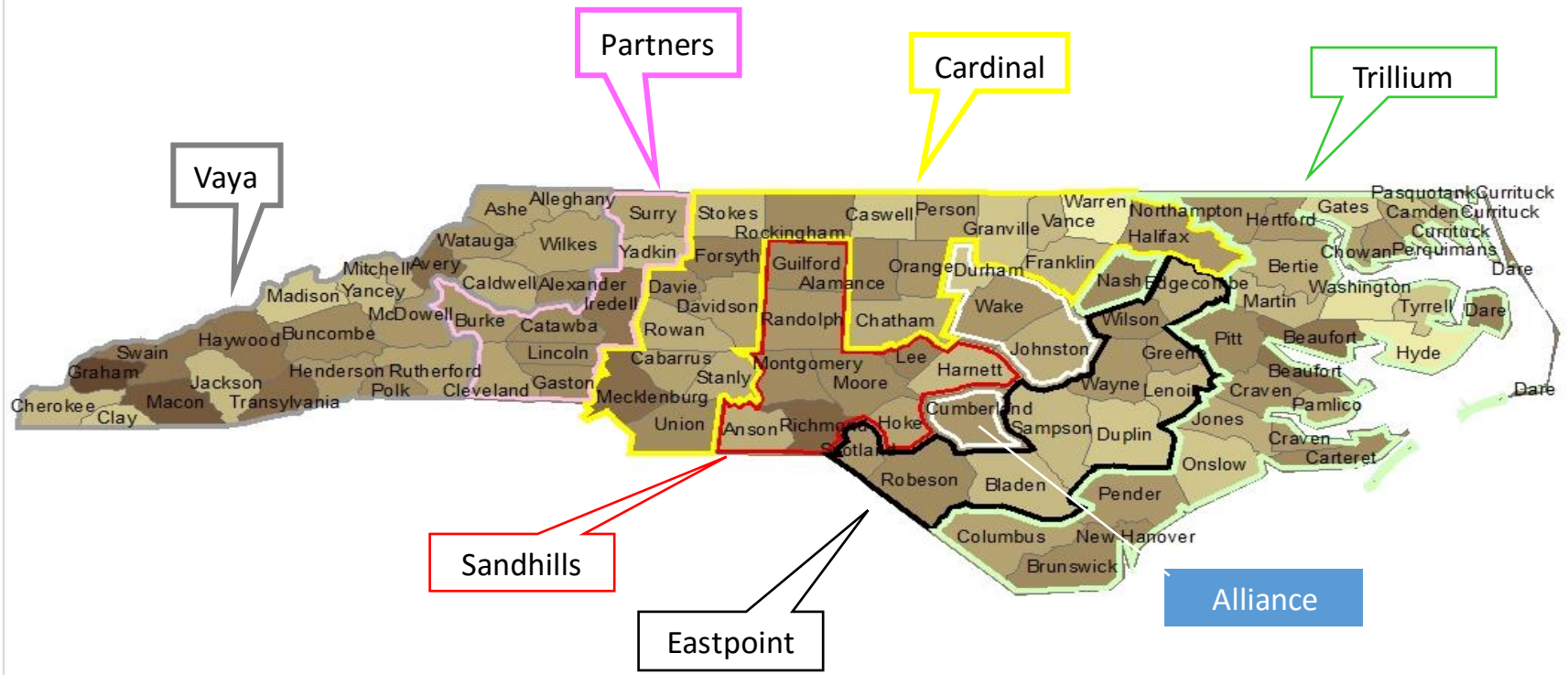
Alcohol – Alcohol-related emergency department visits among individuals aged 12-24 and alcohol-involved fatal crashes rates are presented in Graph 4e.6. The rate of alcohol-related emergency department visits increased from 32 to 39 per 10,000 persons between 2013 and 2014, returning to about 32 per 10,000 persons in 2016 and 2017. Current drinking among high school students steadily decreased over the years in North Carolina, following trends in the U.S. as a whole (see Graph 4e.7). Patterns of NC alcohol-involved fatal crashes and prevalence of current drinking are similar to those observed for the U.S. as a whole. Rates of alcohol-related emergency department visits were higher in the western counties then in counties in other regions of NC in 2016 (see Graph 4e.8).

Graph 4e.6: NC Alcohol Related Consequences



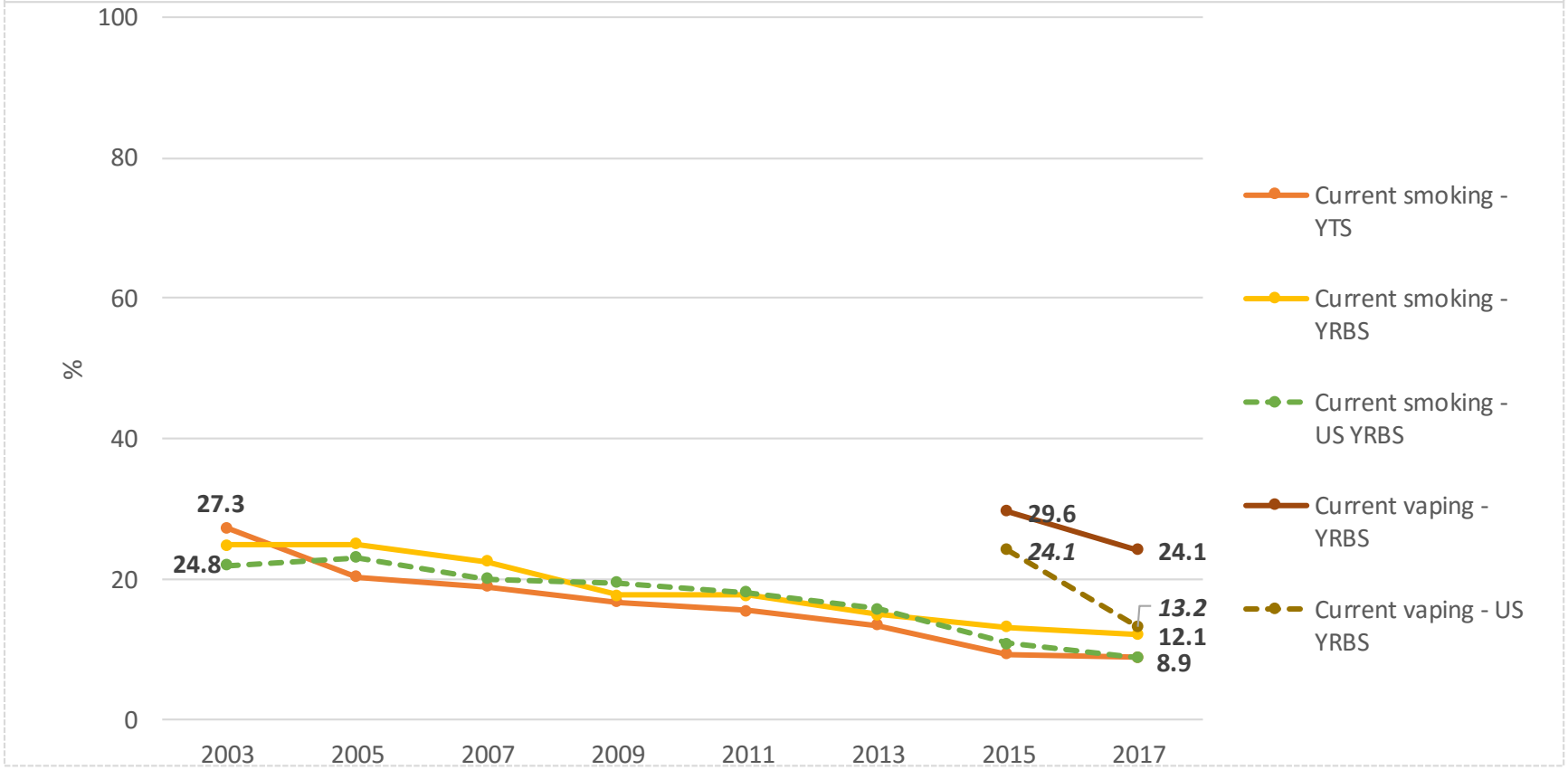


Graph 4e.8: NC Alcohol Related Emergency Department Visit by County and LME (2016)



Tobacco – Current county level data on youth tobacco use are not available, so we present statewide and U.S. data here. Two different data sources, the Youth Risk Youth Risk Behavior Surveillance System (YRBSS) and the Youth Tobacco Survey (YTS) showed that current cigarette smoking among high school students decreased more than half over the years in both North Carolina and in the U.S. as a whole (Graph 4e.9). Starting in 2015, the YRBSS started collecting data on e-cigareete use or "vaping." Although the prevalence of current vaping decreased in NC from 2015 to 2017, the prevalence of vaping in NC was more than 1.5 times greater than in the U.S. as a whole in 2017.

Graph 4e.9: NC Prevalence of Current Cigarette Smoking and Vaping Among High School Students



SAPBG System Strengths and Opportunities

Strengths

The baseline evaluation identified a number of important strengths in the North Carolina SAPBG system. These include the following:

- Substantial progress has been made in transitioning from a system focused largely on individual behavior change to one that focuses on population-based substance abuse prevention strategies. Evidence for this includes our finding that 42.4% of SAPBG program funds were spent on community-based process and environmental strategies in FY 2017, increasing to 63.7% in FY 2018.
- Prevention providers are shifting their Synar time to activities that are most likely to make a meaningful difference in the retail violation rate, such as merchant education; they are also reaching more merchants across more counties in their Synar efforts.
- Encouraging trends are in evidence in North Carolina—as is true nationally—in continuing reductions in rates of prescribing of opioid analgesics.

Opportunities

As is often the case, some of the identified strengths in the system suggest that there are opportunities for continuing improvements. These include:

- An important opportunity for the system is ensuring that community-based process and environmental strategies are implemented effectively, and are aligned with actual needs in communities. While this evaluation report does not include data that bear directly on this question, it is widely recognized that effective planning and implementation of strategies such as these can be challenging. To this end, the WFSM evaluation team has developed several products that may be useful in encouraging effective planning and implementation of these Core strategies. These include a literature review on the effectiveness of various environmental strategies (Wagoner et al., 2018), a guide to implementing and supporting policies (Wagoner et al., 2018), and a guide to developing and implementing effective substance use prevention communication campaigns (Ross et al., 2018). In addition to dissemination of these materials, there may be opportunities for the TTA Center and the TTA Consortium to develop and implement a coordinated effort to stimulate effective planning and implementation of community-based process and environmental strategies.
- Continuing development of the prevention workforce in the state is an important opportunity. There is a high proportion of early career prevention providers, as well as a high proportion who are not certified or registered to be certified as a substance abuse prevention specialist. Concern about this is somewhat mitigated by our

impression that inexperienced prevention providers are supported by a cadre of experienced prevention professionals within every LME/MCO. Nonetheless, there may be opportunities in the coming year for DMH/DD/SAS to encourage LME/MCOs and prevention provider agencies to increase hiring of certified prevention professionals and to offer opportunities to current staff to become certified.

- While progress has been made in the state in reducing rates of prescribing opioid analgesics, there is mounting concern about the dramatic increases in overdoses related to illicitly manufactured synthetic and semi-synthetic opioids and heroin. Unfortunately, there is little evidence on which, if any, prevention strategies related to use of these substances is effective. If it would be useful, the WFSM Evaluation Team could conduct a national environmental scan to identify promising primary prevention strategies being implemented in states and communities to address the evolving nature of the opioid epidemic.
- There may be opportunities to build on recent system improvements in Synar-related activities. This fiscal year (FY 2019), the WFSM Evaluation Team will be conducting an in-depth assessment of Synar activities in each LME/MCO, and the extent to which these activities, as well as other factors, are associated with rates of retailer compliance with the tobacco age-of-sale law. The results of this assessment could inform efforts by DMH/DD/SAS, the TTA Consortium, LME/MCOs, and prevention providers to continue strengthening the state response to youth tobacco use and Synar compliance.
- There are a number of important gaps in data systems that could inform prevention efforts—including the statewide evaluation. These include the following.
    - Data on the implementation of SPF is only available at the LME/MCO and prevention provider level, not county level, and currently only address the implementation phase of the SPF. Indicators of quality of implementation are largely absent. WFSM will be conducting an in depth review of communication campaign implementation using strategic action plan and process evaluation data, with the intent of addressing quality to the extent possible, but also identifying gaps and making recommendations for implementation quality assessments.
    - There are some data quality problems, particularly with respect to counting reach, that limit the usefulness of some of the measures of implementation. WFSM Evaluation Team will be analyzing SAPTG reporting data to identify problems, develop automated screening tools and other processes to more rapidly identify and correct reporting errors.
    - Individual-level data on knowledge, attitudes, and behaviors are highly limited (the only data available are for a single year, limited to youth, and are only available at the LME/MCO level).

It is recommended that the data related gaps be brought to the North Carolina State Epidemiological Outcomes Workgroup for consideration. As a multi-departmental, state level working group, they may be able to work within and across systems to increase data resources for multiple sectors.

NEXT STEPS

The proposed next steps for the evaluation include the following:

- Meet with DMH/DD/SAS staff to discuss the findings and recommendations of this baseline evaluation report and identify appropriate follow-up actions.
- Meet with DMH/DD/SAS and the TTA Consortium to discuss uses of other recent deliverables, including the literature review on the effectiveness of various environmental strategies (Wagoner et al., 2018), guide to implementing and supporting policies (Wagoner et al., 2018), and guide to developing and implementing effective substance use prevention communication campaigns (Ross et al., 2018). In addition to potential dissemination of these materials, there may be opportunities for the TTA Center and the TTA Consortium to collaborate on the development and implementation of a coordinated effort to stimulate effective planning and implementation of community-based process and environmental strategies.
- Conduct an in-depth assessment of Synar activities in each LME/MCO, including an assessment of the extent to which these activities, as well as other factors, are associated with rates of retailer compliance with the tobacco age-of-sale law. The results of this assessment could inform efforts by DMH/DD/SAS, the TTA Consortium, LME/MCOs, and prevention providers to continue strengthening the state response to youth tobacco use and Synar compliance.
- Meet with DMH/DD/SAS staff and the SEOWG to identify and explore possible approaches to addressing gaps in current data systems.
- Conduct interviews with staff from each of the seven LME/MCOs to assess their attitudes, capacity, and direction of prevention efforts.
- Compile updated data on each of the components of the evaluation logic model, as these data come available. Having these data will enable us to report, in the 2nd Annual Report, continuing changes in infrastructure, SPF implementation, intermediate outcomes, and long-term outcomes. This will include a quasi-experimental analysis of the impact of measures of SPF implementation on both intermediate and long-term outcomes (see measures included in Table 3.1). As an example, we will be able to assess, at the LME level, the extent to which shifts from individual-focused to core strategies are associated with reductions in key outcomes, including retailer compliance with tobacco age-of-sale laws and opioid overdose and hospitalization rates.

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Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	(•) Yes ( ) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling ( ) Yes (●) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare ( ) Yes (●) No

d) Inclusion of recovery support services ( ) Yes (●) No

e) Health navigators to assist clients with community linkages ( ) Yes (●) No

f) Expanded capability for family services, relationship restoration, and custody issues? ( ) Yes (●) No

g) Providing employment assistance ( ) Yes (●) No

h) Providing transportation to and from services ( ) Yes (●) No

i) Educational assistance ( ) Yes (●) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

1. Annual monitoring of the SABG Women's Set-Aside programs;
2. Annual cross-site evaluation submission by statewide perinatal and maternal substance use initiative programs;
3. Review of NC TOPPS reporting;
4. Training and technical assistance;
5. Completion by LME-MCOs and review by staff of the SABG Semi-Annual Compliance Reports.

In addition to the Division's policy on plans of correction, the following are applicable:
• The North Carolina Perinatal and Maternal and CASAWORKS programs submit annual cross site reports that include narrative responses to block grant related criteria/questions and aggregate data that provides demographic information on the populations they serve. These reports are submitted in the first quarter following the SFY completion. They are then reviewed by the Women's Substance Abuse Coordinator and the evaluation staff. If there are gaps or questions arising from these reviews, program managers are contacted directly for additional information or clarification. After these one to one contacts by phone and/or email, data forms are updated and report reviews are completed. When global issues arise not specific to just one program, they are addressed in conference calls and face to face meetings with the Women's Coordinator and the evaluation staff. Each narrative report is rated based on completion and compliance with block grant requirements. Additional information such as focus groups or responses to questions from the Division of MH/DD/SAS based on emerging issues, and/or additional information that the program deemed valuable to gather for their own quality improvement are reviewed. This information helps inform efforts, but is not rated since it is not part of the block grant requirements. Reporting forms with demographic data are combined and summary statistics are used by the Division.
• NCTOPPS reporting is reviewed as a part of the annual monitoring reviews to ensure submissions are timely and complete. Additionally, the program evaluator, on at least a bi-annual basis, receives a download of the NC TOPPS data and provides direct follow up with the program administrator if there are any inconsistencies with the data reporting. The program evaluator works with the program administrator to correct any data related issues.
• Division staff review the Semi Annual Block Grant Compliance Reports and request clarification or re-submission for any out of compliance concerns.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(•) Yes ( ) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs	(•) Yes ( ) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	( ) Yes (•) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (•) No
c)	Use of peer recovery supports to maintain contact and support	(•) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	( ) Yes (•) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

1. Review of mandatory reporting measures of LME-MCOs, including the requirement to treat individuals with an SUD as "urgent," therefore requiring appointments for care within 48 hours of a call coming in to the LME-MCO 24/7/365 helpline. LME-MCOs are also required to connect individuals being discharged from an inpatient setting within seven days of discharge.
2. Annual monitoring of all SABG-funded services.
3. Semi-Annual SABG Compliance Reports are completed by LME-MCOs and reviewed by Division staff to assure compliance.
4. Monthly calls with LME-MCO points of contact for SUD services.

It should be noted that compliance with the 90% capacity reporting requirement is specific to the opioid treatment programs across North Carolina. All programs (currently 75) are required to participate in a capacity management/central registry program through a contracted vendor that provides daily census data. Although the majority of PWID are receiving services through one of the 75 opioid treatment programs, individuals who elect to receive services other than medication-assisted treatment would not be captured under this system.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	( ) Yes (•) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	( ) Yes (•) No
c)	Established co-located SUD professionals within FQHCs	( ) Yes (•) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

1. Annual monitoring of all SABG-funded services.
2. Semi-Annual SABG Compliance Reports are completed by LME-MCOs and reviewed by Division staff to assure compliance.
3. Monthly calls with LME-MCO points of contact for SUD services.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for ( ) Yes ( ) No

HIV in areas that have the greatest need for such services and monitoring the service delivery?

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas ○ Yes ○ No

b) Establishment or expansion of tele-health and social media support services ○ Yes ○ No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ○ Yes ○ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? ● Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ● Yes ○ No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ● Yes ○ No

If yes, plese provide a brief description of the elements and the arrangement

SABG treatment funds have been used to purchase nasal naloxone to be distributed to individuals at risk for opioid overdose. Distribution of nasal naloxone has included opioid treatment programs, syringe service programs and other community organizations that have contact with individuals who use opioids.

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — ○ Yes ◉ No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — ◉ Yes ○ No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ○ Yes ◉ No
- **c)** Establish a peer recovery support network to assist in filling the gaps — ◉ Yes ○ No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ◉ Yes ○ No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ○ Yes ◉ No
- **f)** Explore expansion of services for:
  - **i)** MAT — ○ Yes ◉ No
  - **ii)** Tele-Health — ◉ Yes ○ No
  - **iii)** Social Media Outreach — ○ Yes ◉ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? — ◉ Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ○ Yes ◉ No
- **b)** Establish a program to provide trauma-informed care — ○ Yes ◉ No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ◉ Yes ○ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — ○ Yes ◉ No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ○ Yes ◉ No
- **b)** An organized referral system to identify alternative providers? — ◉ Yes ○ No
- **c)** A system to maintain a list of referrals made by religious organizations? — ○ Yes ◉ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — ○ Yes ◉ No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — ◉ Yes ○ No
- **b)** Review of current levels of care to determine changes or additions — ◉ Yes ○ No

c) Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — ( ) Yes (●) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — ( ) Yes (●) No

c) Updating written procedures which regulate and control access to records — ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

During any given year, there are approximately 40 to 50 programs that receive SABG funds through the LME-MCOs. Also, agencies must have attained national accreditation in order to be credentialed by an LME-MCO (for a contract for enhanced services). Each year, 7 to 10 programs participate in Independent Peer Review in NC, typically about 10% of contracted providers.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — ( ) Yes (●) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ( ) Yes (●) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — (●) Yes ( ) No

If Yes, please identify the accreditation organization(s)

i) ☑ Commission on the Accreditation of Rehabilitation Facilities

ii) ☑ The Joint Commission

iii) ☑ Other (please specify)

COA - Council on Accreditation
CQL - Council on Quality and Leadership

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ( ) Yes (●) No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ( ) Yes (●) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state (●) Yes ( ) No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services (●) Yes ( ) No

c) Preformance-based accountability ( ) Yes (●) No

d) Data collection and reporting requirements (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ( ) Yes (●) No

b) Addition of training sessions designed to increase employee understanding of recovery support services ( ) Yes (●) No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ( ) Yes (●) No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ( ) Yes (●) No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? (●) Yes ( ) No

b) Mental Health TTC? ( ) Yes (●) No

c) Addiction TTC? (●) Yes ( ) No

d) State Targeted Response TTC? (●) Yes ( ) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ( ) Yes (●) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ( ) Yes (●) No

b) Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ( ) Yes (●) No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

http://www.ncga.state.nc.us/gascripts/statutes/StatutesTOC.pl?Chapter=0143B

http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_122C.html

http://reports.oah.state.nc.usncac.asp?folderName=%5CTitle%2010A%20-%20Health%20and%20Human%20Services%5CChapter%2027%20-%20Mental%20Health,%20Community%20Facilities%20and%20Services

Footnotes:

In question 1 in the TB section, the Division contracts with seven LME/MCOs to provide funding to local providers for SUD prevention, treatment and recovery services. LME/MCOs require all SABG-funded treatment providers to screen individuals for TB during the diagnostic assessment or comprehensive clinical assessment. Arrangements/referrals are made to local health departments if an individual screens positive for TB.

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11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? ○ Yes ○ No

Please indicate areas of technical assistance needed related to this section.

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12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? ○ Yes ○ No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ○ Yes ○ No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ○ Yes ○ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ○ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight.

Please indicate areas of technical assistance needed related to this section.

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1.	Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?	○ Yes ○ No
2.	Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?	○ Yes ○ No
3.	Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?	○ Yes ○ No
4.	Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?	○ Yes ○ No
5.	Does the state have any activities related to this section that you would like to highlight? Please indicate areas of technical assistance needed related to this section.	

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? (●) Yes ( ) No

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☑ Naltrexone (oral, IM)
- **f)** ☑ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

The number of opioid treatment programs continue to increase in NC; as of September 2019, there were 75 programs serving over 20,000 individuals daily with capacity for 26,000. Monthly calls are held with the Medical Directors of all the OTPs. NC has three state-run facilities and all three now offer MAT.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☐ Psychiatric Advance Directives
- **c)** ☐ Family Engagement
- **d)** ☐ Safety Planning
- **e)** ☐ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☐ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☐ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☐ Crisis Residential/Respite
- **d)** ☐ Crisis Intervention Team/Law Enforcement
- **e)** ☐ Mobile Crisis Outreach
- **f)** ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☐ Peer Support/Peer Bridgers
- **b)** ☐ Follow-up Outreach and Support
- **c)** ☐ Family-to-Family Engagement
- **d)** ☐ Connection to care coordination and follow-up clinical care for individuals in crisis

- **e)** ☐ Follow-up crisis engagement with families and involved community members
- **f)** ☐ Recovery community coaches/peer recovery coaches
- **g)** ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes (●) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Please see the MHBG 20-21 Plan.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The state has integrated recovery oriented principles and values into the North Carolina Substance Abuse Prevention and Treatment Block Grant plan, the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services 1115 SUD Demonstration Waiver and the Opioid Action Plan. Recovery principles are integrated into state contracts as well as in many training events statewide. The state of North Carolina adopted Person Centered Planning in 2006 and has promoted the use of "person first" language since then.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services created a new position in 2015 to ensure that recovery oriented principles are integrated into state policies. This position is the Consumer Policy Advisor and this staff person serves on the Executive Leadership Team. This individual identifies as a person in long-term recovery from mental health concerns and substance use disorder, and has a thorough understanding of the recovery movement as well as long-term recovery supports. This position works closely with the Consumer and Family Advisory Committees throughout the state (local and state-level), as well as stakeholders and advocates throughout the state to promote recovery-oriented principles and ensure the "voice" of individuals in recovery is heard at high levels of policy development.

Additionally, one member of the Addictions and Management Operations team is fully dedicated to ensuring the development, implementation and delivery of recovery supports and services across the state. This individual previously held a position as the Project Director of the Access to Recovery (ATR) grant which concluded in September 2018. Other funds were identified to maintain this position in order to sustain efforts and goals achieved with the ATR grant, as well as provide support in newly identified areas of focus.

The state also provides financial support to recovery community centers and organizations across the state. The Division has recently selected two recovery community organizations through a competitive process to provide leadership, support and mentorship to other recovery community organizations statewide. Recovery community centers are staffed with certified peer support specialists and volunteers to provide a resources and community-based support for individuals seeking or in recovery. Other initiatives in SABG-funded recovery community centers include recovery community messaging to individuals, families, stakeholders and treatment providers, Recovery Coach Academies. The state also encourages treatment providers to learn about recovery messaging and to teach the individuals going through treatment about recovery messaging and advocacy for better health care while in treatment.

Training events focusing on the connection and intersection between substance use disorder prevention and recovery have been conducted at the North Carolina Foundation for Alcohol and Drug Studies, at the North Carolina Opioid Misuse and Prevention Summit and two other meetings specific to this initiative. The focus of these meetings is to emphasize a reduction in silos between prevention and recovery, recognizing that addiction is a chronic condition that may require multiple treatment episodes with an emphasis on wellness promotion as a key component to supporting an individual's recovery. The fields of study between Certified Substance Abuse Prevention Consultants and Recovery Coaches and Peer Support Specialists should include both prevention and recovery content. An existing goal of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services is to enhance North Carolina's substance use disorder prevention and recovery system's capacity to address non-medical prescription drug use by increasing working partnerships between prevention and recovery among state agencies and local communities to promote healthy communities, address risk and protective factors and promote recovery initiatives. Both systems share many common goals.

The state recognized the need to mentor and develop future leaders who identify as being in recovery from mental health concerns and substance use disorders and in response, developed a 12-month Leadership Development Academy which began January 2017 through the University of North Carolina Chapel Hill.

The Division has contracted with the University of North Carolina – Chapel Hill for a number of years to develop and support North Carolina's certified peer support specialist program. As of 09/13/2019, the number of Certified Peer Support Specialist in North Carolina is 3,801. Of the 3,801 Certified Peer Support Specialists, 3,727 reside in NC, and 74 reside in other states. Only six counties out of 100 do not have a peer support specialist residing there. Of the total, nearly 1600 are in recovery from a substance use disorder, 440 are Veterans and nearly 2000 of the total are employed as a peer support specialist, volunteer as such or are employed in a related field.

5. Does the state have any activities that it would like to highlight?

In addition to the above, SABG funds support several collegiate recovery programs across the state, as well as a Director of Scholastic Recovery through a contracted agency. These include programs at the University of North Carolina at Wilmington; East Carolina University; the University of North Carolina at Chapel Hill; the University of North Carolina A&T; the University of North Carolina at Greensboro; University of North Carolina at Charlotte; Appalachian State University and NC State University. Current

areas of focus include developing collegiate recovery programs on community college campuses, as well as the development of high school recovery programs.

Please indicate areas of technical assistance needed related to this section.

The state is in the process of identifying all non-licensed recovery supported housing sites with the intent of beginning work to ensure services are of the quality and quantity needed to promote recovery. Depending on the outcome of various data factors, TA may be requested.

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	○ Yes ○ No
Home and community based services.	○ Yes ○ No
Peer support services.	○ Yes ○ No
Employment services.	○ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ○ Yes ○ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? ○ Yes ○ No

b) The recovery and resilience of children and youth with SUD? ○ Yes ○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ○ Yes ○ No

b) Juvenile justice? ○ Yes ○ No

c) Education? ○ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ○ Yes ○ No

b) Costs? ○ Yes ○ No

c) Outcomes for children and youth services? ○ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ○ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ○ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ○ Yes ○ No

b) for youth in foster care? ○ Yes ○ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
No Data Available				

*Council members should be listed only once by type of membership and Agency/organization represented.
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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**0**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**0**	**0.00%**
State Employees	0	
Providers	0	
Vacancies	0	
Total State Employees & Providers	**0**	**0.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

https://www.ncdhhs.gov/divisions/mhddsas/sabg

c) Other (e.g. public service announcements, print media) ( ) Yes (●) No

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Footnotes: