

North Carolina

UNIFORM APPLICATION

FY 2022/2023 Only Application Behavioral Health Assessment
and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 10/25/2021 11.28.38 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 2022

End Year 2023

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 10/1/2021 4:10:54 PM

Revision Date 10/1/2021 4:11:11 PM

V. Contact Person Responsible for Application Submission

First Name DeDe

Last Name Severino

Telephone 984-236-5122

Fax

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 2022

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
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

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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).
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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.
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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: Kody H. Kinsley _____

Signature of CEO or Designee¹: _____

Title: Chief Deputy Secretary for Behavioral Health and
IDD _____

Date Signed: _____

mm/dd/yyyy

¹If 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:

Please see the signed certification form and letters attesting to signature authority in the attachments.

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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.

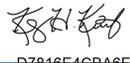
The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

DocuSigned by:

D7816E4CBA6F4A8...

Signature of CEO or Designee¹: _____

10/01/21 | 3:19 PM EDT

Title: Chief Deputy Secretary for Behavioral Health and
IDD

Date Signed: _____

mm/dd/yyyy

¹If 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:

*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).

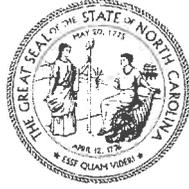
Very truly yours,

A handwritten signature in black ink, appearing to read "RC", written over a faint, larger version of the signature.

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 *AKC*
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

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

Chief Deputy Secretary for Behavioral Health and IDD

Organization

NC Department of Health and Human Services

Signature:

Date:

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

Footnotes:

No lobbying activities, please see signed form 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

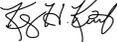
Chief Deputy Secretary for Behavioral Health and IDD

Organization

NC Department of Health and Human Services

DocuSigned by:

Signature:



Date: 10/01/21 | 3:19 PM EDT

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

Footnotes:

No lobbying activities.

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 of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care 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 of care 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:

SABG Assessment and Plan 2022 - 2023

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 executive leadership team is comprised of the Director, Deputy Director, Assistant Director for Policy and Program Design, Assistant Director for System Performance, Assistant Director for Community Engagement and Empowerment, the Chief Medical Officer and the Chief Financial Officer.

The overall structure of DMH/DD/SAS is both functional in nature as well as disability-specific. **Please see the DMH/DD/SAS organizational chart following the end of this document for specific detail.**

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 Justice Populations section, which includes the Drug Control team, as well as the Community Mental Health team and the Intellectual/Developmental Disabilities/Traumatic Brain Injuries team. The Mental Health, Addictions and Management Operations and Intellectual/Developmental Disabilities/TBI 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 86 opioid treatment programs in North Carolina, the NC Problem Gambling Program Administrator and an adolescent services specialist. Additional time-limited staff

function as Project Directors and supporting staff for several federal discretionary grants, including the Pregnant and Post-Partum Women Pilot (PPW-PLT) grant, the State Opioid Response (SOR) 2 grant and the Emergency COVID-19 grant.

The Prevention and Wellness team is responsible for SUD primary prevention . This team is comprised of the Section Chief and staff who 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, the utilization of evidenced based programs, policies and practices, and evaluation. Other areas of focus include underage drinking, fetal alcohol spectrum disorder, 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 Justice Populations team is responsible for the Controlled Substances Reporting System, North Carolina's prescription drug monitoring program (PDMP), and works closely with the SOTA to review and conduct site visits for applicant opioid treatment programs. This team also oversees the criminal and juvenile justice programming, such as TASC and the Juvenile Justice Behavioral Health Partnership (JJBHP).

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

The Assistant Director of Consumer Policy oversees the Consumer Engagement and Empowerment team, Military and Veterans Services and a field-based team. 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 Deputy Director and Chief Operating Officer oversees the Legislative and Regulatory Affairs team, the Chief Financial Officer, Human Resources and several singular positions responsible for facility management and information technology.

The Chief Medical Office oversees the PASSAR team as well as various medical and pharmacy personnel in both DMH/DD/SAS and the Division of State-Operated Health Facilities (DSOHF).

Transformation of System Structure

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 allowed the Managed Care Organizations (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 following the end of this document for the counties covered by each LME/MCO.**

In 2015, the NC General Assembly enacted legislation directing DHHS to transition Medicaid and NC Health Choice from fee-for-service to managed care. Under managed care, the state contracts with insurance companies, which are paid a predetermined set rate per enrolled person to provide all services. In July 2020, legislation authorized NC Medicaid Managed Care to begin July 1, 2021, for Standard Plans and July 1, 2022, for Behavioral Health I/DD Tailored Plans.

NCDHHS has leveraged the move to managed care to build an innovative health care delivery system that puts the health of beneficiaries at the forefront. Features of the state's program include establishing a payment structure that rewards better health outcomes, integrating physical and behavioral health, and investing in non-medical interventions aimed at reducing costs and improving the health of Medicaid beneficiaries.

Starting July 1, nearly 1.6 million Medicaid beneficiaries in North Carolina began receiving the same Medicaid services in a new way through NC Medicaid Managed Care health plans. Most beneficiaries continue to get care from the same doctors but are now a member of a health plan. All beneficiaries moving to NC Medicaid Managed Care were enrolled in one of five health plans (Standard Plans) or the Eastern Band of Cherokee Indians (EBCI) Tribal Option by either selecting a health plan during open enrollment or through the auto-enrollment process. In June 2021, beneficiaries were mailed welcome packets with information from their health plan and new Medicaid ID cards. Beneficiaries have until September 30, 2021, to change plans for any reason.

North Carolina will launch the Behavioral Health and Intellectual/Developmental Disability Tailored Plan on July 1, 2022. This plan is an integrated health plan designed for individuals with significant behavioral health needs and/or intellectual/developmental disabilities (I/DDs). The Behavioral Health I/DD Tailored Plan will also serve other special populations, including Innovations and Traumatic Brain Injury (TBI) waiver enrollees, and waitlist members, and be responsible for managing the state's non-Medicaid behavioral health, developmental disabilities and TBI services for uninsured and underinsured North Carolinians. 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.

Through Tailored Care Management, Behavioral Health I/DD Tailored Plan beneficiaries will have a single designated care manager supported by a multidisciplinary care team to provide integrated care management that addresses all of their needs, spanning physical health, behavioral health, I/DD, TBIs, pharmacy, long-term services and supports (LTSS), as well as unmet health-related resource needs.

The Department recently announced the selection of seven organizations to serve as Behavioral Health and Intellectual/Developmental Disability Tailored Plans (Behavioral Health I/DD Tailored Plans). Individuals who need certain services to address a serious mental illness, serious emotional disturbance, severe substance use disorder, intellectual/developmental disability, or traumatic brain injury, may be eligible to enroll in a Behavioral Health I/DD Tailored Plan.

Following a competitive selection process, the following organizations were awarded a contract to serve as regional Behavioral Health I/DD Tailored Plans:

- Alliance Health Plan
- Eastpointe
- Partners Behavioral Health Management
- Sandhills Center
- Trillium Health Resources
- Vaya Health

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. On March 24, 2021, Democratic Governor Roy Cooper included Medicaid expansion in his biennial state budget proposal for State Fiscal Years (SFY) 2022-2023. The budget assumes that the estimated \$1.3 billion for the state's share of expansion would be more than offset with federal dollars under the incentive in the American Rescue Plan. In 2019, Governor Cooper vetoed the SFY 2020-2021 budget passed by the

Republican-controlled legislature due to omission of Medicaid expansion, and the 2019 legislative session resulted in a budget impasse. In August 2020, Governor Cooper once again included Medicaid expansion in his proposal for coronavirus-related adjustments to the FY 2020-2021 budget, but the legislature has not included expansion in any of its coronavirus relief bills.

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.

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:
 - DMHDDSAS and DHB NC Medicaid are working collaboratively to develop and revise state-funded and Medicaid clinical SUD policies across the ASAM continuum of care. ASAM Level .5 expanding the SBIRT Codes to increase the types of licensed professionals eligible to bill these codes in a primary care setting was implemented. Additionally, the clinical coverage policies under ASAM Level 1, comprehensive clinical assessments and diagnostic assessments, were revised to ensure any individual who is diagnosed with a substance use disorder receives an ASAM level of care determination even when it is not a primary diagnosis. All other ASAM levels of care will be implemented in July 2022 in line with the Tailored Plan implementation.
- Obtaining a waiver of the Medicaid institution for mental diseases (IMD) exclusion for SUD services:
 - As of July 2019, under North Carolina's 1115 waiver authority, Substance Use Disorder ("SUD") services for individuals in an Institution for Mental Disease ("IMD") as well as any other Medicaid State Plan services for which they may be eligible during their stay in the IMD, shall be reimbursed under Medicaid. There is not a day limit nor is there a cap on the rate that may be paid to the IMD.
- Ensuring that providers and services meet evidence-based program and licensure standards:
 - DMHDDSAS and DHB are working closely with the Division of Health Services Regulation to ensure temporary licensure rules or waivers are in place to implement all new or revised ASAM levels of care.
- Building SUD provider capacity;
- Strengthening care coordination and care management for individuals with SUDs:
 - DMHDDSAS is developing a state-funded case management clinical policy for individuals with a behavioral health condition. This will be a time limited, provider-based service incorporating evidenced based practices for individuals with high needs including but not limited to the following:
 - Are placed at an inappropriate level of care or are at risk of being discharged from their current placement due to their complex needs;

- Have a medical co-morbidity (including pregnancy);
 - Have co-occurring mental health, SUD, I/DD, and/or TBI disorders;
 - Have complex behaviors requiring additional supervision than is typically available and/or highly specialized interventions;
 - Have a legal history affecting ability to live in congregate settings and/or in proximity to children.
- Improving North Carolina’s prescription drug monitoring program (PDMP).

Please see the document titled **North Carolina Substance Use Disorder Implementation Plan Protocol** following the end of Step 1 for more details.

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), the Office of Rural Health and Community Care 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 over 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.

Prevention and Wellness Services

Seven LME/MCOs currently subcontract with local prevention providers in their catchment areas to deliver primary substance use prevention services across the state. There are 23 local nonprofit prevention providers across the state that serve all 100 counties. The LME/MCO is responsible for monitoring, reporting, and participation in any evaluation of the local prevention providers. The LME/MCO receives guidance from the state’s Prevention and Wellness team about federal substance abuse prevention guidelines and policies to support their oversight and monitoring of local prevention providers. The LME/MCO and their designated prevention providers enter into contract agreements that outlines specific prevention activities including target population, use of evidence-based practices and programs, and reporting requirements. Local contract prevention providers conduct community need assessments to determine services and activities. Each LME/MCO works with the contract substance abuse prevention provider to assist with identifying target populations and services based on local needs assessment results. In addition to the LME/MCO-Provider network, there are several partnerships, alliances, coalitions and collaboratives providing individual and population-based strategies to communities throughout NC.

North Carolina has transitioned our prevention system to one that requires local prevention providers to utilize the **Strategic Prevention Framework (SPF)** to assess local needs, build

community capacity, plan strategically, implement evidence-based strategies for the prevention of alcohol, tobacco, and other drugs, and evaluate program reach and effectiveness. Additionally, statewide training and technical supports are framed by the SPF.

- **Needs Assessment** - 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. To support local needs assessment and planning efforts, the state provided administrative data for all 100 counties for the completion of a needs assessment in FY20. 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. To support further needs assessment efforts, the state plans to administer the next statewide youth prevention survey in FY21.
- **Planning** – Utilizing the results of the needs assessment process, providers identify evidence-based practices, programs and policies to effectively address identified needs. To support the identification and selection of evidence-based strategies, the state has thoroughly researched and provided an approved list of evidence-based strategies for providers use. The approved list includes evidence-based strategies across the CSAP Six strategies (education, community-based processes, environmental strategies, information dissemination, problem identification and referral and alternative activities).
- **Capacity building** – To support local providers, the state has formed a Statewide Prevention Consortium (SPC) that consists of training and technical assistance agencies, discretionary grant leads, prevention evaluation center, and other statewide prevention resources. The consortium ensures the effective implementation of high-quality prevention services, delivered in alignment with state business policies for the prevention system. Partners within the consortium supports the state and local providers through the provision of training in evidence-based programs, policies and practices; developing CSAP Six strategies best practice guidance; training and technical support in conducting local needs assessment and strategic planning; supporting process and outcome evaluation efforts; workforce development that supports credentialing and local capacity building efforts. Additionally, the state communicates policies and procedures for the delivery of primary prevention services at least every six months during regional statewide meetings. Regional meetings and state sanctioned trainings are published online with support from the statewide training and technical assistance center to ensure

ongoing access to up to date state communications as well as training and technical support resources.

- **Implementation** - A majority of funds, approximately 80%, are expended for universal and population-based strategies. Local prevention providers implement data-informed, individual and community-center approaches and programs framed within the CSAP Six strategies and through the SPF in each of their assigned counties. Local prevention providers infuse diversity, inclusion and equity policies into all prevention activities. Furthermore, local providers implement programs and practices according to the guidance provided by the developers of the selected evidence-based programs as well as by best practice action steps provided by the state.
- **Evaluation** - The state has contracted with Prospectus Group to utilize their ECCO data collection system to capture primary prevention implementation plans and reporting. ECCO is cloud-based platform for reporting data to support Substance Abuse Block Grant Reporting requirements in North Carolina. The statewide training and technical assistance center, within the SPC, provides daily oversight of ECCO and works with Prospectus to ensure that ECCO accurately captures key program/provider metrics. Metrics include but are not limited to demographics (race, ethnicity, gender, age), tracking fidelity to best practice steps for specific CSAP Six strategies, individual and population reach, capacity building efforts, development and dissemination of resources, community-based processes metrics, and Synar efforts metrics. Furthermore, the state has a contract with a local university for evaluation services since FY18.

The NC Prevention and Wellness team 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.

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 that 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.

SUD Treatment and Recovery System

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, recovery supported housing and other recovery services and supports, as well as 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 worked together to develop a statewide Peer Supports service definition. The state-funded service definition became effective August 1, 2019, and Clinical Coverage Policy 8G – Peer Support Services - was added to the State Plan Amendment, and most recently amended in December 2020. 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.

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 management for at-risk children (CMARC).

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).

The COVID pandemic has impacted this Initiative in a variety of ways. The Work First and Food and Nutrition Services requirements of individuals meeting certain criteria, to participate in a substance use disorder assessment, shifted in order to account for health and safety precautions. This has meant that significantly fewer referrals have been made to the QPSAs, for their services under this Initiative. The rate of referrals from Child Protection Services has continued and maintained during the pandemic. The QPSAs have remained available to all 100 county department of social services, as contracted through the LME/MCOs. They have been available to provide services through telehealth, when possible for the applicant to participate in that manner.

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). 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, which has been particularly important

during a time when providing services have required many adaptations. 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. 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

The State is currently assessing and reviewing the adolescent SUD workforce and the network of community-based SUD treatment providers. The State is seeking to identify options for supporting

the adolescent SUD workforce and ensuring they have the necessary skills and learning to provide effective treatment services. The State is also seeking to identify options that will allow service users, referral sources etc. to easily locate adolescent treatment providers and have confidence in the treatment providers ability to deliver quality treatment 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

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) Alexander Youth Network's 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. The State is currently working with the LME/MCO's to expand statewide residential services for adolescents and enhance best practices within these facilities.

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 continued service and discharge criteria. The average length of stay ranges from 90 to 120 days.

The Department of Public Safety implemented "Raise the Age" legislation in December 2019 which welcomes 16 and 17-year-old into the Juvenile Justice system. Many of these youth 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.

Juvenile Justice Behavioral Health Partnerships (JJBHP)

Juvenile Justice Behavioral Health Partnerships is a network of local teams across the state working together to deliver effective, family-centered services and supports for juvenile justice-involved youths with mental health, substance use, or co-occurring challenges. Currently, 21 teams are operational, serving 97 counties across NC with an organized person-centered system working from a System of Care perspective. Partnerships can include any interested person or agency but at minimum contain representatives from the local LME/MCO, juvenile court, and treatment providers.

JJBH Partnerships collaborate to ensure that justice-involved youth are appropriately served through the provision of comprehensive clinical assessments by licensed professionals, evidence-based treatment options for justice-involved youth with behavioral health needs, use of child and family team meetings, involvement of family members and youth advocates, and involvement of Juvenile Crime Prevention Councils in their programming. Partnerships also work to promote collaborative relationships between parties involved in the care of justice-involved youth to address problems that arise in the areas of service planning, referrals, and funding related to services for these youth.

Treatment Alternatives for Safer Communities (TASC)

Treatment Alternatives for Safer Communities (TASC) is a cross-area service program supported predominately by SABG funds which provides specialized care management and facilitates access to services for high-risk individuals under criminal justice supervision who have substance use disorders, either alone or co-occurring with a mental illness. TASC services are currently delivered by three organizations, which between them provide services in every North Carolina county.

Since its inception in the 1970s, TASC has supported thousands of North Carolinians with substance use disorders. In 2019, prior to the onset of the COVID-19 pandemic in the United States, TASC served approximately 25,000 people. TASC services have been shown to promote decreases in subsequent re-offense rates and substance use, and increases in access to and utilization of behavioral health services and resources.

State Opioid Treatment Authority/Medication Assisted Treatment

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 86 opioid treatment programs in North Carolina serving an average of over 21,600 patients with an OUD daily. With a capacity of approximately 27,000 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 following the end of this document.**

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 86 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 Opioid Action Plan 2.0 in the Attachments section for more detail.** For example, we have entered into a partnership with the North Carolina Community Health Center Association (NCCHCA). NCCHCA is the HRSA funded state Primary Care Association and Health Center Controlled Network that contracts with and oversees operations of the non-profit, consumer-governed Federally Qualified Health Centers (FQHCs) that provide integrated medical, dental, pharmacy, behavioral health, and enabling services to over one-half million patients in North Carolina. FQHCs receive federal assistance for sliding-fee discounts to assure no one is denied access to care. This project, which will be funded through the SABG CARES Supplemental funds will focus on expansion of OBOT and integrated care services for uninsured individuals with an opioid use disorder.

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 (SEPs) 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. Public funds may be used for other program development and operation costs (rent, salaries and stipends, testing resources, naloxone training and distribution, etc.). Included in the law is a provision that protects SEP employees, volunteers, and participants from being charged with possession of syringes or other injection supplies, including those with residual amounts of controlled substances present, if obtained or returned to a SEP. SEP employees, volunteers and participants must provide written verification (including a participant card or other documentation) to be granted limited immunity.

Syringe exchange programs in North Carolina are required to provide the following services:

- Syringe disposal

- Distribution of sterile syringes and new injection supplies at no cost and in sufficient quantities to prevent sharing or reusing
- Site, personnel and equipment security, including annual written plans to police and/or sheriff's departments within whose jurisdictions they operate
- Education materials concerning:
 - Prevention of disease transmission, overdose and addiction
 - Treatment options, including medication-assisted therapy (MAT) and referrals
 - Naloxone distribution and training, or referrals for those resources
- Consultations/referrals to mental health or substance use disorder (SUD) treatment

The law encourages syringe return to ensure that they are disposed in a safe and secure manner, but does not require participants to return used syringes. Prior to commencing operations, NC SEPs are required to register with the NC Department of Public Health (DPH), by completing and submitting the form Starting a Syringe Exchange Program in NC and each SEP is required to submit annual reports to DPH. There are currently over 50 mobile and fixed site syringe services programs in North Carolina.

Syringe exchange programs are financially practical ways to reduce costs associated with treating HIV and hepatitis A and C infections. Recently, multiple states, including North Carolina have reported upticks in outbreaks of hepatitis A associated with person-to-person transmission. Cases have occurred primarily among three risk groups: (1) persons who use injection or non-injection drugs; (2) persons who are experiencing homelessness; and (3) men who have sex with men. 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.

Syringe exchanges are important for public safety. Fear or hesitation to disclose syringe possession puts law enforcement officers and other emergency responders 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 dispose of used syringes safely and securely, 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.

As mentioned in the previous section, North Carolina has 86 opioid treatment programs, with capacity to serve 27,000 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 of 728,000 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 2021 average of 5600 persons 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
- Governor's Challenge to Prevent Veteran Suicide
- The "Ask the Question – Have You or a Loved One Ever Served in the Armed Service" Campaign

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 sponsored the creation of four (4) regional network coordination centers, each housed in an existing community provider. In 2020, the State acquired, consolidated, and expanded NCServes services to all 100 counties, in advance of the merger of the NCServes and NCCARE360 systems, which took place in July 2021 (<https://ncserves.org>).

- NCServes Central: Veterans Bridge Home operates the Care Coordination Center for the 45 counties of Central NC (855-425-8838)
- NCServes Western and NCServes Coastal: Veterans Services of the Carolinas through the Asheville Buncombe Community Christian Ministry (ABCCM) operates the Care Coordination Center that serves 55 counties in western and coastal North Carolina (855-962-8387)

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.

Since 2017, the state has contracted 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.

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 90% of RHA program staff are deaf. Funds from the SABG support sign language proficient (SLP) 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 continues to work with RHA to develop

services, including Substance Abuse Intensive Outpatient Programs in 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 following the end of this document. 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.

Health Disparities and Inequities

Health inequities and disparities among historically marginalized populations (HMP) in the United States and North Carolina existed long before COVID-19, however the pandemic has spotlighted these glaring problems. While race and ethnicity have been and continue to be the basis for much of the discrimination and oppression seen throughout society, they are not the only defining characteristics of a historically marginalized population. Several other communities have also endured longstanding and well documented structural marginalization, and it is important to also

acknowledge, engage and consider their unique needs as we strive for health equity. These communities include, but are not limited to, individuals with disabilities, the LGBTQ+ community, homeless populations, rural communities, and refugee and immigrant populations.

In July 2021, the Department revised and issued the *Historically Marginalized Populations Engagement Toolkit*, which can be accessed at:

<https://www.ncdhhs.gov/search/cse?keys=equity%20and%20inclusion#gsc.tab=0&gsc.q=equity%20and%20inclusion#gsc.sort=> This toolkit is geared towards healthcare systems and providers and is intended as a guide for NC healthcare providers to help ensure historically marginalized populations are appropriately engaged in all aspects of public health and healthcare delivery – from planning to evaluation, whether emergency preparedness and response efforts or everyday programs and services. The toolkit is organized to provide a framework for embedding health equity into organizational infrastructure for long-term reduction in health disparities and improved health outcomes beyond the pandemic as well as health equity considerations and strategies specific to COVID-19 response efforts.

Within the NC DHHS, the Office of Minority Health and Health Disparities promotes and advocates for the elimination of health disparities among all racial and ethnic minorities and other underserved populations in North Carolina, and provides specific services and resources to that end. Examples include the NC Minority Diabetes Prevention Program, Cultural and Community Health Initiatives, NC Culturally and Linguistically Appropriate Services (NC CLAS) Program and the Community Health Ambassadors Program. The Culturally & Linguistically Appropriate Services (CLAS) Program offers free training and technical assistance to organizations and community members interested in learning more about cultural competence and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). The goal of the CLAS Program is to equip organizations with the information and resources that they need to address the changing demographics and health care needs of North Carolinians and eliminate the cultural and linguistic barriers that diminish quality care and sustain health disparities.

In January of 2021, the DMHDDSAS officially launched its own Diversity, Equity and Inclusion (DEI) Council. The DEI Council is an advisory group composed of staff that help guide the Division's DEI process. It is a vehicle for changing the Division's culture and policies that will ideally lead to a more diverse, equitable and inclusive workplace and behavioral health system. The DEI Council is the official entity within the Division that is responsible for evaluating the Division's progress and providing information and recommendations to leadership to help guide the Division in reaching its DEI mission and goals, and manifesting its values as articulated in its charter.

The DEI Council's responsibilities include the following:

1. Research, assess and set forth the Division's DEI strategy and action plan, which focuses on improvements and leads to systemic changes in the division's current practices, procedures, and climate.
2. Develop a mission statement and create policies and initiatives that are in accordance with the mission statement.
3. Create, manage, and assess DEI action plans in consultation with staff and executive team.
 - Ensure Division infrastructure, policies, practices, procedures, resources, and metrics are sufficient and aligned to drive DEI efforts across the Division.
4. Communicate DEI action plans, efforts, and successes consistently and repeatedly to all internal stakeholders.

5. Develop links and partnerships with external DEI-related industry groups and community stakeholders.
6. Provide helpful counsel to leaders and staff regarding DEI issues.
7. Champion and model positive DEI behaviors and actions.

The standing workstreams and their respective functions as of January 2021 are as follows:

1. Data
 - The functions of the Data workstream are to: collect, analyze, and report on key data metrics that illuminate DEI trends across several human resources domains including hiring, recruitment, promotions, pay, performance evaluations, corrective actions, terminations, etc.; and identify and recommend to leadership key DEI improvement metrics and benchmarks as evidence of the Division's ongoing commitment to DEI principles.
2. Education and Communications
 - The functions of the Education and Communications workstream are to: develop and implement a strategy to educate Division staff on DEI principles, practices and effects using peer-reviewed research and industry practices; provide regular education via webinars, virtual meetings, All-Staff presentations, and sharing of written documents; and identify and invite DEI industry experts to present on emerging trends in DEI within government agencies.
3. System Reform (internal)
 - The functions of the System Reform (internal) workstream are to: using historical and contemporaneous data to help create a work environment wherein everyone can do their best work by establishing best practices based on internal data and diversity, equity, and inclusion research; and engaging and empowering staff through fostering a more culturally diverse and inclusive work environment by removing barriers resulting from systemic inequities and social injustices.
4. System Reform (external)
 - The functions of the System Reform (external) workstream are to: examine external practices including contracts, engagement, and access; make recommendations for systemic and structural changes that better reflect DEI principles; ensure a fair and equitable distribution of system resources.
5. Policy
 - The functions of the Policy workstream are to assist the DEI Council in developing a policy to define its scope of authority and operations in accordance with the mission statement and to identify policies within the Division that are best reflective of DEI practices; make recommendations on policies that need review and establish benchmarks and standards

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.

The fundamental precepts of cultural competence include developing respect for differences; cultivating successful approaches to diversity; increasing awareness of oneself 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>

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 objectives of this contract are to increase access to and improve the quality of prevention, treatment, and recovery support services for individual with behavioral health disorders by: (1) Expanding the use of prevention, treatment and recovery support services for behavioral health that demonstrate success in improving outcomes and/or supporting recovery; (2) Enhancing the quality of the behavioral health workforce providing prevention, treatment and/or recovery support services, with a special emphasis on service members, veterans and their families; (3) Enhancing the ability of provider agencies to determine the effectiveness of the behavioral health promotion, treatment and recovery support services they provide; (4) Enhancing the ability of physicians and other health care providers in primary care settings to provide better prevention, treatment, and recovery services to their patients particularly in regard to treating opioid use disorders, including medication assisted treatment; (5) Enhancing the ability of physicians and other health care providers to provide patient education and resources to augment self-management skills, and in so doing, improve health status and outcomes for patients with other chronic diseases; (6) Promoting systems of health and human services that 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; (7) Utilize a health equity lens when implementing the performance requirements including:
 - Ensuring the program design, implementation and evaluation efforts are promoting health equity such as specific outreach to underserved communities and engagement with historically marginalize populations
 - Using disaggregated data to identify priority populations when applicable
 - Engaging priority populations in program planning, implementation and/or evaluation
 - Providing opportunities for staff and partners to learn about health equity and social determinants of health, and apply these concepts to program design, implementation, and evaluation
 - Ensuring education and communication materials are culturally sensitive, linguistically appropriate and at an appropriate comprehension level to accommodate stakeholders with varying backgrounds

- Partnering with organizations, agencies and/or community groups that focus on the social determinants of health or health equity.

Highlighted projects include the following: (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) and select Criteria A schools to provide funds 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 - 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) Support for Veteran Service Officers and the Veteran Service Specialist Program - This program will host, update and expand the Veteran Service Specialist (VSS) a program designed to encourage the use of evidence-based tools to support Veterans in North Carolina. (6) New Audience Acquisition and Community Engagement Through Targeted Communications - This pilot program will advocate and promote non-profits, organizations and campaigns across North Carolina that offer myriad services and supports aimed at engaging people with substance use disorders and mental health conditions and promoting resilience and long-term recovery. The program will also help distribute evidence-based tools to support Veterans in North Carolina and seek to expand the pool of Veterans, service members and their families who benefit from the wide array of support services available in the Tar Heel State. (7) Decreasing Youth Access to Tobacco and Advancing Statewide Tobacco Enforcement - The project objectives are to assess and reduce youth access to tobacco products by persons under the age of 21 in NC. (8) 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.

- **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. As of March 2020, there were 281 homes in North Carolina with more than 2176 beds, with a total of 17 homes that accommodate women with dependent children. 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 Community Mental Health and Substance Abuse Block Grants.
- **University of North Carolina, School of Social Work, Behavioral Health 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 training, with an emphasis on ASAM training; (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 Behavioral Health 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 Addictions team's Women's Services Coordinator.

- **Alcohol/Drug Council of North Carolina** – This contract provides for the operation of a 24/7/365 substance use disorder information and referral to treatment helpline to provide resources and referrals to individuals with substance misuse and disorders and their families, primarily provided by Peer Call Responders. 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. It also provides prevention advocacy and education for recovery advocates, stigma reduction training, as well as an annual conference for addiction professionals. This agency also houses the National Guard Project, whose mission is to strengthen the overall fitness and effectiveness of the NCNG workforce, to conserve manpower, and enhance the combat readiness of soldiers through the provision of assessments for Guard who have been identified with a potential SUD, as well as up to four (4) brief intervention sessions conducted by Licensed Clinical addiction Specialists.
- **UNC – General Administration** – The purpose of this contract is to continue the collegiate wellness and recovery projects at 13 university campuses, as part of the Crisis Solutions Initiative that 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.” These collegiate wellness and recovery programs focus on the issues related to substance use on college campuses by providing enhanced and expanded prevention, intervention, treatment and particularly recovery-oriented services to address the growing needs of students on college campuses. Each of the 13 schools submit plans to develop, continue, expand or enhance services and programs; four campuses have very recently been identified and are more in the development phase. Additionally, efforts will be focused on identifying two more historically black colleges and universities (HBCUs) interested in developing or enhancing their collegiate recovery programs in SFY22. Five of the 13 current schools are HBCUs. Schools currently funded through this contract include: (1) East Carolina University, (2) NC A&T, (3) UNC-Charlotte, (4) UNC-Chapel Hill, (5) UNC-Greensboro, (6) UNC-Wilmington, (7) NC Central University, (8) Appalachian State, (9) NC State University, (10) Fayetteville State University (11) Elizabeth City State University, (12) UNC-Pembroke, and (13) Winston-Salem State University.

- **Sunrise Community for Recovery and Wellness** - The purpose of this contract is to provide funding for a Recovery Community Organization and Center in Buncombe County to support individuals seeking to sustain recovery from substance use disorders. The Recovery Community Center is a “hub” for recovery resources and offers a safe space within the community for individuals to utilize for support. Other initiatives include provision of peer support specialists as recovery coaches training, recovery messaging and stigma reduction training and development/implementation of specialized Peer Support Ambassadors who have been trained in problem gambling . Additionally, funds will also support the continuation of one (1) recovery community center located within the Qualla Boundary of the Eastern Band of the Cherokee Indians, as well as further expansion of a minimum of three (3) recovery community centers located in the western region of the state, selected through a competitive process.
- **Recovery Communities of North Carolina** - The purpose of this contract in SFY22 is to provide funding for a Recovery Community Center in Wake County to support individuals seeking to sustain recovery from substance use disorders. The Recovery Community Center is a “hub” for recovery resources and offers a safe space within the community for individuals to utilize for support. Other initiatives include provision of peer support specialist trainings and recovery coach curricula, recovery messaging and stigma reduction training . Additionally, funds provided to RCNC will also support the continuation of four (4) additional recovery community centers located in Durham, Wilson, Orange and Craven counties.
- **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 contract addresses the training, technical assistance and education needs of the substance use disorder prevention and treatment professionals by providing training and professional development scholarships, expanding professional development opportunities with conferences and regional trainings and expanding opportunities to learn about substance use disorder policies.

This contract also provides a mechanism for providing support to treatment and recovery organizations who are grappling with decreased revenue, minimal staff, and required changes in operational capacities to address COVID-19 currently, and the impacts on addiction during and after the virus subsides.

This contract will provide supports to organizations through state system reforms, as we move through Medicaid transformation and whole person, integrated care.

This agency also employs a Director of Scholastic Recovery who oversees several collegiate initiatives including (1) Rapid Deployment of Support Across College Campuses; (2) Bridging Prevention and Recovery Training; (3) Recovery Program Training and Assistance for Collegiate Recovery Programs; (4) NC Collegiate Leadership Academies. This position works

directly with all 13 collegiate recovery programs and in collaboration with UNC which shares general oversight responsibilities.

This contract funds a Recovery Support Services (RSS) Outreach Coordinator for Western North Carolina, which focuses on 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.

Substance Abuse Prevention - This initiative under the APNC contract 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.

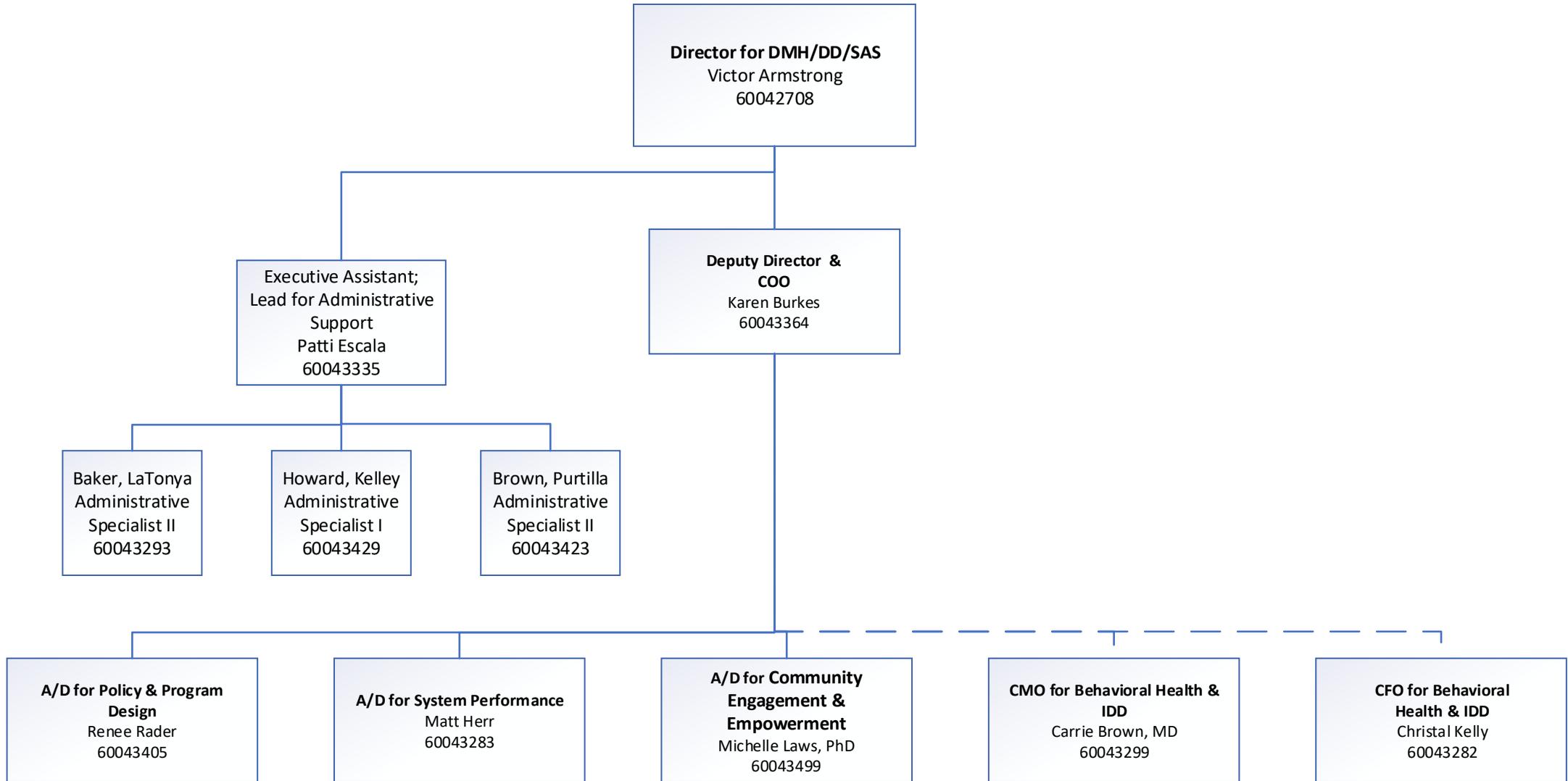
Health Policy/Funding Technical Assistance - The goal of this program is to provide substance use disorder treatment, prevention and recovery providers operations-level technical assistance in implementing emerging best practices in service delivery, business operations (including necessary changes related to Medicaid transformation), assurances of confidentiality and patient protections and new funding models that would assist in the long-term sustainability of their programs.

- **UNC-Chapel Hill, School of Medicine, 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

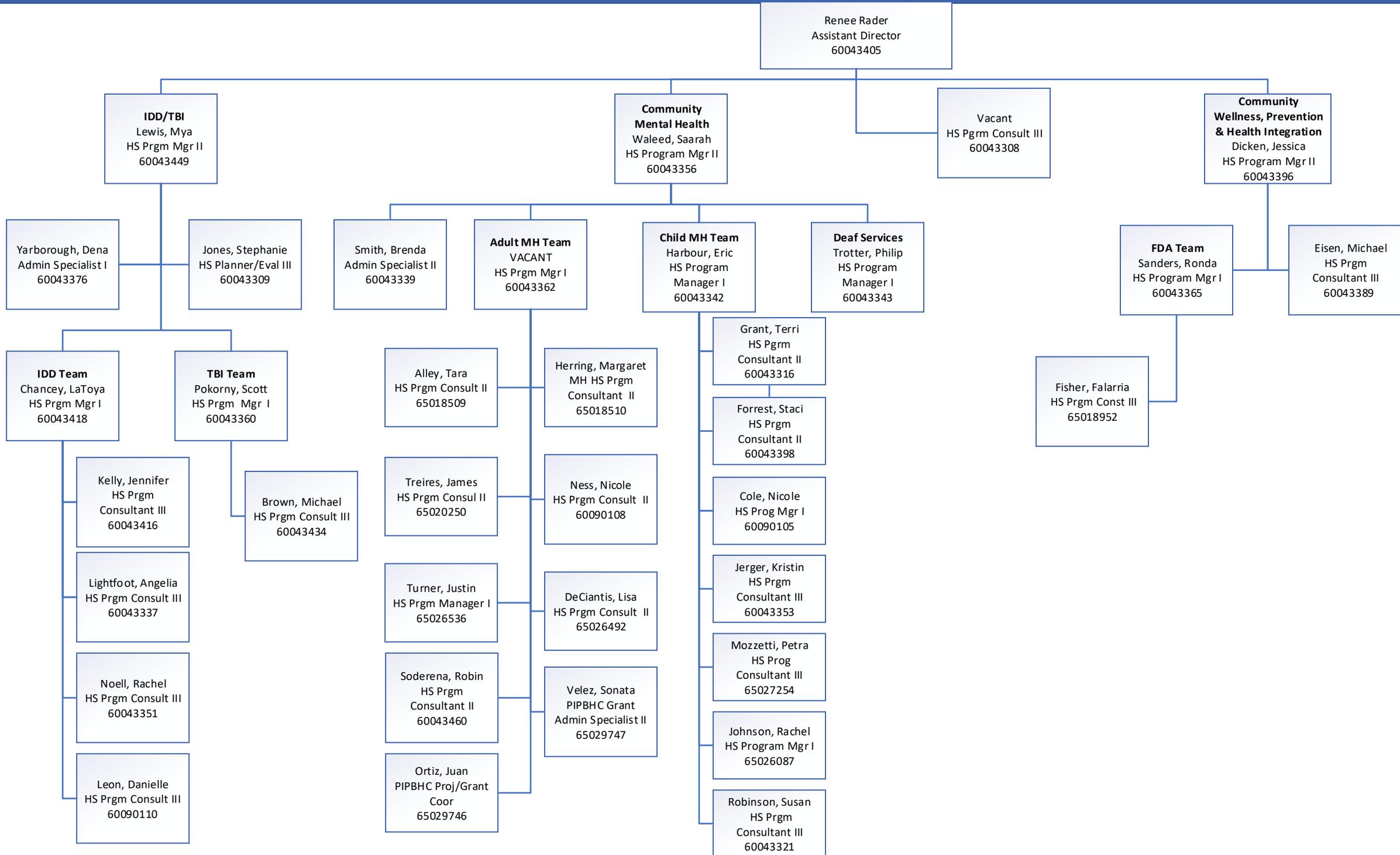
emphasis on prevention certification and additional support around retaining and recruiting prevention workforce has been an ongoing identified need.

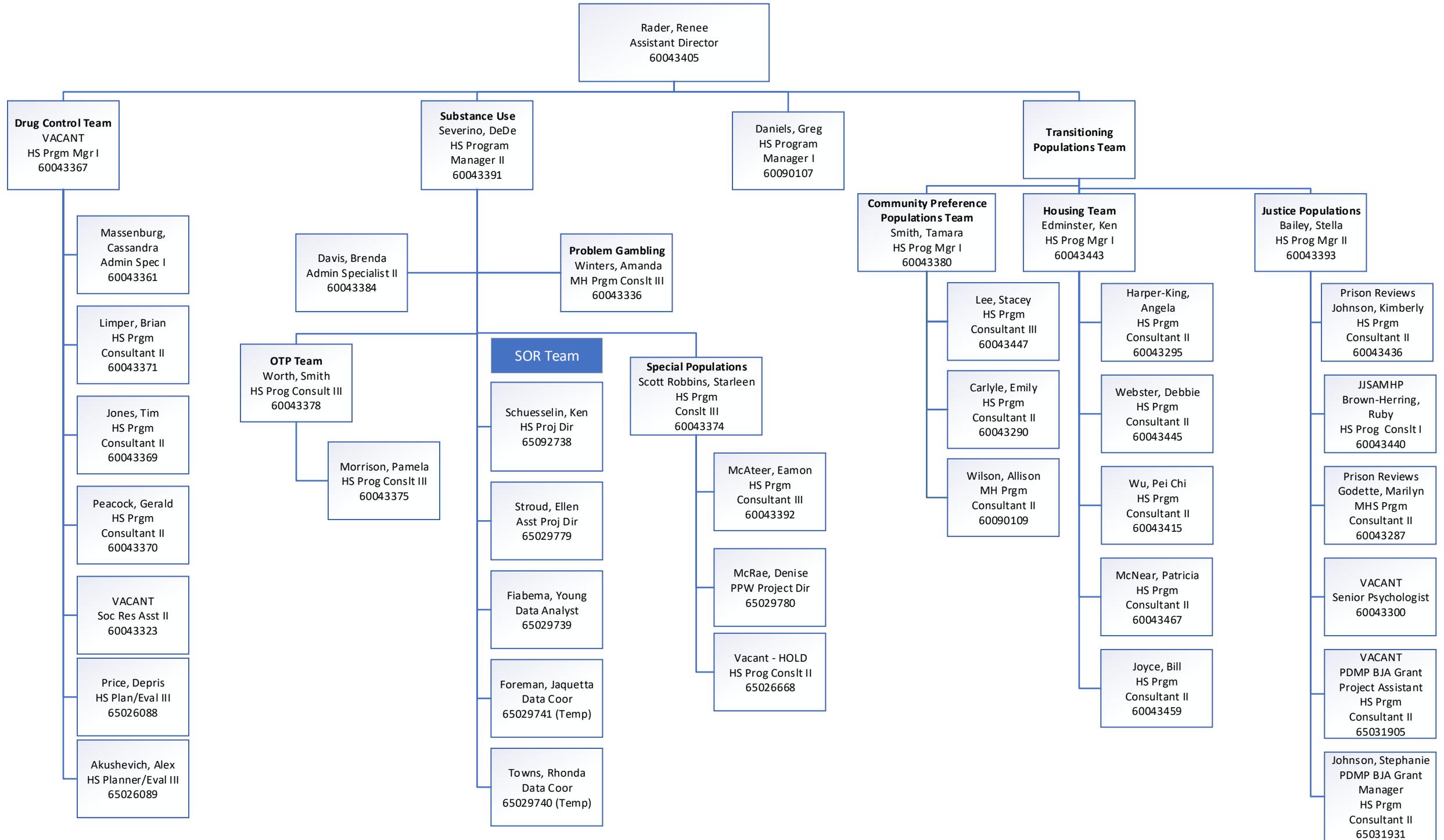
- **Community Impact NC** - This contract identifies and provides support to alcohol, tobacco and other drug prevention coalitions and connects with the existing training, technical assistance and evaluation contractors to provide support in starting and successfully maintaining coalitions with communities 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.

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
Organizational Chart as of February 11, 2021
Executive Leadership Team

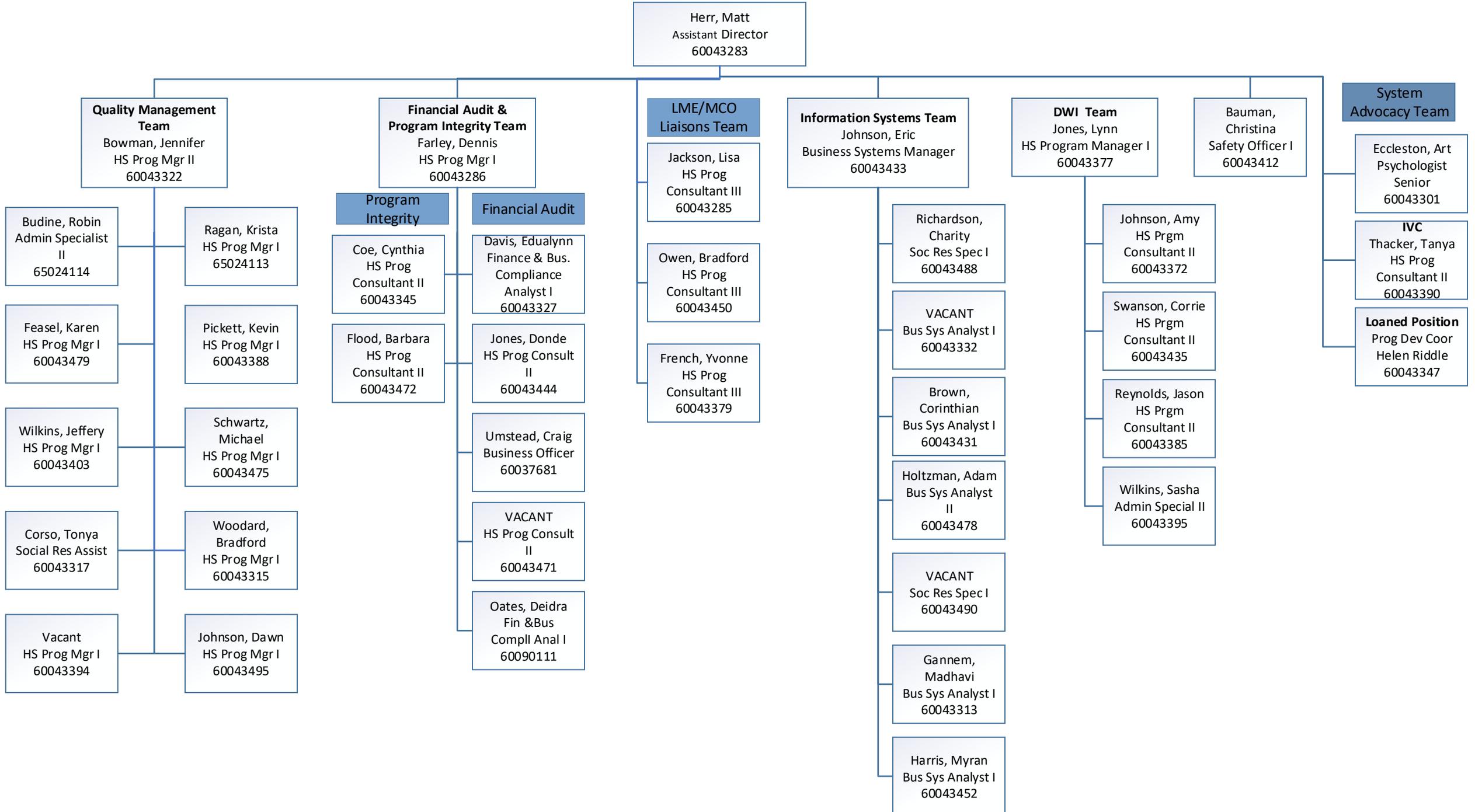


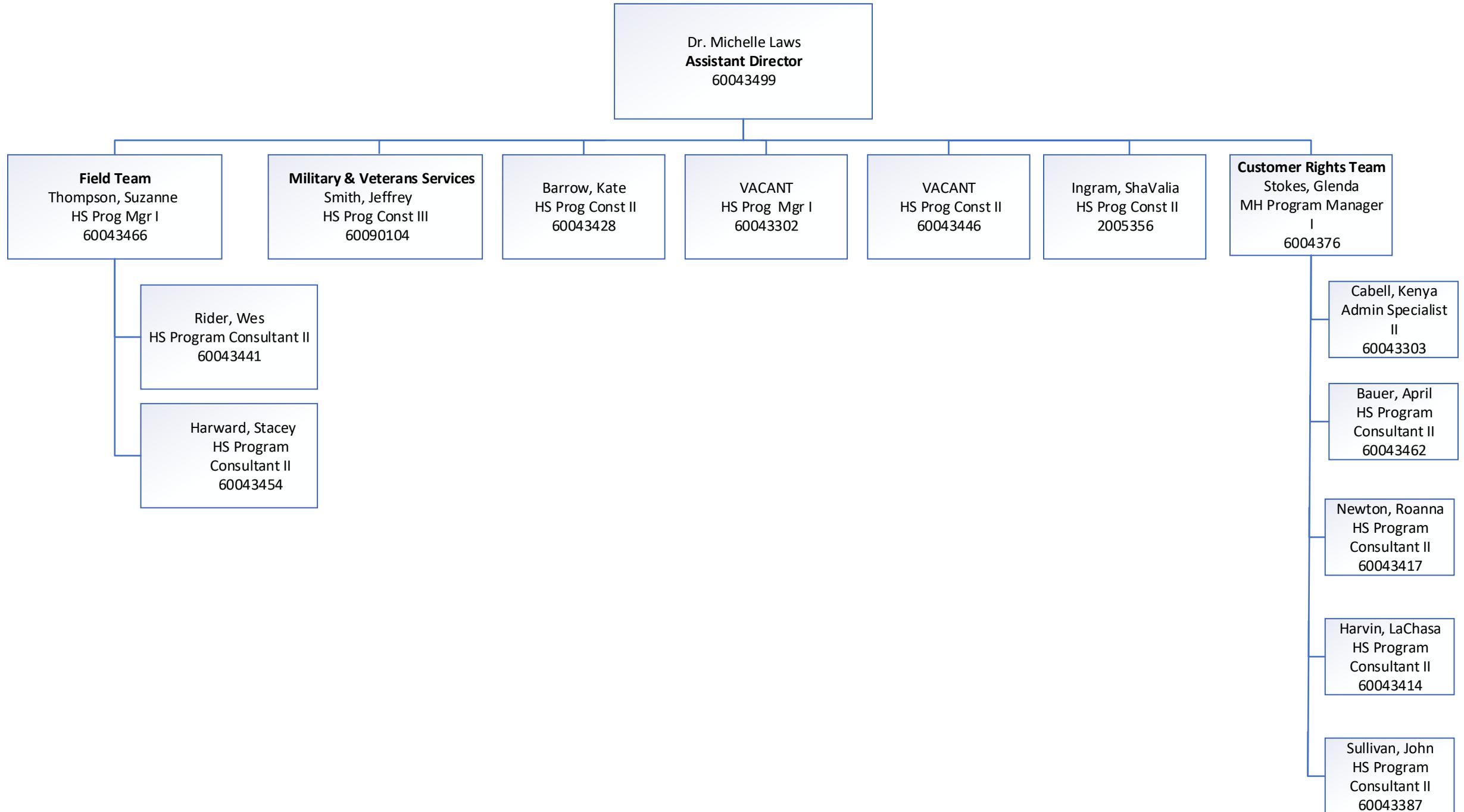
Policy and Program Design (page 1)



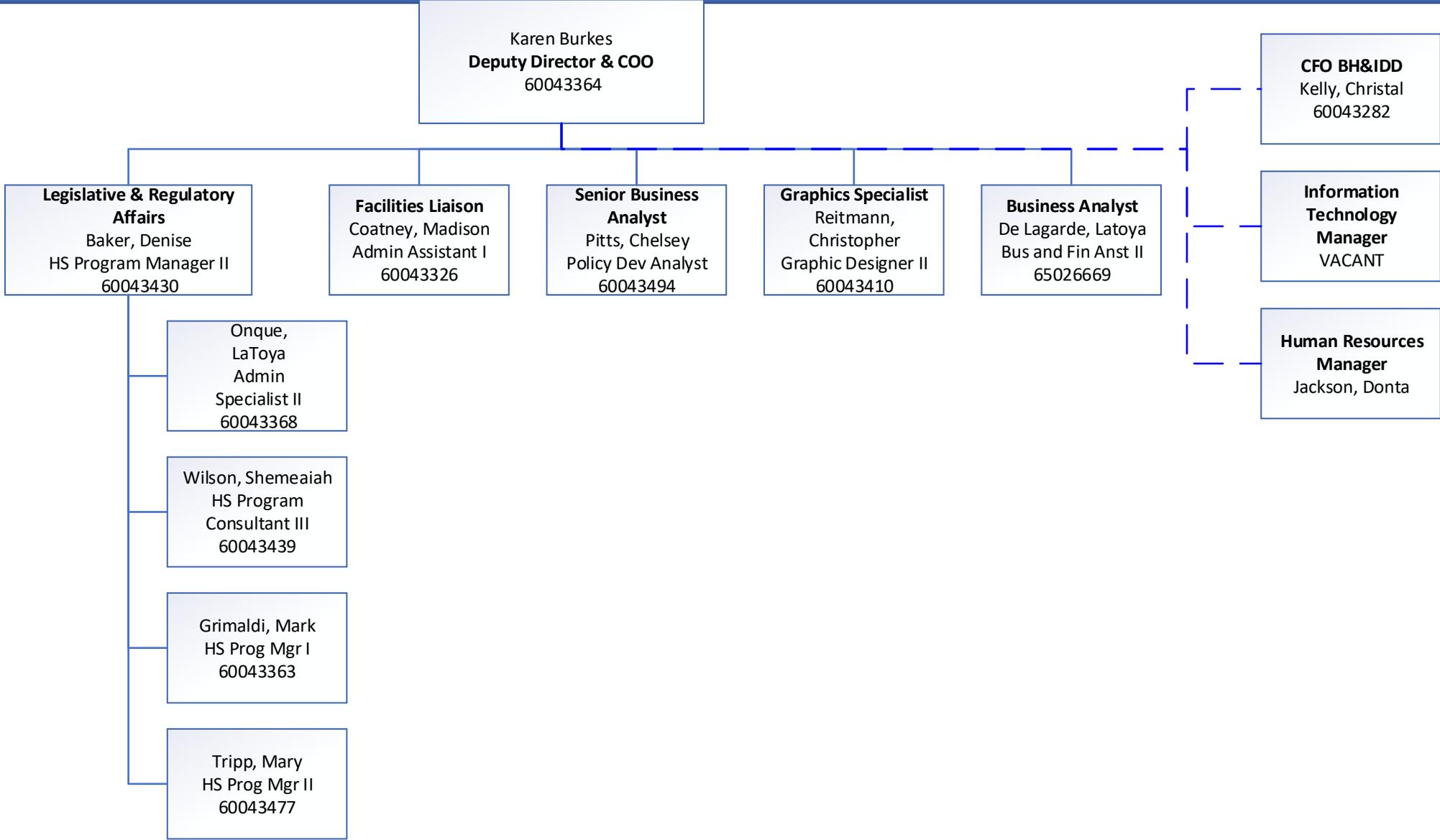


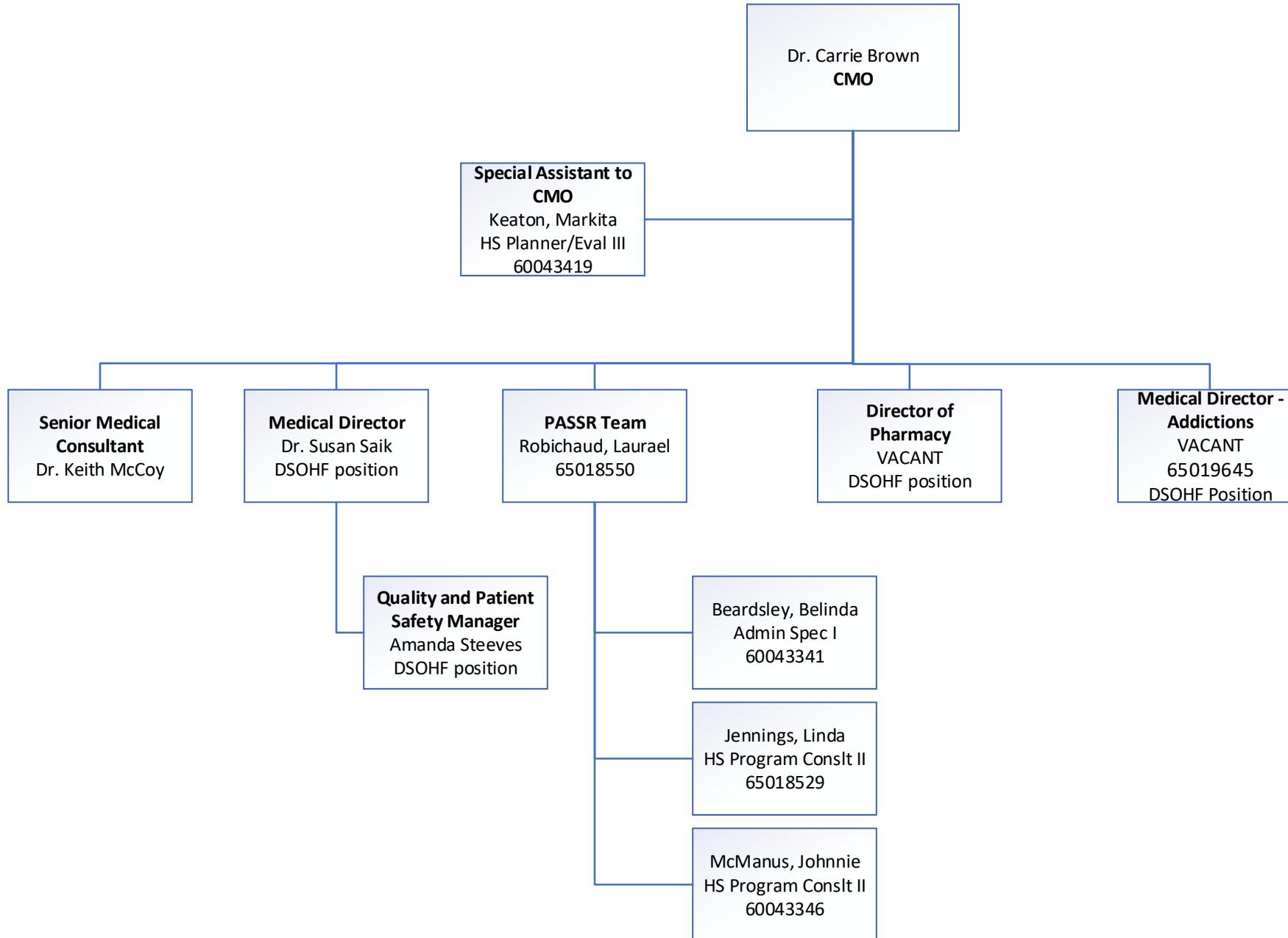
System Performance Team



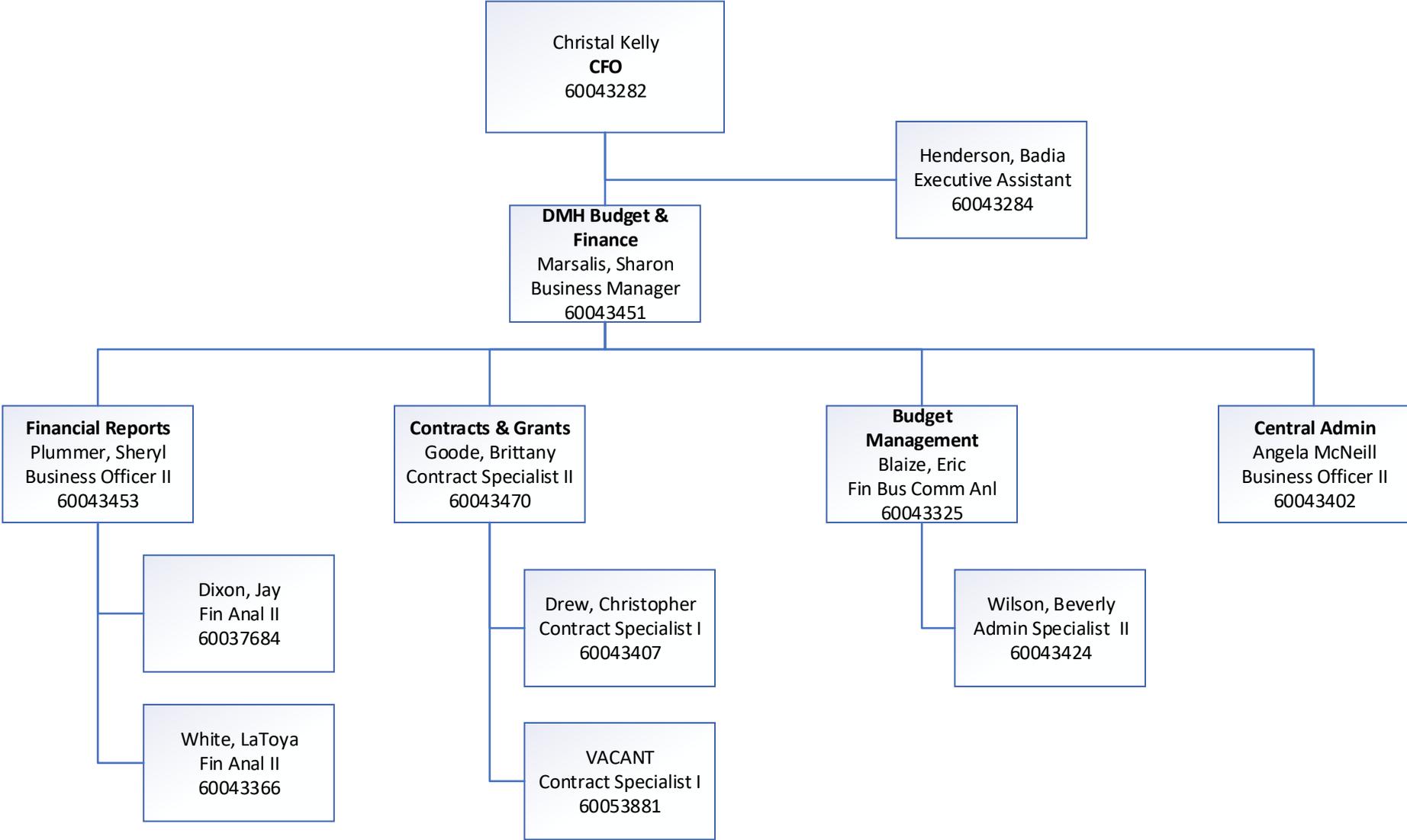


Office of the Chief Operating Officer

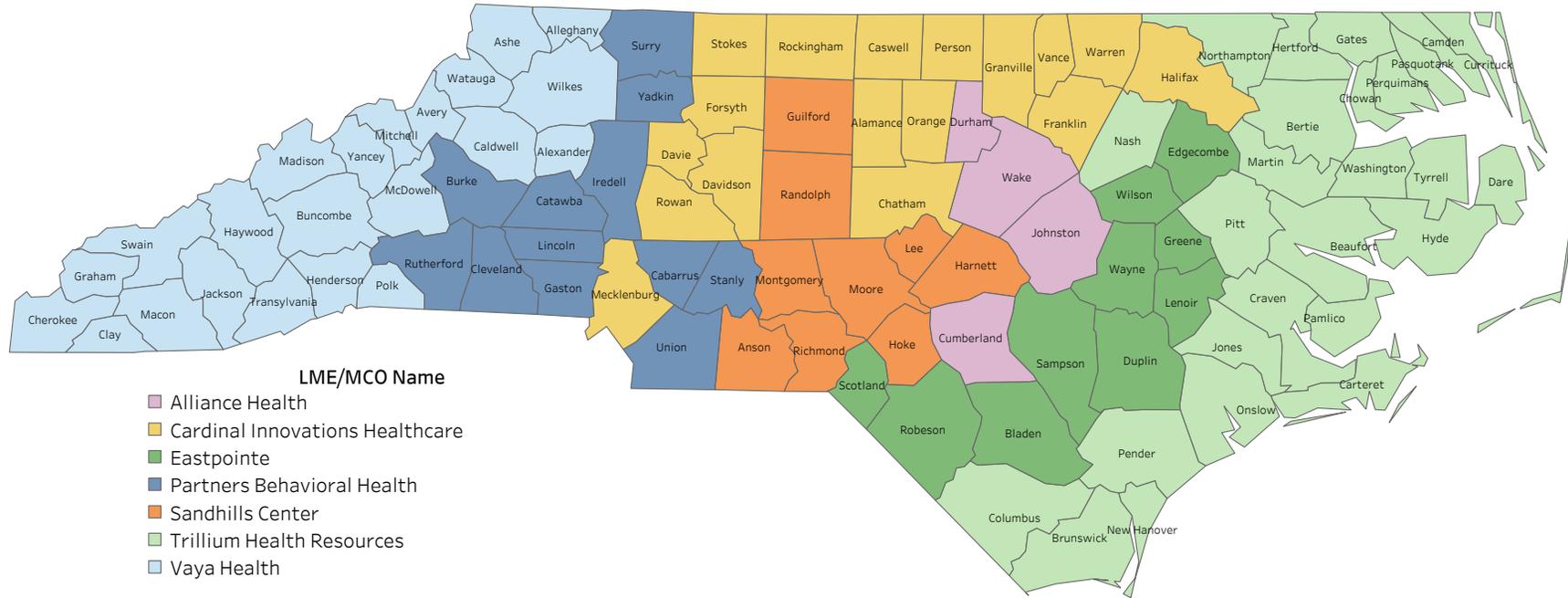




Office of the Chief Financial Officer



**Local Management Entity/Managed Care Organizations (LME/MCOs)
 NCDHHS Currently Has 7 LME/MCOs Operating Under the Medicaid 1915 b/c Waiver**



This map shows LME/MCO configuration as of 9/1/21.



North Carolina

Substance Use Disorder Implementation Plan Protocol

March 8, 2019

NC DHHS Division of Health Benefits

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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](https://files.nc.gov/ncdhhs/NC%20Opioid%20Action%20Plan%2008-22-2017.pdf), 2017-2021. Available at <https://files.nc.gov/ncdhhs/NC%20Opioid%20Action%20Plan%2008-22-2017.pdf>.

² North Carolina Opioid Overdose Factsheet, June 2017. Available at https://files.nc.gov/ncdhhs/Opioid_Overdose_Factsheet_FINAL_06_27_17.pdf.

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- **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

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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).

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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

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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

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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

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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

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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.

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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

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- 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. DHR 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

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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 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: 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.

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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 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

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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

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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

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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.

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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.

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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

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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

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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

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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.

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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>.

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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

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Summary of Actions Needed Across All Service Levels

Action	Implementation Timeline
Current Services⁴	
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	
<i>Standard and BH I/DD Tailored Plan Services</i>	
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
<i>BH I/DD Tailored Plan Services Only</i>	
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.

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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.

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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.

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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

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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.

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- 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>.

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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>.

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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

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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	

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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

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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:

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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).

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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

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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.

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- **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

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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 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.

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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](https://www.ncleg.net/gascripts/billlookup/billlookup.pl?Session=2017&BillID=H243).

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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).

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- **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.

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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.

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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.

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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.

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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.

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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.

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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.

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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

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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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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). <p>Timeline: September 2018 – April 2020</p>
2. Enhanced “ease of use” for prescribers and other state and federal stakeholders.	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Continue to approve additional prescribers and pharmacies for integration with the CSRS, as well continue its integration efforts with the HIE. <p>Timeframe: September 2018 - September 2019</p>

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	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	<ul style="list-style-type: none"> ▪ 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. 	<p>prescribing practices, and overdose rates in their area.</p> <ul style="list-style-type: none"> ▪ 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.	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Complete the interface with HealthConnex in September 2019. <p>Timeframe: September 2018 - September 2019</p>
4. Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns (see also “Use of PDMP” #6, below).	<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Continue to partner with Medical, Nursing and Pharmacy Boards to refine reports. ▪ Establish partnerships with additional state licensing boards. ▪ Deploy clinical alerts in

NC DHHS Division of Health Benefits

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ 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. 	<p style="text-align: center;">September 2019.</p> <p>Timeframe: September 2018 - September 2019</p>
Current and Future PDMP Query Capabilities			
<p>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).</p>	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ DMH/DD/SAS plans to continue its efforts to improve identity resolution among prescribers, patients and dispensers, including leveraging the HIE’s MPI capabilities. 	<ul style="list-style-type: none"> ▪ 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

NC DHHS Division of Health Benefits

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	<p>their prescriptions.</p> <ul style="list-style-type: none"> ▪ 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. 		<p>obtain permissions and consult with GDAC on defining the methodology for patient and prescriber entity resolution.</p> <ul style="list-style-type: none"> ▪ Begin discussions with the HIE Authority on additional strategies to coordinate NC HealthConnex and CSRS information. <p>Timeframe: September 2018 - September 2021</p>
Use of PDMP – Supporting Clinicians with Changing Office Workflows			
<p>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.</p>	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ All HCEs using EHRs and PMS will have CSRS data integrated into their workflows 	<ul style="list-style-type: none"> ▪ Continue to collaborate with vendor to integrate EHR/PMS and CSRS data and acquire additional licenses for pharmacies and prescribers. <p>Timeframe: November 2018 - December 2023 (Contingent upon available funds)</p>

NC DHHS Division of Health Benefits

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	<p>providers' abilities to query the report while a patient is in clinic without interrupting the clinician's workflow.</p> <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> The state will enhance educational resources available to users on effective NarxCare usage 	<ul style="list-style-type: none"> Extend NarxCare funding to continue availability of NarxCare analytics to CSRS users. <p>Timeline: September 2018 - December 2019</p>

NC DHHS Division of Health Benefits

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
	<ul style="list-style-type: none"> ▪ 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.	<ul style="list-style-type: none"> ▪ 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." 	<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ 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. <p>Timeframe: September 2018 - September 2021</p>
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	<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ 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

NC DHHS Division of Health Benefits

	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program Functionalities			
pay for opioids.		<p>data to the Department on a weekly basis.</p> <ul style="list-style-type: none"> ▪ 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. 	<p>information on prescribers who may be overprescribing opioids and patients who have or may be at risk of developing OUDs.</p> <p>Timeframe: September 2018 - July 2021</p>

NC DHHS Division of Health Benefits

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

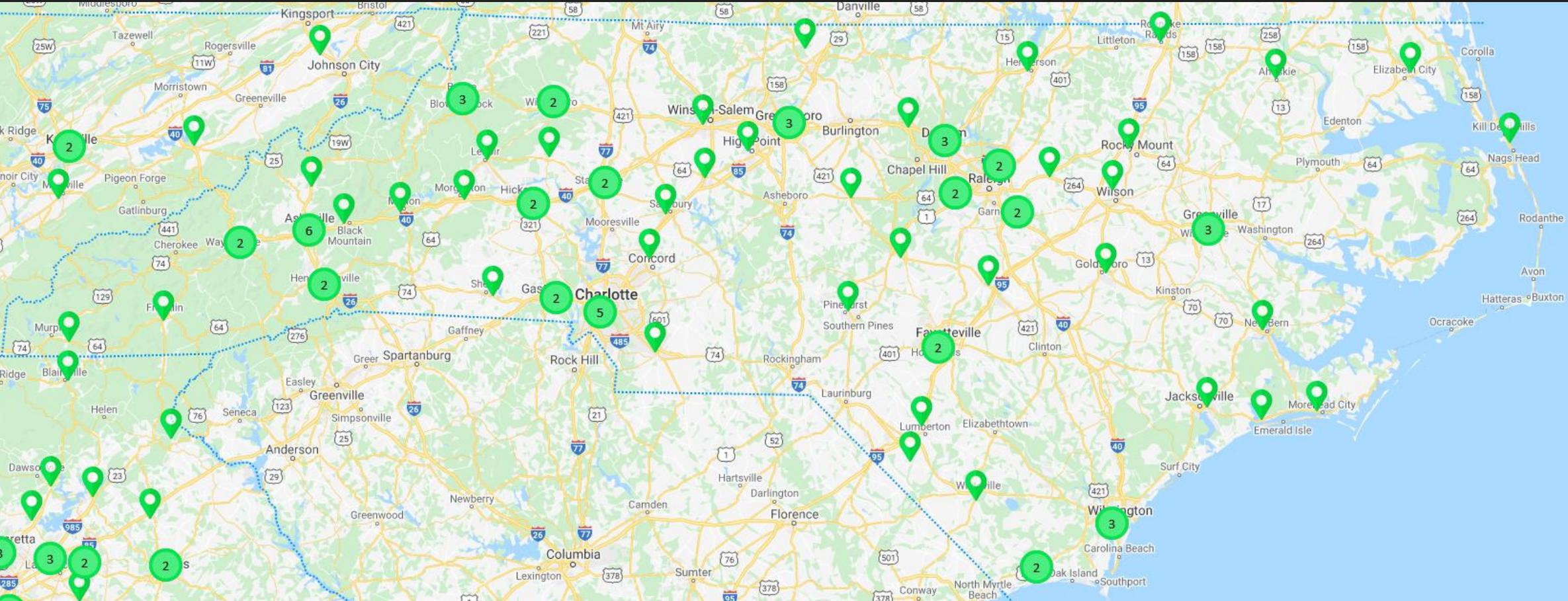
Telephone Number: 919-715-2027

Email Address: Katherine.Nichols@dhhs.nc.gov

Attachment A, Section III—Relevant Documents

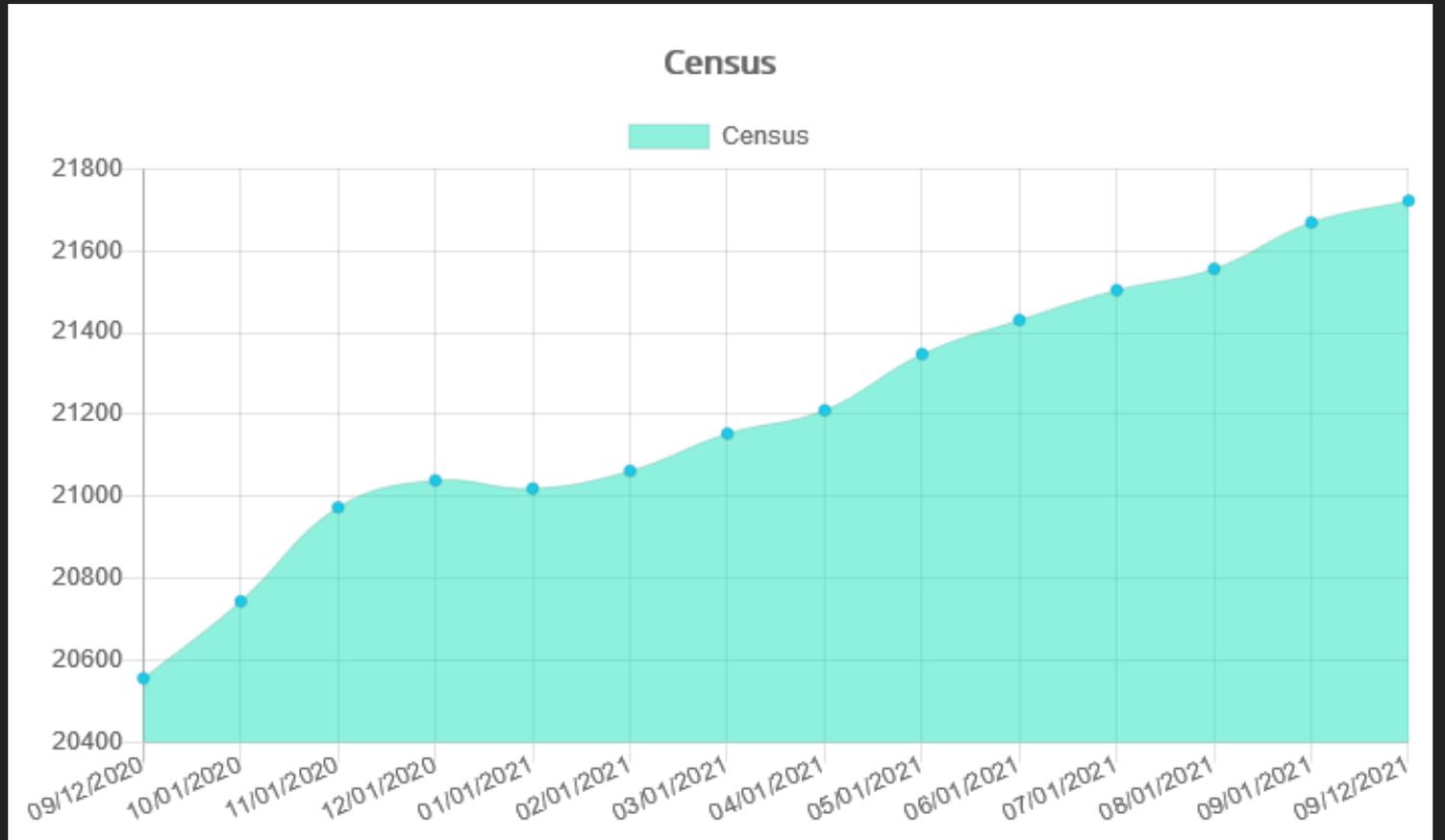
Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

OTP Programs in NC



OTP Programs in NC

- 86 OTP Programs across the state
- 3 are North Carolina state operated inpatient Alcohol and Drug Abuse Treatment Centers (ADATC)
- 21,642 patients currently enrolled



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?

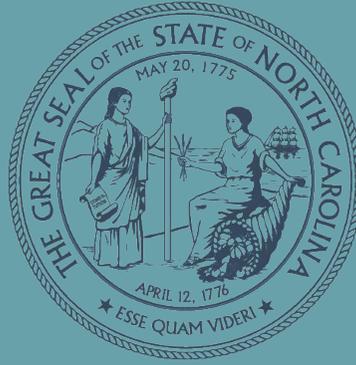
(Although the first four symptoms above are common among individuals with active TB, they are nonspecific and are also consistent with other diagnoses, including bacterial pneumonia, acute bronchitis, cancer of the lung, HIV-related lung disease and others. Other symptoms include lumps or swollen glands 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).



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%**

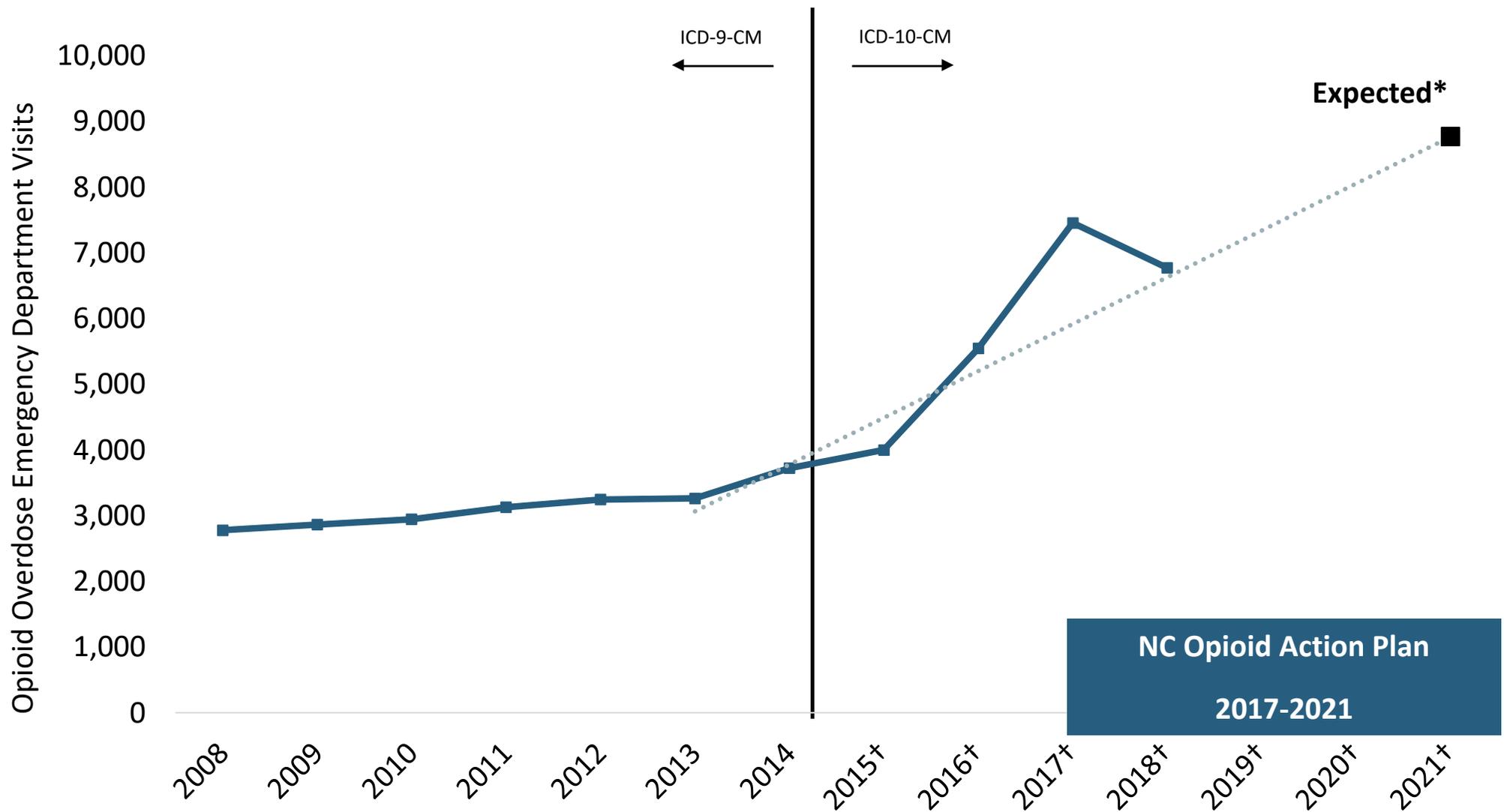


Buprenorphine dispensing has **increased 15%**



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

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 ...

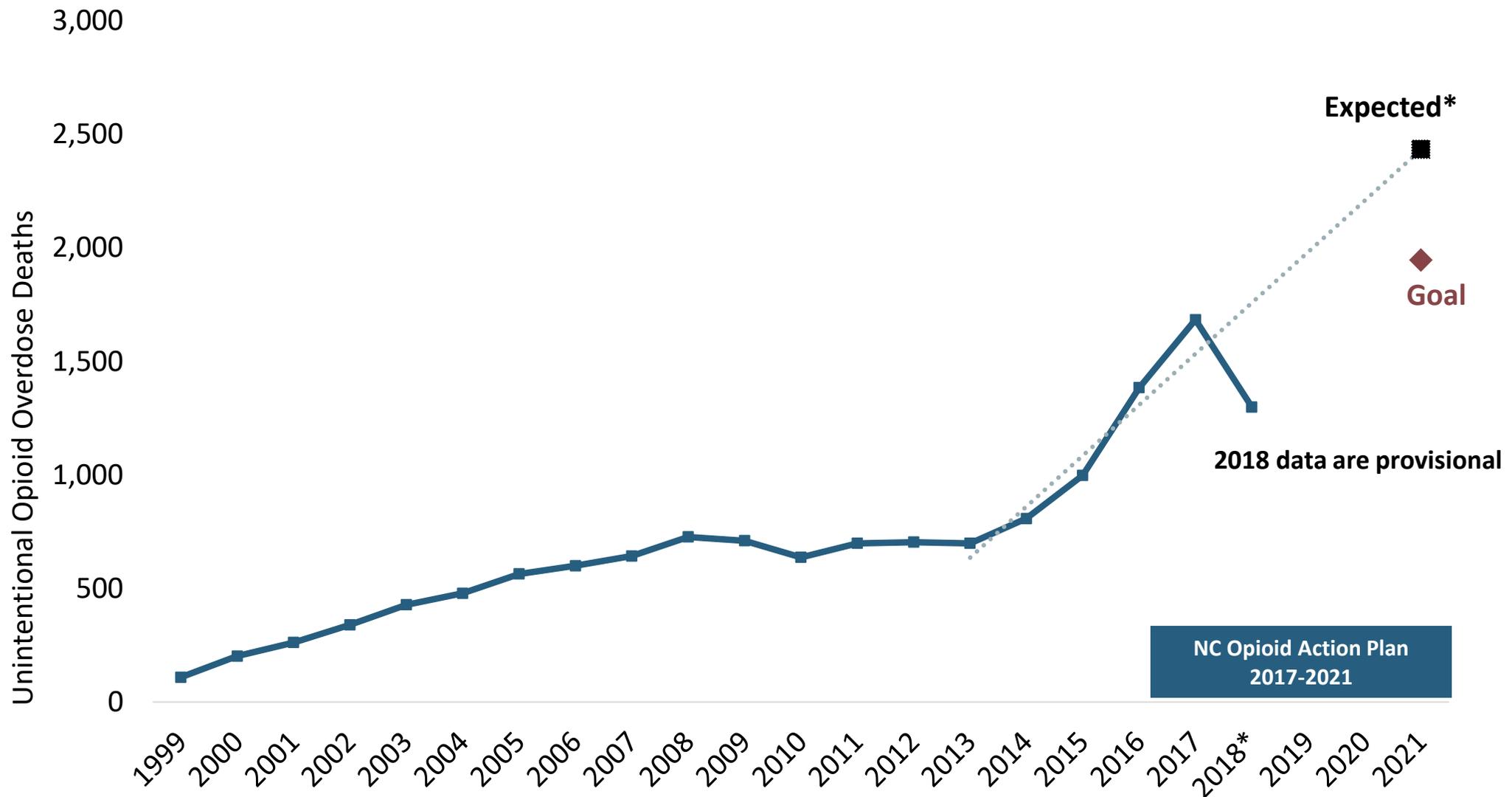


NORTH CAROLINA'S OPIOID ACTION PLAN

Updates and Opportunities

Version 2.0

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

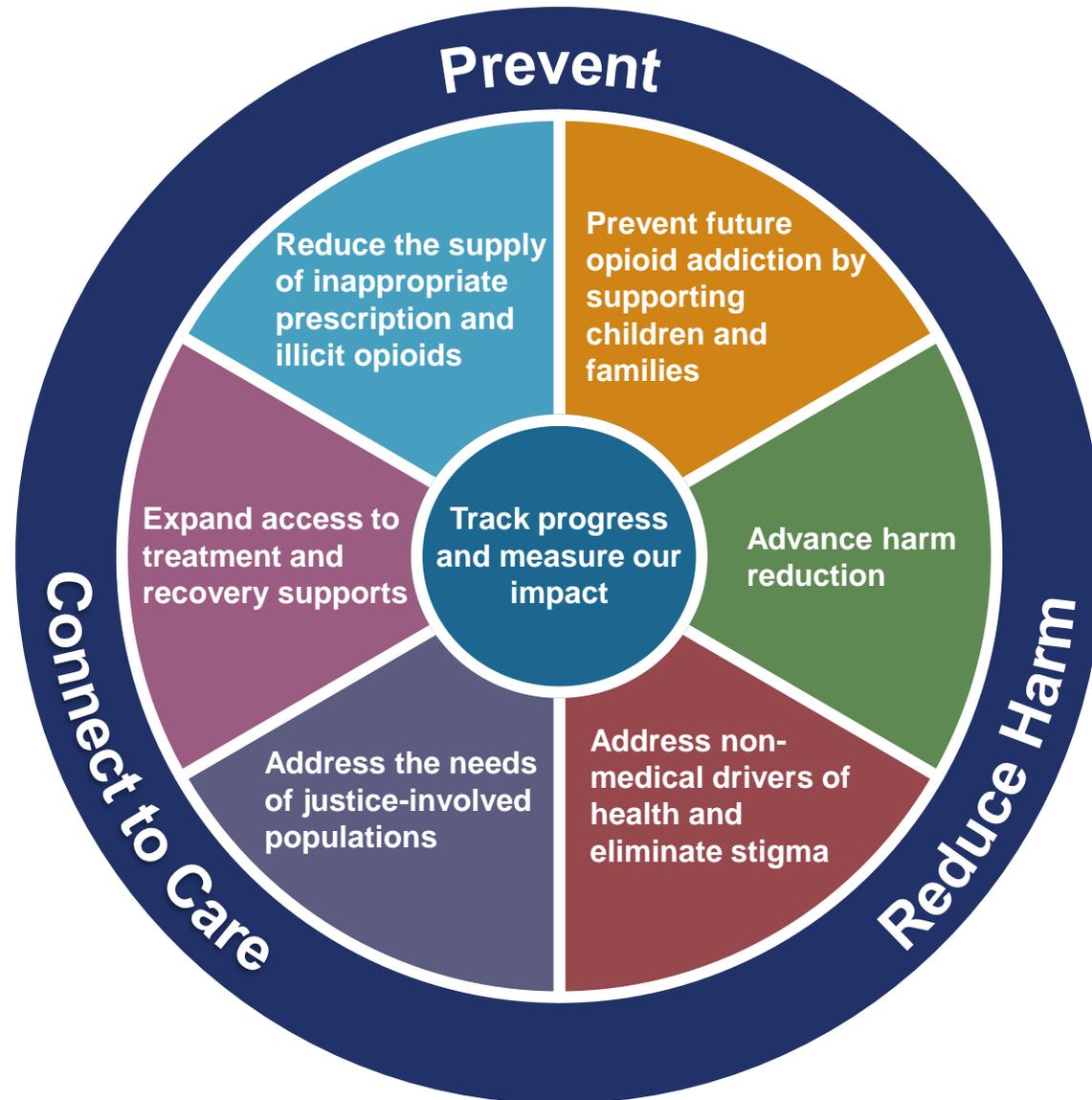


*Data are preliminary and subject to change

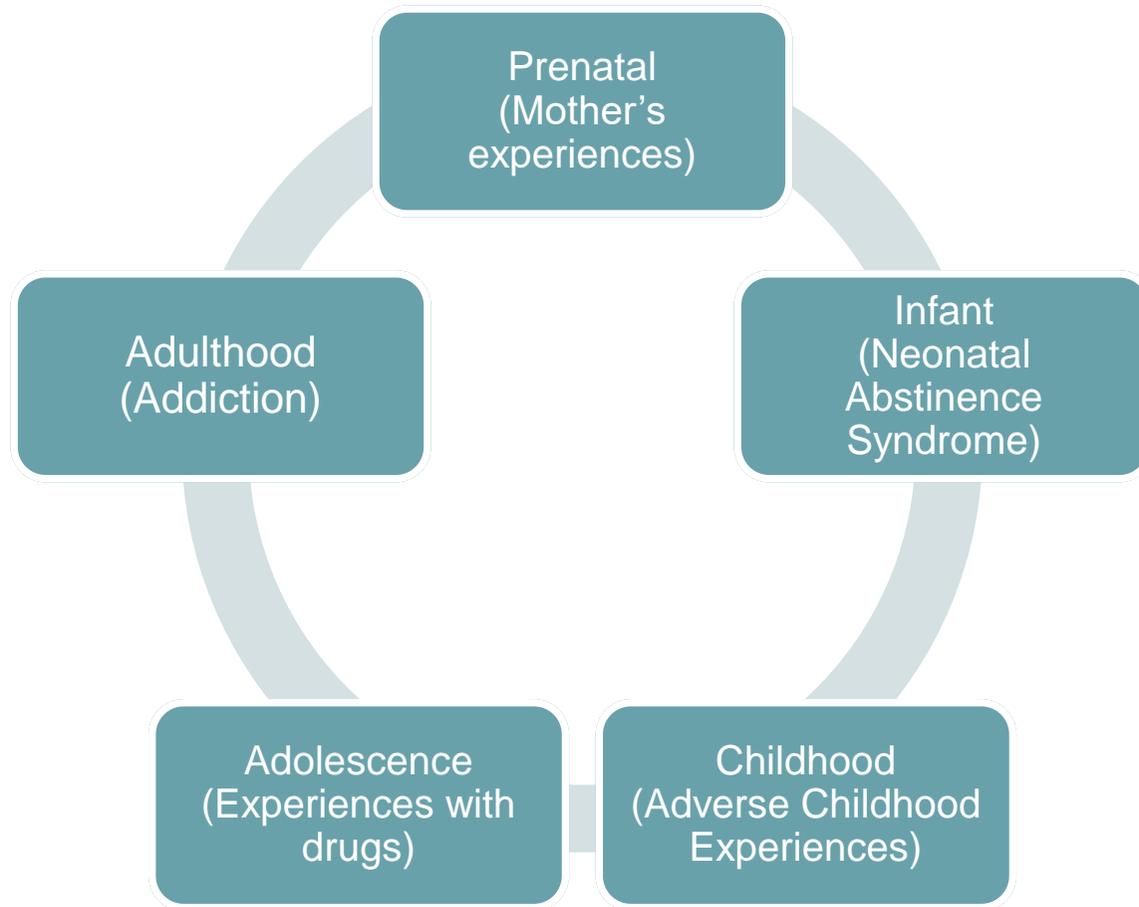
Source: NC State Center for Health Statistics, Vital Statistics-Deaths, ICD10 coded data, includes NC Resident deaths occurring out of state, 1999-2018 Q2

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



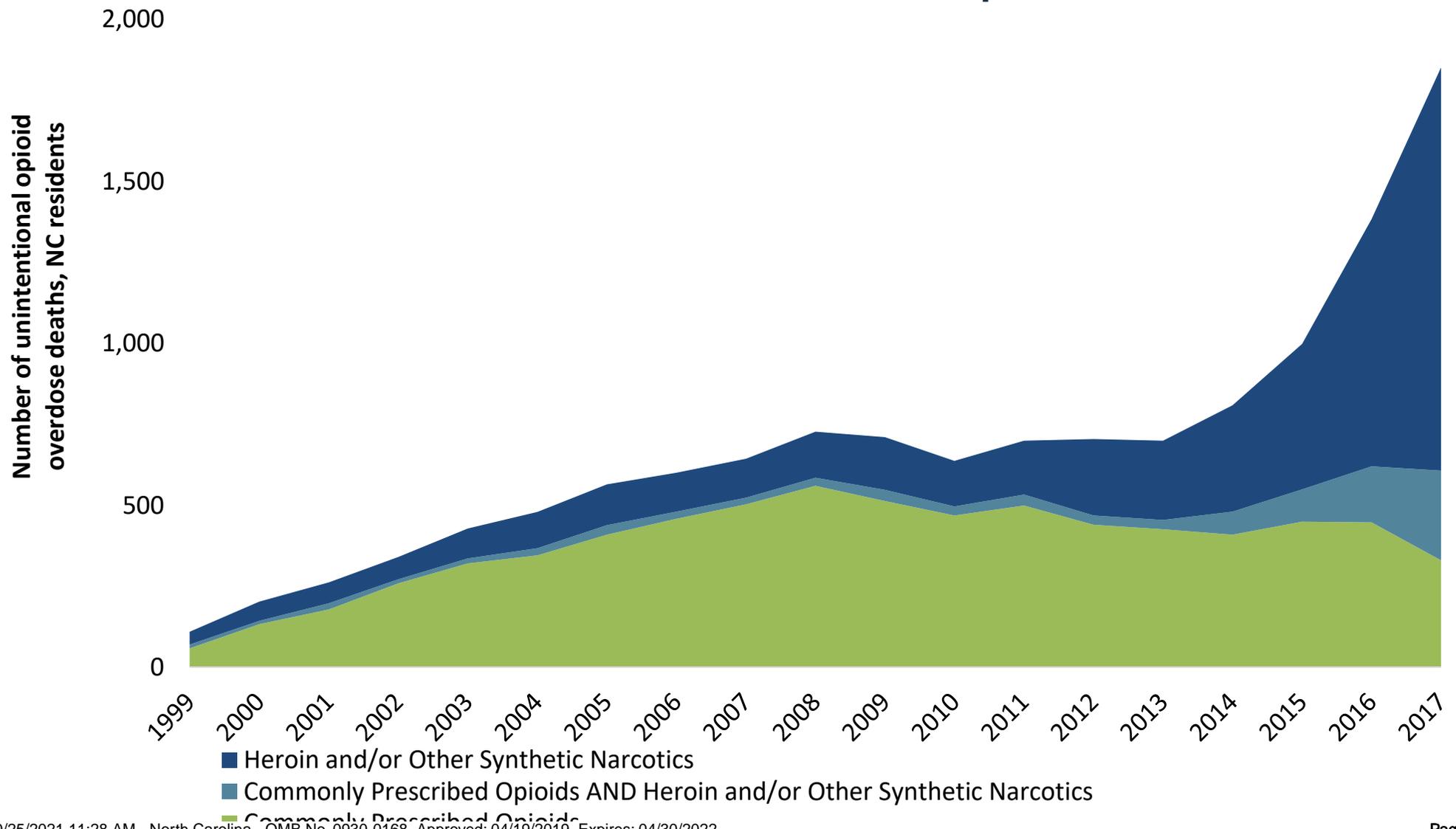
The epidemic is part of an intergenerational cycle of trauma and harm.

Prevent: Plan Priorities

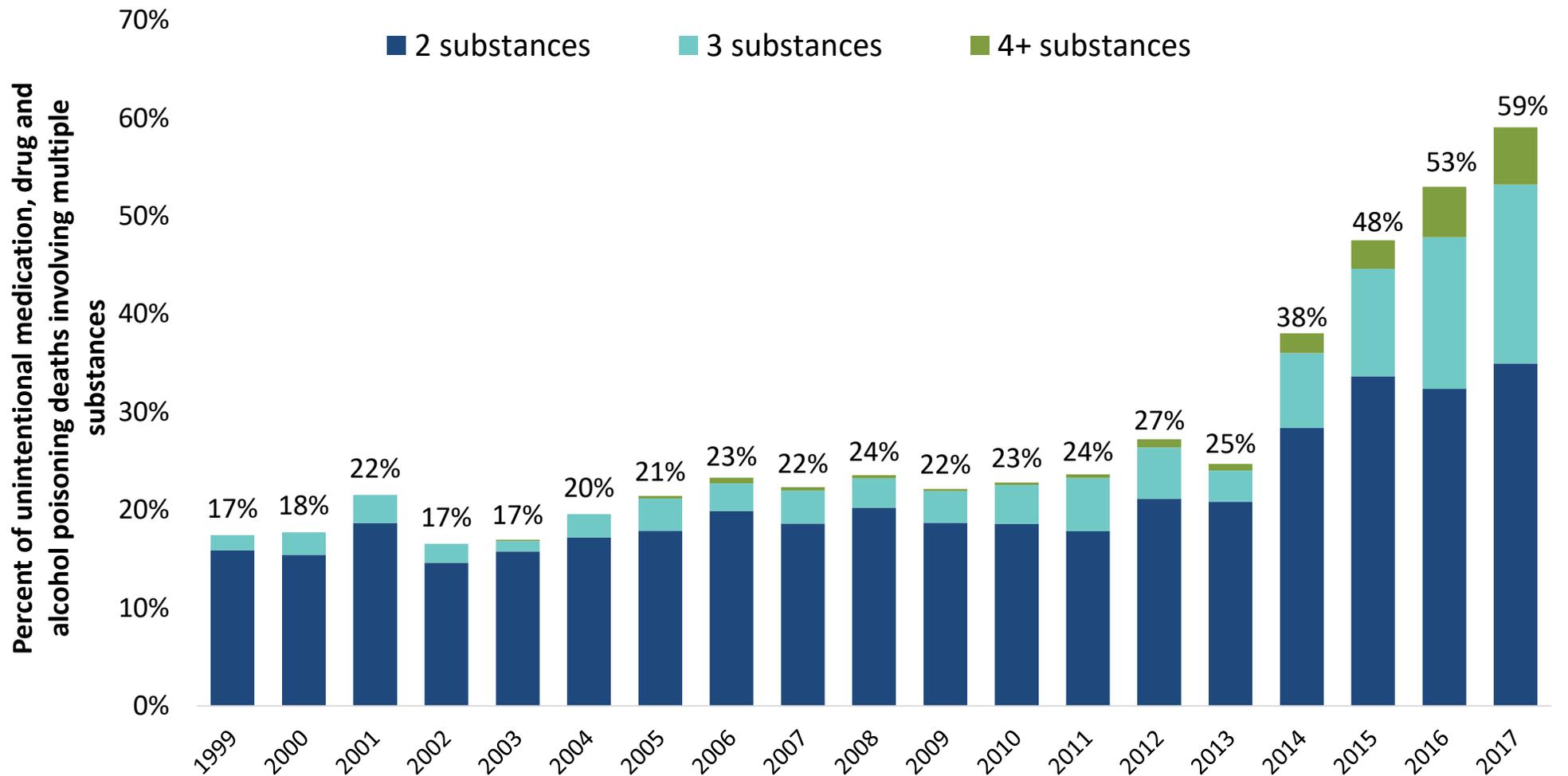
- Increase judicious opioid prescribing and the use of **non-opioid pain treatments**.
- Prevent youth misuse by **addressing the upstream causes** of substance use disorders, including trauma and adverse childhood experiences (ACEs).

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	58,014,500	52,137,500	43,348,100
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.

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 of care 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 of care.

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, SUD prevention, and SUD treatment goals at the state level.

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

Footnotes:

SABG Assessment and Plan 2022 - 2023

Step 2: Identify the unmet service needs and critical gaps within the current system

Populations and Prevalence

With a population estimate of 10,439,388 residents in 2020, North Carolina has the ninth largest population among 50 states, ranking 16th in population change between 2010-2020 (*US Census Bureau, <https://www.census.gov/library/stories/2021/08/more-than-half-of-united-states-counties-were-smaller-in-2020-than-in-2010.html>*).

Currently, an estimated 10,658,717 people reside in North Carolina. Adults ages 18 and older make up a little more than 78.4% (8,359,026) of the total population. Youth ages 12-17 make up almost 7.8% (825,898) of the total population. (*Population Source: NC Office of State Budget and Management (NC OSBM), State Demographer's Office, July 2021 population estimates, <https://www.osbm.nc.gov/demog/county-projections>.*)

Based on prevalence estimates for persons in North Carolina with a substance use disorder, 611,769 adults (7.26%) and 32,293 youth ages 12-17 (3.91%) are in need of services for a substance use disorder. (*Prevalence Source: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2018 and 2019, published 12/15/20, Table 23, Substance Use Disorder in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2018 and 2019 NSDUHs, <https://www.samhsa.gov/data/report/2018-2019-nsduh-state-prevalence-estimates>*).

The table below illustrates the number of North Carolina residents in need of SUD services by age range, with prevalence percentages from the National Surveys on Drug Use and Health, 2018 and 2019, published 12/15/20.

July 2021 Population Estimates				Persons in Need of SUD Services				
Ages 12-17	Ages 18-25	Ages +26	Total (Ages 12+)	Ages 12-17 Prevalence = 3.91%	Ages 18-25 Prevalence = 13.68%	Ages 26+ Prevalence = 6.26%	Total Estimated Adults (18+) with SUD	Total Estimated Persons (12+) with SUD
825,898	1,192,647	7,166,379	9,184,924	32,293	163,154	448,615	611,769	644,062

NC Substance Use Disorder Prevalence Rates Source: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2018 and 2019, published 12/15/20, Downloaded 1/5/21. Table 23, Substance Use Disorder in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2018 and 2019 NSDUHs. Prevalence rate in NC for adolescents (ages 12-17) is 3.91%. Prevalence for adults (ages 18-25) is 13.68% and for adults (ages 26+) is 6.26%. Total (age

12+) = 6.95%, Total (age 18+) = 7.26%. 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/report/2018-2019-nsduh-state-prevalence-estimates>).

US Substance Use Disorder Prevalence Rates Source: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2019, published Aug 2020, Downloaded 9/25/20. Table 5.8B, SUD in Past Year among Persons Aged 12 or Older, by Age Group and Geographic and Socioeconomic Characteristics: Percentages 2018 and 2019. Prevalence rate in the US in 2019 for adolescents (ages 12-17) is 4.5%, 5.0% for those with Medicaid/CHIP, and 5.0% for those with no health insurance. Prevalence rates for adults (ages 18-25) is 14.1%, 12.4% for those with Medicaid/CHIP, and 12.5% for those with no health insurance. Prevalence rates for adults (ages 26+) is 6.7%, 10.0% for those with Medicaid, and 11.3% for those with no health insurance. Prevalence rates for all adults (ages 18+) is 7.7%, 10.5% for those with Medicaid/CHIP, and 11.6% for those with no health insurance. Prevalence rates for persons (ages 12+) is 7.4%, 9.3% for those with Medicaid/CHIP, and 11.3% for those with no health insurance.

Population Data: NC Office of State Budget and Management (OSBM). July 2021 population estimates. Last updated: 2/15/21. Downloaded: 4/7/21

(<https://www.osbm.nc.gov/demog/county-projections>).

According to the National Survey on Drug Use and Health (NSDUH), 2019, for persons in the US:

- The prevalence of a substance use disorder in the past year for those with annual incomes less than 100% of the federal poverty level was 9.8% for individuals aged 18+ and 9.1% for individuals aged 12+.
- The prevalence of a substance use disorder in the past year for those with annual incomes between 100 and 199% of federal poverty level was 7.8% for individuals aged 18+ and 7.5% for individuals aged 12+.
- The prevalence of a substance use disorder in the past year for those with annual incomes of 200% or more of federal poverty level was 7.2% for individuals aged 18+ and 7.0% for individuals aged 12+.
- The prevalence of a substance use disorder in the past year for persons aged 18+ with no health insurance was 11.6% compared to 7.7% for persons aged 18+ in the total population.
- The prevalence of a substance use disorder in the past year for persons aged 12+ with no health insurance was 11.3% compared to 7.4% for persons aged 12+ in the total population.

The NSDUH does not provide prevalence data by poverty level and health insurance status at the state level. Therefore this information was not available for persons in NC.

(Prevalence Source: Results from the 2019 National Survey on Drug Use and Health: Detailed Tables, August 2020, Table 5.8B Substance Use Disorder in Past Year among Persons Aged 12 or Older, by Age Group and Geographic and Socioeconomic Characteristics: Percentages, 2018 and 2019, <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>).

North Carolina is not a Medicaid expansion state. An estimated 13.4% (1,159,091) of non-elderly persons (under age 65) are uninsured based on applying uninsured rates for North Carolina from the Model-based Small Area Health Insurance Estimates (SAHIE) for Counties and States, 2019, to July 2021 NC OSBM population estimates for persons under age 65. Of this number of persons, 987,850 are aged 12-64, the age group for which prevalence estimates are available. Applying the 11.3% US prevalence rate for persons with a substance use disorder in the past year for persons aged 12+ with no health insurance to the number of uninsured ages 12-64 indicates **there may be 111,627 uninsured persons in North Carolina in this age group who are in need of services for a substance use disorder. According to data compiled from SFY2020 LME/MCO quarterly performance measures reports, 45,677 individuals received at least one state-funded service for a substance use disorder. This is a 40.9% penetration rate.**

(Uninsured Source: Model-based Small Area Health Insurance Estimates (SAHIE) for Counties and States 2019, produced by the U.S. Census Bureau/Small Area Health Insurance (SAHIE) Program, Internet Release Date: 5/19/21, <https://www.census.gov/data/datasets/time-series/demo/sahie/estimates-acs.html>.

Population Source: NC Office of State Budget and Management (OSBM), July 2021 population estimates, last updated: 2/15/21, <https://www.osbm.nc.gov/demog/county-projections>.

Prevalence Source: Results from the 2019 National Survey on Drug Use and Health: Detailed Tables, August 2020, Table 5.8B Substance Use Disorder in Past Year among Persons Aged 12 or Older, by Age Group and Geographic and Socioeconomic Characteristics: Percentages, 2018 and 2019, <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>.

Persons Served Source: LME/MCO Quarterly Performance Measures: Performance Report Fourth Quarter SFY 2019-2020, prepared by the Quality Management Team, NC DHHS, Division of MH/DD/SAS, Revised June 10, 2021).

Older Populations

The NC Office of State Budget and Management (NC OSBM) estimates that nearly 25 percent of North Carolina's population will be over age 60 by the year 2030, an increase of 60 percent from 2012. Of the state's residents, 36.6 percent are now 50 or older, 23.5 percent are 60 or older, 11.7 percent are 70 or older, and 3.8 percent are 80 or older. The proportion of North Carolina's population that is 60 and older is growing more rapidly than other components of the population. By 2031 NC OSBM projects there will be more older adults (ages 65 and older) than there will be children (under age 18). (<https://www.osbm.nc.gov/demog/county-projections>). This is significant because while overall SUD treatment admissions remained relatively flat, the proportion attributable to older adults, including African Americans and women, increased from 3.4% to 7.0% during the period from 2002 through 2012 nationally. Additionally the proportion of admissions for alcohol use showed a downward trend, with upticks in admissions for cocaine, cannabis, heroin, non-

prescription methadone and other opiates. The proportion of admissions with prior history of substance abuse treatment increased from 39% to 46%, although there have been more recent reports that found that compared to younger adults, the proportion of older adults seeking treatment for illicit drugs abuse for the first time is on the rise.

(<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5568321/>). This information, coupled with the fact that North Carolina's aging population continues to increase, requires continued monitoring by the SSA to assure services are accessible and appropriate to meet the needs of the older population. Other strategies may be necessary to encourage older populations to seek services, such as stigma campaigns, transportation accommodations, integrated care, specialized workforce training on comorbidities specific to older populations, etc.

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.

The number of acute HBV cases diagnosed in North Carolina in 2019 was 185, a rate of 1.8 cases per 100,000 population, a decrease from 227 cases in 2017 (2.1 per 100,000). The highest rates of acute HBV occurred among the 30 to 54-year-old age group. This age group comprised 60% of the total acute HBV cases. In 2018, acute HBV diagnoses among White/Caucasian men and women comprised 75% of the total acute HBV, at rates of 2.6 and 1.6 per 100,000, respectively. In 2019, the exposure most frequently reported by people with acute hepatitis B was heterosexual contact (49%), followed

by injection drug use (IDU) (25%). Exposure is based on self-reported data. People may report more than one risk, and the source of exposure is difficult to determine for many cases. These data likely reflect under-reporting of higher risk exposures, such as IDU.

The number of acute HCV cases diagnosed in North Carolina in 2019 was 184 at a rate of 1.8 cases per 100,000 population, which is slightly lower than the 197 cases diagnosed and reported in 2018. The highest rates of newly diagnosed acute HCV occurred among the 25 to 39-year-old age group. This age group comprised 57% of the total acute HCV cases. In 2019, American Indian/Alaska Native men and women had the highest acute hepatitis C rates (6.7 and 6.2 per 100,000 respectively), but only made up 4.3% of the acute hepatitis C cases. The majority of cases (82.6%) were white/Caucasian men and women, with rates of 2.3 and 2.3 per 100,000, respectively. In 2019, the most frequently reported risk factor by people with acute hepatitis C was injection drug use (IDU) (46.7%), followed by sexual contact (14.7%). As stated above, exposure is based on self-reported data. People may report more than one risk, and the source of exposure is difficult to determine for many cases. These data likely reflect under-reporting of higher risk exposures, such as IDU.

Hepatitis A outbreaks are expanding nationwide. North Carolina is entering into its third year responding to an outbreak of hepatitis A. While cases had plateaued prior to the COVID-19 state of emergency, NC has observed a marked increase in cases reported during 2020 and 2021. To date, North Carolina has observed 667 outbreak-related cases (beginning April 1, 2018) characterized with high hospitalization rates (63.1%), high comorbidity prevalence (48.0% hepatitis C, 13.0% hepatitis B, 2.2% HIV), and elevated mortality rates (1.5%). An increase in the number of cases in the Western North Carolina and Triad regions has been observed since June 2020. The majority of cases reported in this outbreak are among people who use drugs (PWUD) and persons experiencing homelessness.

Hepatitis A outbreaks have continued to expand nationwide; the Centers for Disease Control and Prevention (CDC) has received reports from multiple states of more than 38,568 cases of hepatitis A infections associated with person-to-person transmission beginning in late 2016. Cases nationwide have occurred primarily among the same two risk groups as the NC outbreak.

(https://epi.dph.ncdhhs.gov/cd/hepatitis/hepa_outbreak.html)

In 2019, 1,383 new HIV diagnoses were reported among the adult and adolescent (over 13 years old) population, a rate of 15.6 per 100,000 population. This rate is a slight increase from 2018, where 1,201 adults and adolescents were newly diagnosed with HIV (rate =13.7 per 100,000). There were two perinatal (mother-to-child) HIV transmissions documented in 2019. People from 20 to 29 years old had the highest rate of newly diagnosed HIV in 2019 (41.5 per 100,000) and comprised 43% (N=594) of the newly diagnosed population. For adults and adolescents newly diagnosed with HIV in 2019, the most likely route of transmission was male-male sex in 55.7% of all cases, heterosexual sex in 12.6% of cases, injection drug use (IDU) in 3.3% of cases, and combined male-male sex and injection drug use in 2.6% of cases; the most likely route of transmission was unknown for 25.9% of new HIV diagnoses in 2019.

Adolescents

The number of youth ages 12 to 17 treated for a primary SUD in North Carolina has traditionally been a small number (2630 in SFY20), although prevalence rates indicate there are over 32,000 youth in

our state with substance misuse or substance use disorder. It is also noted that 52% of males and 57% of females involved in the juvenile justice system have a substance use disorder. Youth typically present with other behavioral or mental health issues and substance use may not be listed as the primary diagnosis – so while more youth than are accounted for under the SABG-funded services system are receiving care, current efforts are underway to analyze the adolescent SUD services system to determine what strategies may be implemented to better assure a more accessible and responsive system. Emphasis will be placed on identifying and removing any barriers to accessing these services, increasing referrals and improving outcomes. An additional focus will be on transitional age youth with recovery supported housing needs.

Minorities and Historically Marginalized Populations and Communities

Non-Hispanic Black individuals in four U.S. states experienced a 38% increase in the rate of opioid overdose deaths from 2018 to 2019, while the rates for other race and ethnicity groups held steady or decreased, according to a new study by the National Institutes of Health published in the American Journal of Public Health. These alarming data are in line with other research documenting a widening of disparities in overdose deaths in Black communities in recent years, largely driven by heroin and illicit fentanyl. The research emphasizes the need for equitable, data-driven, community-based interventions that address these disparities. (<https://www.drugabuse.gov/news-events/news-releases/2021/09/disparities-in-opioid-overdose-deaths-continue-to-worsen-for-black-people-study-suggests>).

Methamphetamine overdose deaths surged in an eight-year period in the United States, according to a study published in JAMA Psychiatry. The analysis revealed rapid rises across all racial and ethnic groups, but American Indians and Alaska Natives had the highest death rates overall. This research was conducted at the National Institute on Drug Abuse (NIDA), part of the National Institutes of Health.

Deaths involving methamphetamines more than quadrupled among non-Hispanic American Indians and Alaska Natives from 2011-2018 (from 4.5 to 20.9 per 100,000 people) overall, with sharp increases for both men and women in that group. The findings highlight the urgent need to develop culturally tailored, gender-specific prevention and treatment strategies for methamphetamine use disorder to meet the unique needs of those who are most vulnerable to the growing overdose crisis. (<https://www.drugabuse.gov/news-events/news-releases/2021/01/methamphetamine-overdose-deaths-rise-sharply-nationwide>).

As indicated above, in addition to an aging population, North Carolina, like the nation, is becoming more racially and ethnically diverse. At least 38% of North Carolinians are Black, Hispanic, Asian, American Indian, or multiracial. These race/ethnic groups have accounted for almost two-thirds of the total population growth since 2010 and will account for approximately two of every three persons added between now and 2030. The latest population projections suggest that by 2030, 41% of North Carolinians will be a person of color (4.8 million of 11.7 million total people). This transformation can be seen in the diversity of our schools. By 2019, close to half of the under 18 population was a child of color, and Hispanic, Asian, and multiracial children accounted for all the

growth in the childhood population since 2010. (<https://www.osbm.nc.gov/facts-figures/population-demographics>).

In SFY20, the SABG funded SUD treatment services for a total of 83,089 individuals. Of that total, 22,733 or 27% were African American, 1791 or 2% were Indigenous and 2410 or 3% were Hispanic. The total number of minority individuals served was 24,676 or 30%, which is an under-representation of the population mix. In SFY20, the SABG funded SUD primary prevention services for a total of 3,153,059 individuals reached. Of that total, 546,226 or 17% were African American, 8933 or .28% were Indigenous and 213,918 or 6.7% were Hispanic. The total number of minority individuals served was 690,743 or 2%, which is an under-representation of the population mix.

There are initiatives underway to better assure a workforce that is illustrative of our population demographics through scholarship opportunities in Criteria A schools for students of color pursuing a career in SUD counseling, as well as targeted growth of collegiate recovery programs in Historically Black Colleges and Universities (HBCUs). However, assuring an adequate workforce is only one component of an approach that must be multi-pronged. Efforts to develop resources in marginalized and traditionally under-served communities are also planned, particularly through expansion of medication assisted treatment opportunities in OBOT and FQHC and community health center settings.

Problem Gambling

Due to rising unemployment and global economic instability, some Individuals are increasingly turning to gambling as a source of income. Major risk factors for problem gambling are social isolation and online gambling; mental health issues, and psychological distress, all of which are prevalent during this pandemic.

- 32% of online gamblers indicated that COVID-19 influenced the decision to gamble;
- COVID-related financial impacts and higher anxiety and depression were associated with increased likelihood of online gambling;
- COVID-related employment impacts were associated with problem gambling and gambling motives;
- Online gambling has increased by 30-40% nationwide since the pandemic impacted the US, with increased activity among younger age groups and men in particular;
- During the period of the pandemic, states have seen a 153% increase in the number of individuals experiencing problems with online gambling;
- During the period of the pandemic, states have seen a 22% increase in reports of serious financial consequences from gambling;
- During the period of the pandemic, states have seen a 10% increase in the reporting of co-occurring substance use issues.

According to new polling released by the *National Council for Behavioral Health*:

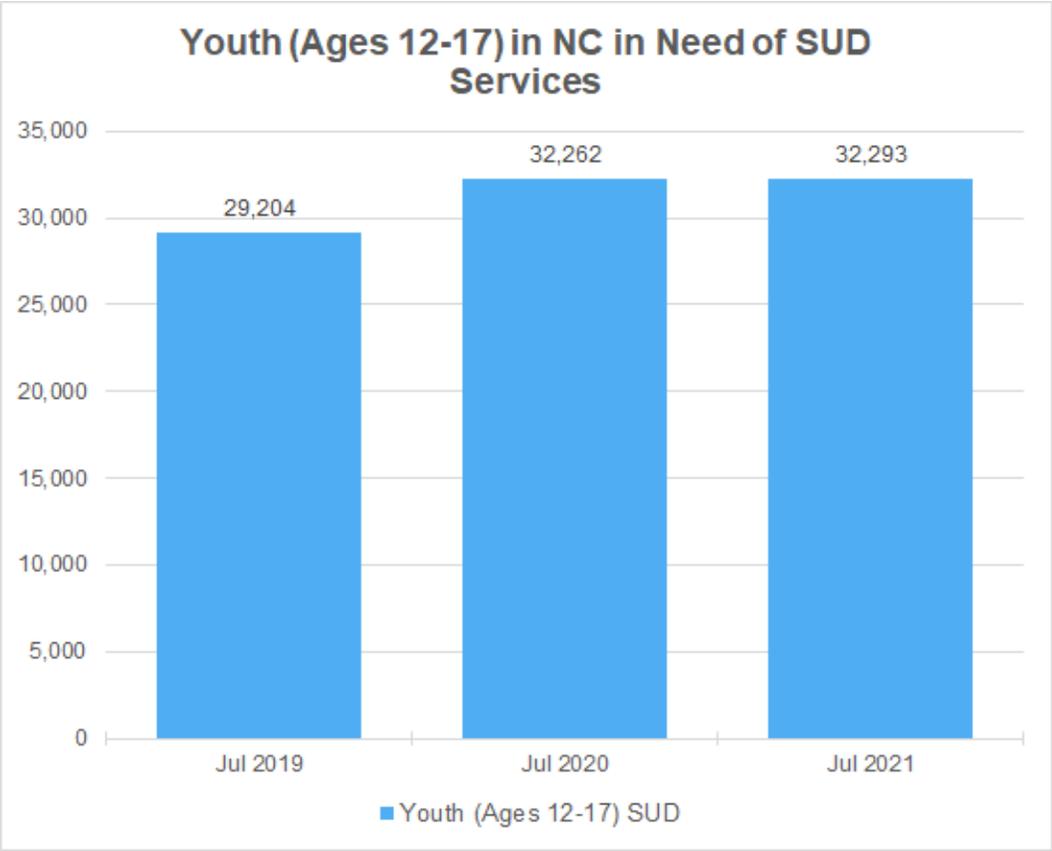
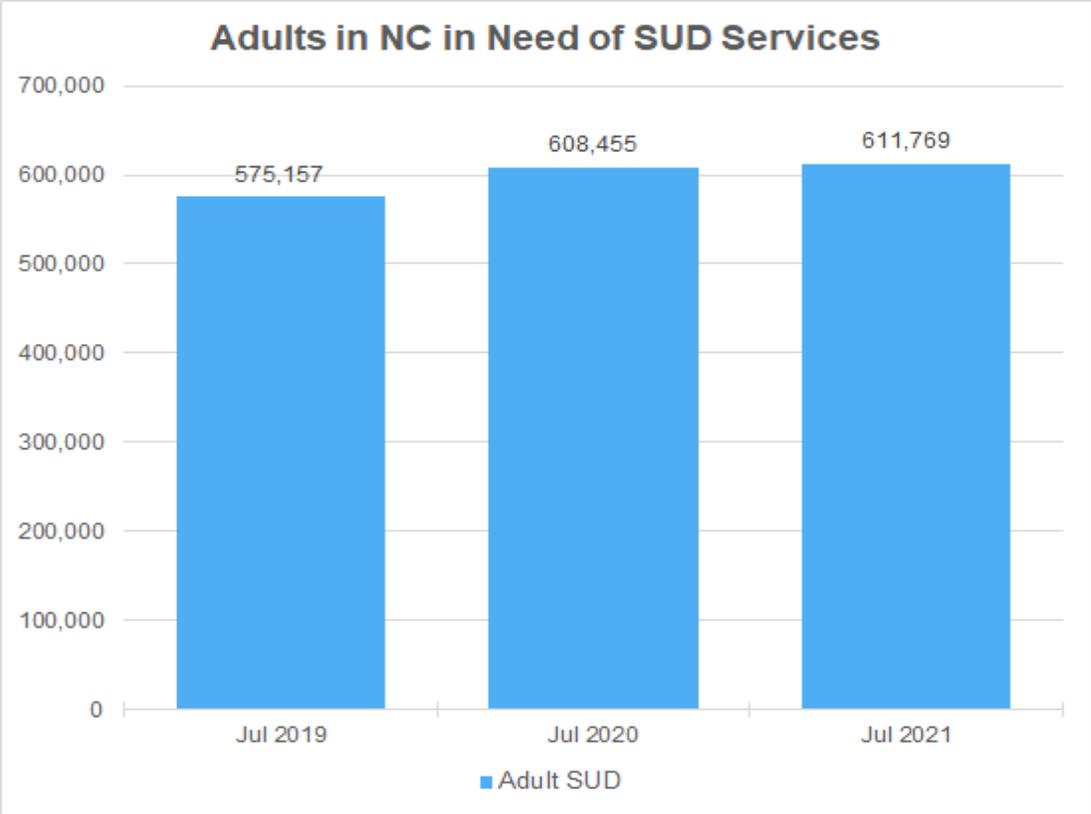
- 52% of behavioral health organizations are seeing an increase in the demand for services;
- 54% of organizations have had to close programs, while 65% have had to cancel, reschedule or turn away patients;
- Organizations have lost, on average, nearly 23% of their annual revenue, and 39% believe they can only survive six months or less.

COVID Impacts

As noted above, North Carolina has not expanded Medicaid, and roughly 10% of the state's population, slightly over one million people, are uninsured. Data suggests that the COVID-19 pandemic has increased unemployment rates, particularly among lower income adults who were less likely to have additional resources. Reductions in hours worked and benefits have also impacted lower income populations more severely. According to a survey by the Pew Research Center, these types of experiences continue to be more common among adults without a college degree and Black and Hispanic Americans.

The LME/MCOs with which the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the SSA) contracts have reported increased demand for substance use disorder (SUD) services, and as COVID restrictions are eased, it is expected this will continue. Overdose death rates had plateaued and were expected to decrease over the next year; however, 2020 death data indicates 2322 North Carolinians died in 2020, which was an increase from 1808 deaths in 2019. These increased death rates are at least partially attributable to continued prevalence of fentanyl, most often found in heroin and cocaine. The state's network of 86 opioid treatment programs that provide medication assisted treatment to nearly 22,000 individuals daily have reported increases in self-pay patients, as well as increases in patient drop out due to financial reasons and inability to afford care.

Numerous data sources report increased alcohol use during the past year, particularly among individuals with co-occurring anxiety and depression. Other studies have reported women in particular exhibited a 41% increase in alcohol consumption, as well as increases in binge drinking behaviors. The tables below illustrate the increase in need for SUD treatment and recovery services for adults and adolescents over the past three calendar years:



The pandemic has resulted in job losses, household income declines and housing and food insecurities for many adults in North Carolina.

Job Loss:

- North Carolina has a current unemployment rate of 4.4% as opposed to 8.8% this time last year (NC Commerce Press Release, August 2021).

Increased Stressors:

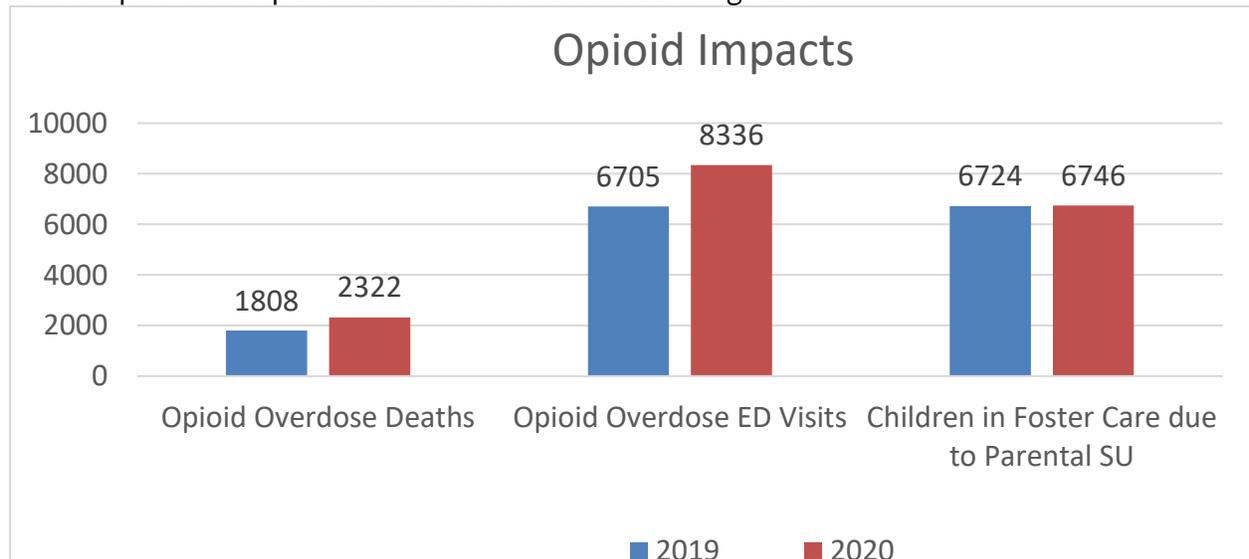
- Uncertainty about the pandemic, worry of getting sick, economic stresses and increased isolation for many people has led to higher levels of stress, anxiety and depression;
- 53% of adults in the United States reported their mental health has been negatively impacted due to worry and stress over the COVID-19 pandemic (Kaiser Family Foundation).

Alcohol Use:

- Alcohol retail sales increased by 39% from last year based on the average from April, May and June (NC Alcoholic Beverage Control Commission);
- Increased alcohol use can compromise the immune system putting people at greater risk for contracting COVID;
- Respondents with children/youth reported an increase in drinks per day that was more than four times as large on average than the subgroup without children/youth (RTI International, Survey 2020);
- Impacts of alcohol use can include increase in domestic violence and child neglect, potential for escalation into alcohol use disorder and morbidity and mortality associated with increased alcohol consumption.

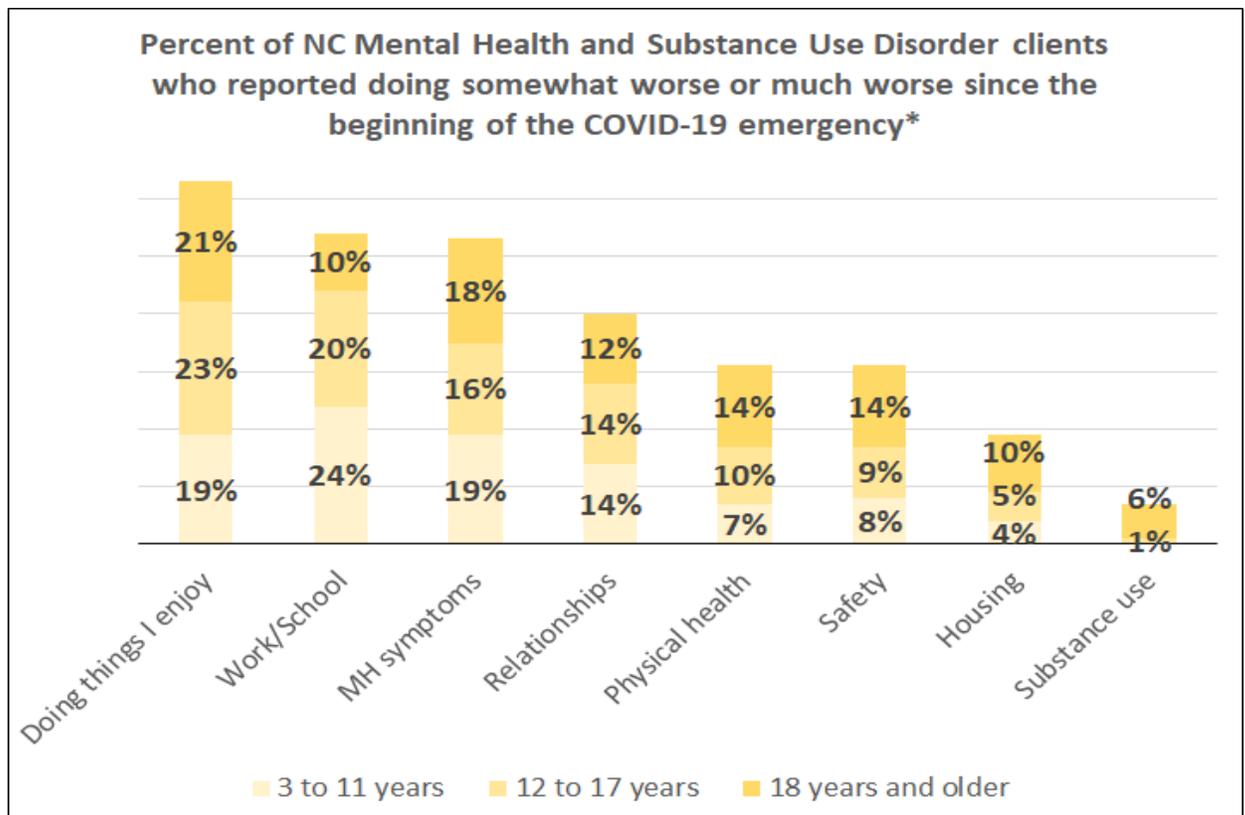
The number of and proportion of ED visits for medication and drug overdoses increased in 2020 compared with 2019. The proportion of visits increased 43%. The count of visits increased 22% from 12,163 visits in 2019 to 14,826 visits in 2020. These visits were for unintentional and undetermined overdoses involving drugs and medications with dependency potential, including heroin, cocaine and prescribed opioids and benzodiazepines

Other impacts of the pandemic can be seen in the following table:



Individuals who were receiving behavioral health services during the pandemic reported a worsening of symptoms during the pandemic, as reported in the North Carolina’s 2020 *Mental Health and Substance Use Disorder Services Client Perception of Care Survey*.

- More than one out of six respondents reported somewhat worse or much worse mental health symptoms since the beginning of the pandemic;
- Nearly one quarter of child family members reported their children under age 12 were doing worse in school;
- Substantial minorities of all age groups reported greater challenges in doing things they enjoyed.



These factors of an increased uninsured population and increased usage of substances point to a need and demand for treatment services that will potentially exceed current resources both from a programmatic as well as fiscal perspective.

The table below illustrates number of individuals in need of SUD services in the total population based on applying the prevalence percentages to the population for each age group in each LME/MCO. It should be noted that these are total numbers in need of SUD services in the total population in each LME/MCO’s catchment area and therefore an over-representation of the number of uninsured individuals in need of SUD care.

LME/MCO	July 2021 Population Estimates				Persons in Need of SUD Services				
	Ages 12-17	Ages 18-25	Ages 26+	Total	Ages 12-17 Prevalence = 3.91%	Ages 18-25 Prevalence = 13.68%	Ages 26+ Prevalence = 6.26%	Total Estimated Adults (18+) with SUD	Total Estimated Persons (12+) with SUD
Alliance Health	164,645	230,613	1,293,479	1,688,737	6,438	31,548	80,972	112,520	118,957
Cardinal Innovations	257,212	344,873	2,202,694	2,804,779	10,057	47,179	137,889	185,067	195,124
Eastpointe	54,691	72,878	439,658	567,227	2,138	9,970	27,523	37,492	39,631
Partners Health Mgmt.	80,638	106,577	714,351	901,566	3,153	14,580	44,718	59,298	62,451
Sandhills Center	90,391	132,901	752,529	975,821	3,534	18,181	47,108	65,289	68,823
Trillium Health Resources	108,206	191,914	1,000,988	1,301,108	4,231	26,254	62,662	88,916	93,147
Vaya Health	70,115	112,891	762,680	945,686	2,741	15,443	47,744	63,187	65,929
State Total	825,898	1,192,647	7,166,379	9,184,924	32,293	163,154	448,615	611,769	644,062

The Division of MH/DD/SA Services and NC Medicaid require the LME/MCOs to annually complete a Needs and Gaps Analysis. However, it should be noted that the submission date for the annual network adequacy reports was extended due to the substantial increase in workload during the pandemic. 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 86 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. In order to better assure access to a site-based service that offers regular participation options, 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 (state) 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. North Carolina has also begun to explore and potentially develop policy to allow for the utilization of mobile units for medication assisted treatment.

For examples of network adequacy plans, please see the documents from two LME/MCOs, Alliance and Trillium, following the end of this section. These plans were submitted in August and September 2021 and reviews by DMHDDSAS are currently underway.

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, as well as explore recent opportunities for partnership with HUD.

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 use services including prevention, intervention, treatment and recovery for pregnant and parenting women and their families and women seeking custody of their child(ren). The NC 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, family-centered, substance use disorder services that include, but are not limited to the following: screening, assessment, case management, outpatient substance use disorder 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, substance use prevention services, etc. Childcare and transportation are also provided or arranged for individuals to access services. 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 seven 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 has emphasized improved access to and retention in opioid treatment programs for pregnant women. All outpatient and residential programs in these two initiatives provide or arrange for medication assisted treatment. The programs coordinate care with Opioid Treatment Programs as well as OBOTS in their respective communities to support MAT for OUD.

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. And while strides were made in recent years that resulted in more individuals accessing treatment, decreased overdose and ED visit rates and decreased deaths due to overdose, some of these trends have reversed since the onset of the pandemic.

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. The plan was updated in June 2019 (Opioid Action Plan 2.0), through feedback from partners and stakeholders, to continue to address the opioid crisis. It includes local actions that counties, coalitions and communities can use to fight the opioid epidemic, which in 2018 alone, claimed nearly five lives per day due to unintentional overdose. The Plan focuses on three areas:

- Prevention
 - Reducing the supply of inappropriate prescriptions and illicit opioids;
 - Preventing future opioid addiction by supporting children and families
- Reducing harm
 - Advancing harm reduction
 - Addressing non-medical drivers of health and eliminating stigma
- Connecting to care
 - Expanding access to treatment and recovery supports
 - Addressing the needs of justice-involved populations

For more information on the NC OAP2.0, visit: <https://www.ncdhhs.gov/opioids>. The table below is a replication of the some of the data elements that can be found on the DHHS website.

Metric Summary Table: NC (Population: 10,658,717)

Sample Metrics	Data		
	2019	2020	2021
Reduce Deaths/ED Outcomes			
Number of unintentional opioid-related deaths to NC Residents (ICD-10)	1808	2322	Not available
Number of ED visits that received an opioid overdose diagnosis (all intents)	6705	8336	5686 (Jan - Aug)
Reduce Oversupply of Prescription Opioids			
Number of opioid pills dispensed	1,609,091	1,432,749	801,967 (Jan - May)
Reduce Diversion/Flow of Illicit Drugs			
Percent of opioid deaths involving heroin or fentanyl/fentanyl analogues	87.9%	91.9%	Not available
Number of acute hepatitis C cases	183	42 (Jan - Mar)	Not available
Increase Access to Naloxone			
Number of law enforcement naloxone administrations	176	49	Not available
Number of community naloxone reversals	2960	3237	2415 (Jan - June)
Treatment and Recovery			
Number of uninsured individuals and Medicaid beneficiaries with an opioid use disorder served by treatment programs	38,010	39,281	25,201 (Jan - Apr)
Number of certified peer support specialists (CPSS)		3637	3824 (to date)

For detailed technical notes on these visit the “How to Use” tab on the following website:
<https://www.ncdhhs.gov/about/department-initiatives/opioid-epidemic/opioid-action-plan-data-dashboard>

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. North Carolina is home to over 750,000 veterans and has the greatest number of active duty troops on the East Coast. North Carolina is also in the top 5 per capita nationally for 21st Century veteran residents. In 2018, some 9,268 unique individual veterans from the state contacted or were referred to the VA as homeless or at risk of becoming homeless. Veterans account for only approximately 9.8% of the total population of North Carolina, but 18-20% of all homeless individuals in North Carolina. More than 2,589 veterans are currently incarcerated in North Carolina, of which some 22.7% are likely 21st Century veterans. On average, 3.5 veterans commit suicide in North Carolina every week.

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).

Additionally, in August 2020, the Veterans Life Center officially opened in Butner, North Carolina. The first of its kind, the Veterans Life Center is a residential program designed to help at-risk 21st Century veterans. The programming for this 100-bed facility includes provision and coordination of services for substance use, mental and physical health needs, life skills training, spiritual and family counseling and vocational education. (<https://vlcnc.org/>)

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.

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.

Primary Prevention Needs

Initiating substance use during childhood or adolescence is linked to substantial long-term health risks. Early (aged 12 to 14) to late (aged 15 to 17) adolescence is regarded as a critical risk period for the initiation of alcohol use (1,2,3), with multiple studies showing associations between age at first alcohol use and the occurrence of alcohol misuse or dependence (2,3,4). Nearly 97% of heavy adult drinkers started drinking before the age of 21 (5). Moreover, there is evidence across a range of other substances—including marijuana, cocaine, other psychostimulants, nicotine and inhalants—that the risk of developing dependence or misuse is greater for individuals who initiate use of these substances in adolescence or early adolescence than for those who initiate use during adulthood. (3,4,6) For example, young people who have ever used e-cigarettes have seven times higher odds of becoming smokers one year later compared with those who have never vaped. (7)

In an effort to delay and prevent the onset of substance use in childhood and adolescence, the Prevention and Wellness team has made a concerted effort over the past seven years to ensure that SAPBG funding is utilized in such a way that meets the identified needs of local communities. Data-driven efforts have centered on addressing consumption and consequences related to alcohol (underage drinking, FASD), tobacco, vapes, marijuana and opioids. While the intentional implementation of core evidence-based prevention strategies (i.e., environmental strategies) was associated with decreases in alcohol involved fatal crashes, alcohol attributable deaths, and emergency department visits related to heroin, a review of recent statewide data reflect a need to continue addressing the following substance consumption and related consequence through evidence-based prevention strategies.

1. *Alcohol Consumption* – Gross alcohol sales increased from FY 2019 to FY 2020 (Figure 1) and remained higher in CY 2021 (Figure 2). (NC ABC Commission, Monthly Sales and Annual Revenue, 2021). The proportion of people exceeding drinking guidelines increased 39% between February and November 2020 in terms of drinks per month. The largest increases in consumption were observed in Black and Hispanic women, Black men, people with children, and those with mental health problems who drink to cope or for enhancement. Increased alcohol in the home is associated with increased access/availability for youth. 44.9% of NC youth report that it is easy to get alcohol (2017 NC Youth Prevention Survey). 81.7% of NC youth report moderate to great risk from drinking alcohol (2017 NC Youth Prevention Survey). According to the 2019 Youth Risk Behavior Survey, 24% of high school youth report drinking alcohol on at least one day during the 30 days prior to the survey; 12.5% report binge drinking on at least one day during the 30 days prior to the survey; and 38.4% of youth drinking in the past 30 days report receiving it from someone else. (Figure 3)

Figure 1

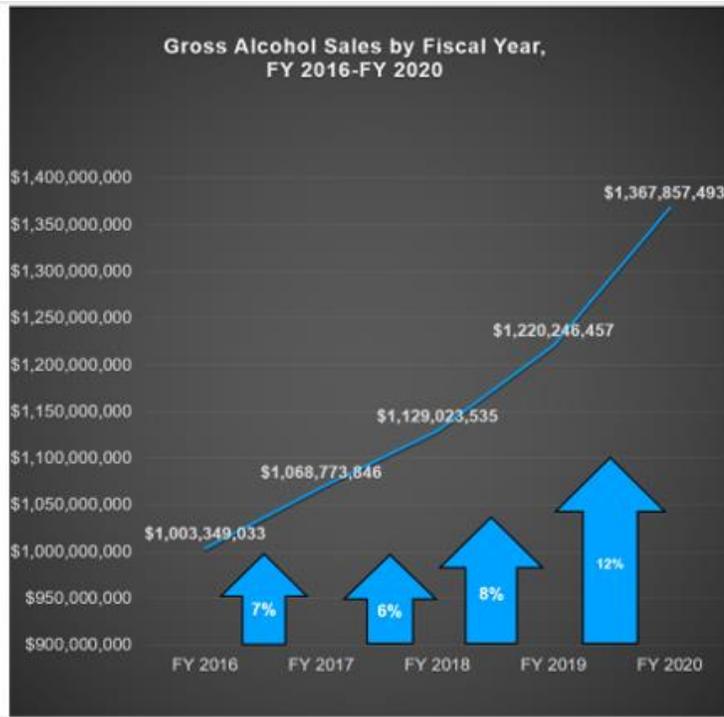


Figure 2

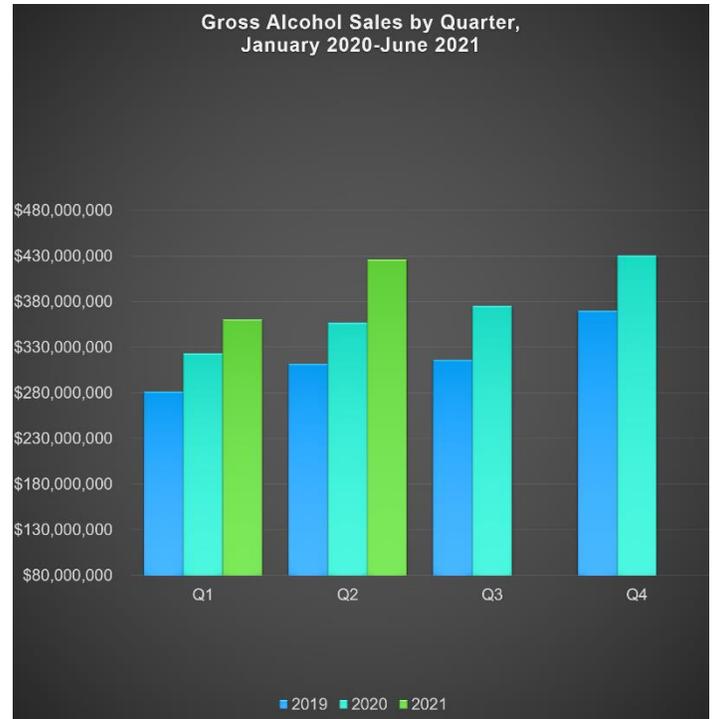
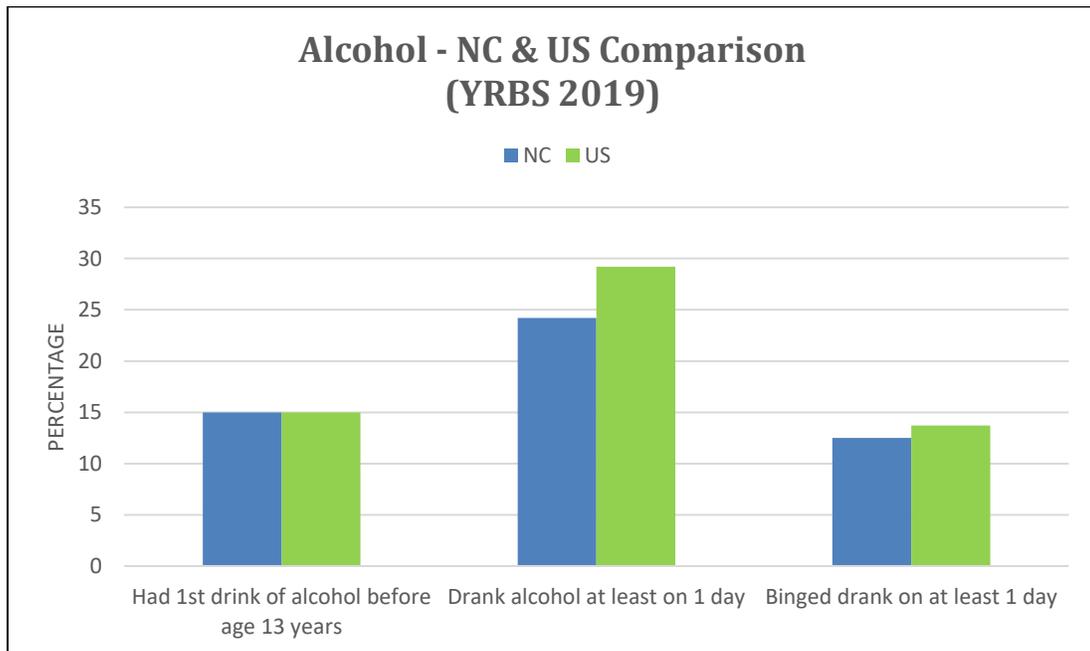


Figure 3



- Tobacco and E-cigarette Use** – Youth tobacco use increased to 19.7% reflecting an average above the national average of 12.6% (Healthy North Carolina 2030 Report, 2020). According to the 2019 Youth Risk Behavior Survey, 52.4% of high school youth report ever using vapor products; 35.5% report using vapor products on at least one day during the 30 days prior to the survey; 11.1% report using vapor products on 20 or more days during the 30 days prior to the survey (Figure 4). Vaping increased among youth and young adults during COVID-19 pandemic. 41% of youth and 23% of young adults reported vaping more than they did before the pandemic (Figure 5). Additionally, 46% of youth e-cigarette users reported being able to find their preferred vape flavor and 58.2% reported trying a new vape flavor (Monitoring E-Cigarette Use Among Youth Survey: North Carolina, Spring 2021, Figure 5).

Figure 4

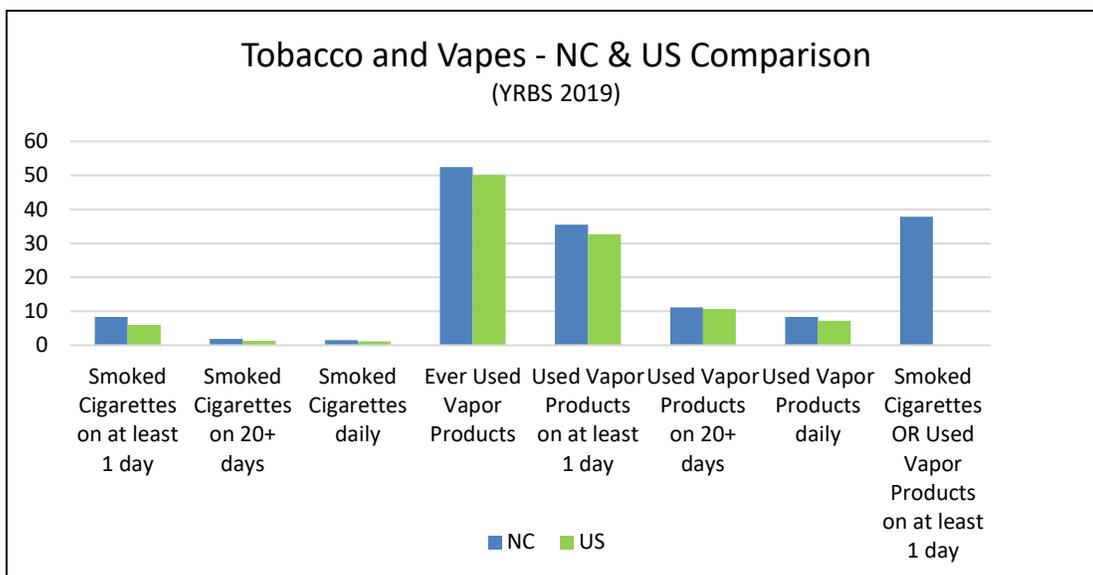
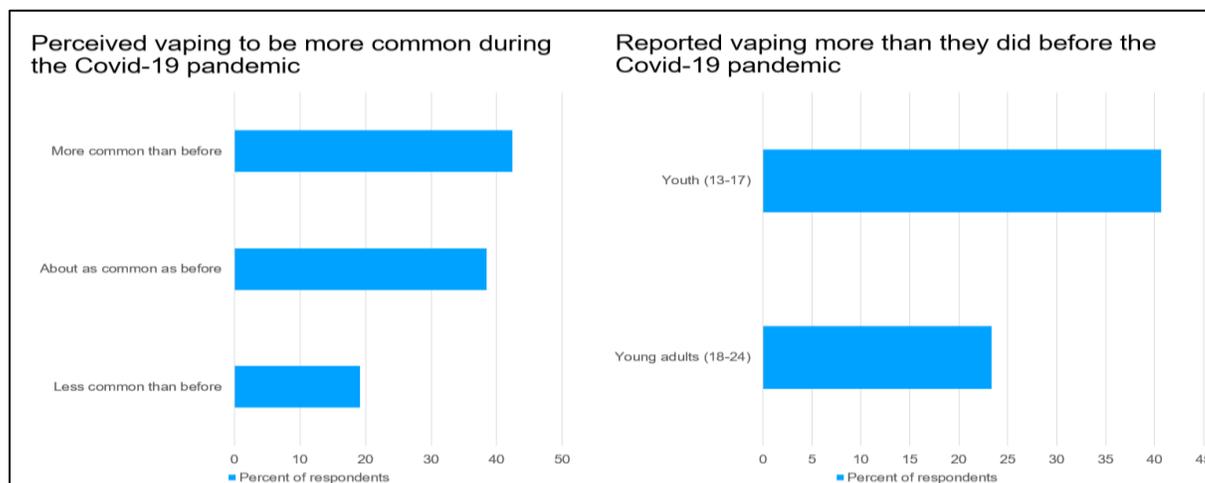
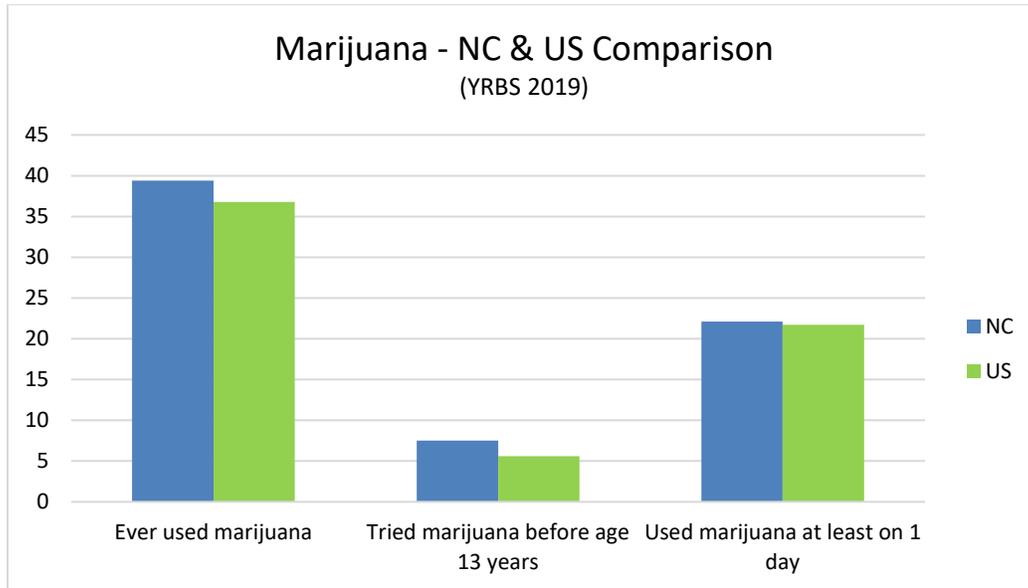


Figure 5



3. *Marijuana* – NC youth report higher marijuana rates compared to national rates (Figure 6). According to the 2019 Youth Risk Behavior Survey, 39.4% of high school youth report ever using marijuana; 22.1% report using vapor products on at least one day during the 30 days prior to the survey; and 7.5% report trying marijuana before the age of 13 years. (Figure 6).

Figure 6



4. *Opioids and Other Synthetic Narcotics* - Emergency department visits related to **commonly prescribed opioids decreased 28%** from 2010 to 2018. However, ED Visits due to commonly prescribed opioids increased by 14% from 2019 to 2020; and remained elevated in 2021 (Figures 7 and 8). ED visits due to heroin and other synthetic narcotics increased from 2019 to 2020, 1% and 25% respectively. Overall, ED visits due to other synthetic narcotics continued to rise in 2021.

Figure 7

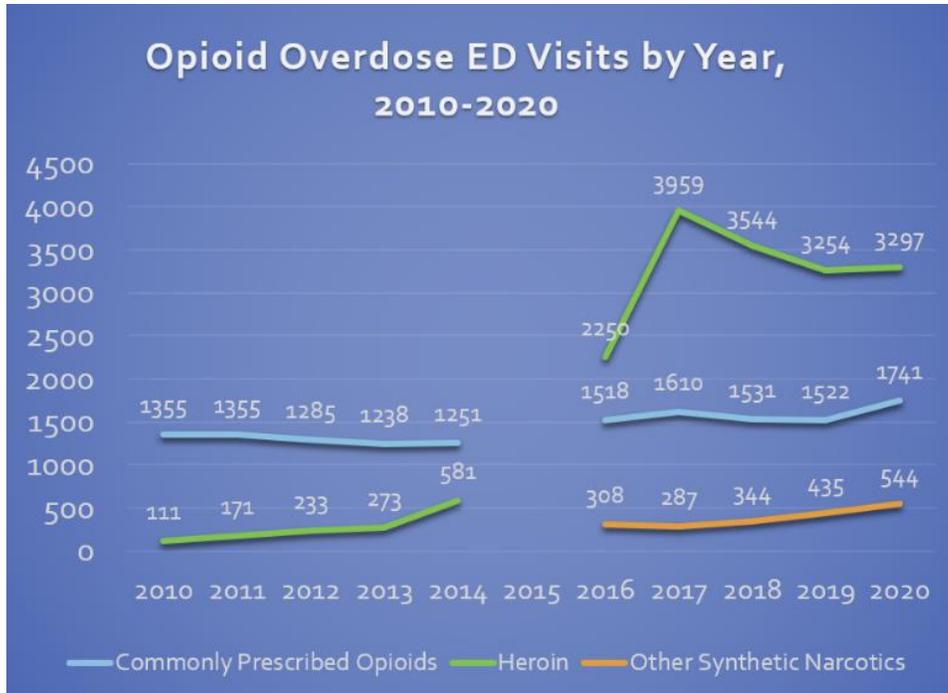
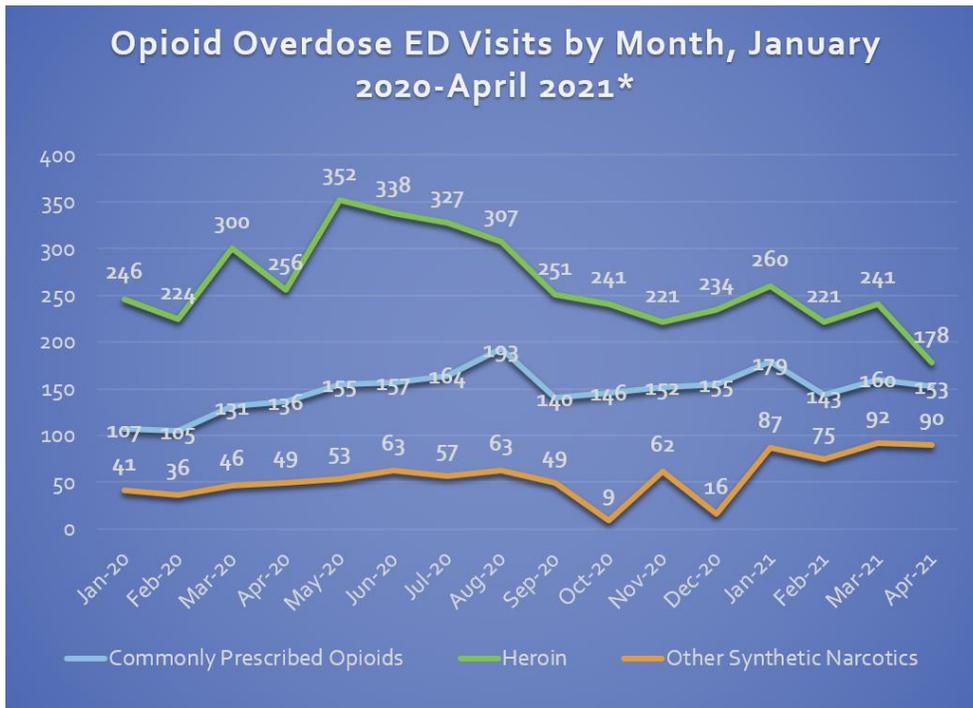


Figure 8

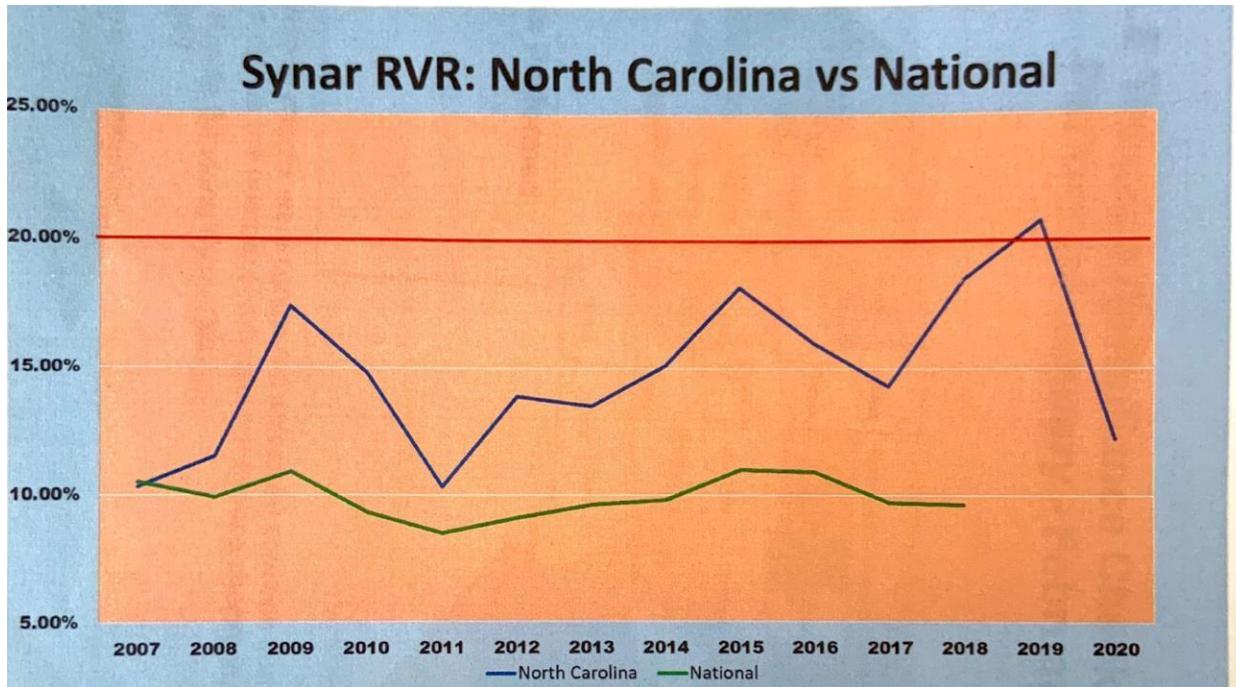


As such, the prevention, Health Integration and Wellness team has identified the following unmet priority needs:

1. Decreasing perceived easy access to alcohol, tobacco, vapes, marijuana and prescription drugs by youth (intermediate outcome).
2. Increasing perception of harm for youth use of alcohol, tobacco, vapes, marijuana and prescription drugs (intermediate outcome).
3. Decreasing past 30-day use of alcohol, tobacco, vapes, marijuana and prescription drugs among youth (long-term outcome).

In addition to aforementioned priorities, **lowering the state tobacco retail violation rate (RVR)** has been identified as a priority unmet need, as North Carolina has been close to and/or over the SAMHSA threshold rate of 20% in 2017, 2018 and 2019 and higher than the national weighted average RVR. In federal fiscal year (FFY) 2020, the annual Synar Survey was conducted between June-September 2019 by the DPS-ALE surveying a total of 622 tobacco retailers which resulted in a **12.2%** retailer violation rate (RVR).





In addition to the Synar Survey, North Carolina DHHS has a Food and Drug Administration (FDA) contract which conducts tobacco compliance checks. FDA primarily focuses on emerging tobacco products such as e-cigarettes, vapors and cigars.

Due to COVID, the FDA issued a “stop work order” which eliminated compliance checks from March 2020-September 2020. Per the FDA tobacco website, between July 2019-June 2020, the North Carolina FDA team conducted:

- 2,525 retail tobacco compliance inspections involving an underage person were completed by FDA. Of these 2,525 inspections, 516 (**20.4% violation rate**) resulted in violations issued from FDA due to sale to an underage person.

The products sold during the 516 violations were:

- 196 e-cigarette/vapor
- 262 cigars
- 47 cigarettes in a package
- 9 smokeless tobacco

On December 20, 2019, the President signed legislation that raised the federal minimum age of sale from 18 to 21. Prior to this, FDA completed 1,872 inspections that resulted in 454 violations (24.3% violation rate). After December 20, FDA completed 653 inspections which resulted in 62 violations (10% violation rate). Only individuals under the age of 18 were involved in compliance inspections between July 1, 2019 to June 30, 2020.

Critical Gaps

NC state law will, at some point, need to be changed to be consistent with federal law. Currently, NC's challenge is educating retailers on both the state and federal laws and exclusive enforcement of the state law due to jurisdiction restrictions.

The N.C. Youth Access to Tobacco Products law G.S. 14-313 (currently age 18) has several weak provisions such as no tobacco retailer licensing system, penalties for violations are only against the clerk and not the retailer, and preemption of the authority for state agencies and local sale, promotion, display, and distribution of tobacco products. Given the federal law change, there is a timely opportunity to educate policymakers on model elements to enable better enforcement and maintain good compliance rates.

DMH and DPH has worked with internal and external partners over the last several months mobilizing and building capacity to gain momentum on a T21 law that will enhance the NC's citizens public health and reduce youth tobacco access.

North Carolina Department of Public Safety Alcohol Law Enforcement (ALE) has statewide statutory authority and is currently enforcing the NC Youth access tobacco law. One provision requires retailers to have signage related to §14-313 prohibiting the purchase of tobacco products by persons under the age of 18 in contradiction to current federal law.

Due to COVID FFY2021, NC wasn't not able to conduct a Synar Survey. However, DPS-ALE was able to complete 985 "Be A Responsible Seller/Server-BARS" trainings to 2,419 retail personnel on state laws and penalties for selling tobacco or alcohol to minors, 69 tobacco citations and 14 written warnings. Direct Service Providers completed 5,185 merchant education visits, 180 retailers completed the online tobacco training.

North Carolina worked with a national Synar expert, to assist with updating the methodology, protocols, and survey tool. In FFY2019, direct service prevention providers were able to complete over 5,035 merchant education visits. As a result, some of these factors may have contributed to the lowering RVR rates in FFY2020.

Addressing Gaps - Compliance Checks

DMH/DD/SAS and the Division of Public Health (DPH) requested to continue funding in the biennium budget in long general assembly session 2021 for state 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 currently contracts 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.

- ALE completed a total of 655 compliance checks resulting in 14 written warnings.
- Between January 2020-February 2020, ALE conducted 79-90-day follow-up compliance checks resulting in 66 citations/arrests.

- ALE will follow-up with the 79 stores out of compliance during the FFY20 Synar survey and issue citations if stores continue to sell to minors.

Addressing Gaps - Synar Survey protocols

In October 2021, DMH/DD/SAS contracted with Growth Partners, a national Synar expert for-profit organization to improve NC Synar program and survey procedures. Between October 2018-April 2020, DMH/DD/SAS worked with Growth Partners, APNC and ALE to make the following changes to the Synar program including, but not limited to:

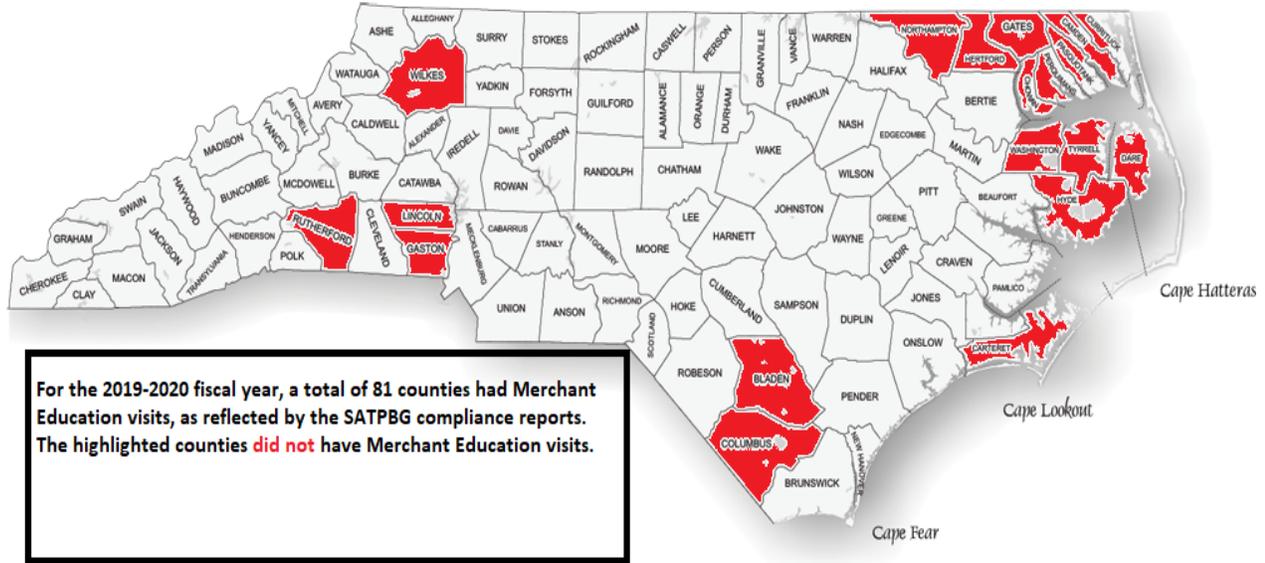
- Trained 108 ALE Agents on the new Synar protocols and procedures.
- 2022 NC is due to conduct Coverage Study. Growth Partners are working on
- Annual Synar survey protocols were adjusted to reflect the following changes:
 - Survey design went from an area to a list frame,
 - Minors were required to 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 was 81 out 100 counties from SFY 2019 to SFY 2021. 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), continue to update their retail list and identify new and closed tobacco retailers in their catchment area.
- 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.
- Encouraging providers to expand upon merchant education and to conduct tobacco purchase surveys with a younger looking 21-year-olds and to share results where retailers “sold” products with local law enforcement and ALE officers from July 1-September 30, 2021.

A total of **5185** establishments were visited by LME/providers during the fiscal year 2019-2020.



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 a 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 FFY19 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 21.

- 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 22 to ensure continued law enforcement commitment to conducting more compliance checks and education to retailers regarding 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 utilizing 18-20 years for the survey.

Prevention System Needs

North Carolina is embarking on a redesign of its prevention system which will significantly reduce substance use-related injuries, morbidity, and mortality for all North Carolinians. A central element of the redesign is enhancing grantee and contractor performance and accountability by standardizing expectations for the use of the Strategic Prevention Framework, particularly with regard to assessment, evidence-based strategies, process and outcome evaluation, and reporting.

The redesign reflects a shift to results-based management (RBM) with its focus on the following key elements:

- Identifying clear and measurable results to be achieved (e.g., impacts, outcomes, outputs)
- Identifying process and outcome indicators and associated targets for all desired results
- Targeting funding and other resources to the achievement of desired results
- Developing/strengthening systems to collect process and outcome data
- Using evaluation and monitoring data to compare actual results to desired results and make decisions about changes to strategies, activities, implementation, and future funding.

Key supports for this redesign involve (1) replacing the current intermediary structure for prevention with a more streamlined structure aligned with state prevention goals, and (2) redirecting prevention funding to better support the implementation and ongoing evaluation and monitoring of needed prevention strategies and services.

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 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 was approved for an 1115 SUD Demonstration Waiver that will allow for reimbursement of SUD services in facilities with more than 16 beds. 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 any time in the near future, 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 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. Some of these practices, such as the FQHCs, serve not only individuals with an opioid use disorder, but other/all SUDs.

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 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 likelihood individuals will seek help.

Sources:

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- 3) King, K. M., & Chassin, L. (2007). A prospective study of the effects of age of initiation of alcohol and drug use on young adult substance dependence. *Journal of Studies on Alcohol and Drugs*, 68(2), 256-265.
- 4) Lopez-Quintero, C., Pérez de los Cobos, J., Hasin, D. S., Okuda, M., Wang, S., Grant, B. F., & Blanco, C. (2011). Probability and predictors of transition from first use to dependence on nicotine, alcohol, cannabis, and cocaine: Results of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). *Drug and Alcohol Dependence*, 115(1-2), 120-130. doi: 10.1016/j.drugalcdep.2010.11.004
- 5) SAMHSA 2001
- 6) Chen, C.-Y., Storr, C. L., & Anthony, J. C. (2009). Early-onset drug use and risk for drug dependence problems. *Addictive Behaviors*, 34(3), 319-322. doi: 10.1016/j.addbeh.2008.10.021
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- 8) NC ABC Commission, *Monthly Sales and Annual Revenue* (2021). Retrieved from: <https://abc.nc.gov/StoresBoards/SalesRevenueReports>.

Section B – Network Access Plan for State-funded Services (SFS)

The BH I/DD Tailored Plan shall develop a Network Access Plan for SFS and provide documentation that demonstrates that it has the capacity to serve the expected enrollment in its entire Region in accordance with the Department’s BH I/DD Tailored Plan Network Adequacy Standards (as found in *BH I/DD Tailored Plan RFA Section VII. Attachment F.2. BH I/DD Tailored Plan Network Adequacy Standards for State-funded Services*), state and federal law where applicable, and the terms of this Contract.

The Network Access Plan must be provided:

- Thirty (30) days after Contract Award
- As specified by the Department (i.e., at the request of Department)
- Annually
- Within thirty (30) days of a significant change, including merger or county disengagement
- Within forty-five (45) days of a significant change to the provider network

The Network Access Plan for SFS must address each of the following prompts. A Plan that includes any blank items will be deemed to not meet expectations, and the BH I/DD Tailored Plan may be subject to corrective action and/or other penalty as outlined in the BH I/DD Tailored Plan Contract.

The BH I/DD Tailored Plan shall add additional pages as necessary to provide a complete response to each item. The response should note if additional pages or supplemental information is attached to the report. All attachments should be labeled to align with the appropriate item by Section and number.

1.	<p>BH I/DD Tailored Plan’s plan to maintain State-funded Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of State-funded Services recipients in the Region.</p> <p>Alliance Health (Alliance) is committed to developing and maintaining a provider network that enables access to all services covered under the contracts for state funded populations. Consistent with DHHS contractual requirements, BH I/DD Tailored Plan Network Adequacy Standards, and 42 CFR § 438.207, the provider network will offer an appropriate range of services and access, and will have a sufficient number, mix, and geographic distribution of service providers to assure that medically necessary Covered Services for Alliance State-funded recipients are delivered in a timely and appropriate manner. Access and availability standards will meet at a minimum the access and choice requirements contained in the LME-MCO contracts with DHB and DMH, and will include additional access standards, per NCQA requirements, for behavioral healthcare practitioners such as licensed clinicians.</p> <p>Our <i>state-funded</i> behavioral health network is currently sufficient to meet standards for Outpatient behavioral health, Inpatient, Community/Mobile and Employment & Housing service categories. For the remaining categories, we are preparing to address current network gaps for the following services:</p> <p><u>Location-Based:</u></p> <ul style="list-style-type: none"> • Psychosocial Rehabilitation: currently, 80% of recipients have a choice of two PSR providers within 30 minutes/miles, so we will be exploring options to improve choice in Cumberland and Durham counties, both of which currently have only one state-funded PSR provider.
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- **SA Comprehensive Outpatient:** we have sufficient capacity to allow a choice of one provider for all state-funded individuals, but currently only 67% have a choice of two providers within 30 minutes/miles. We will be exploring options for expansion of choice in areas without a choice of two providers.
- **Opioid Treatment:** we are in the process of expanding contracts to meet this standard by adding state-funded contracts in Cumberland (Fayetteville Treatment Center) and Durham (Durham Treatment Center) counties
- **Partial Hospitalization:** we no longer meet LME-MCO network adequacy standards for this service due to changes in DHHS network adequacy standards that require a choice of two providers within 30 miles/minutes, and will need to add programs in Cumberland, Durham and Johnston counties to meet TP standards that require access to one provider within 30 miles/minutes. We will begin discussions with local hospitals as well as behavioral health providers in each community to assess interest in adding this service, and will pursue a competitive RFP if necessary.

Crisis Services:

- **Professional treatment services in facility-based crisis program:** although we meet current network adequacy standards for this service, the Tailored Plan requirements for one facility per 450,000 regional population will require us to increase capacity or seek a waiver from the Department. We currently have programs in Wake, Durham and Cumberland, and will be adding a child facility-based crisis facility within the region by the Summer of 2021. If funding is available to add additional facilities, priority areas will be development of a program in Johnston and an additional program in Wake.
- **Ambulatory Detoxification, ambulatory withdrawal management with extended on-site monitoring, and clinically managed residential withdrawal:** we currently do not have these services in our network, but we are working on network development of the SUD continuum in collaboration with current providers and community stakeholders. Since there are non-contracted physicians in our community who provide office-based opioid treatment and other SUD treatment within their practices, we will be reaching out to them as well as currently contracted behavioral health providers to identify additional providers of these services. If needed, we will pursue expansion through a competitive RFP process.

Residential Treatment Services: we currently do not meet TP standards for Residential Treatment Facility Services and have gaps for adolescent SA Halfway House as well as SA Non-Medical Community Residential Treatment for adolescents. We plan to work with current providers of residential care and possibly new providers to develop expansion plans for these services.

An important consideration in our future plans for state-funded services is the availability of sufficient state funds to support service expansion. Several factors that may limit funding availability are the impact of the financial downturn associated with the COVID-19 pandemic on number of uninsured seeking care as well state revenue that supports availability of service funding. Decisions about priority services for expansion will be made based on funding availability, service impact and the capacity for services to address needs of priority populations.

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2.	BH /DD Tailored Plan’s procedures for referrals.
	<p>Recipient referrals may occur through multiple approaches, including self-referral for behavioral healthcare, referral by treatment providers when transitioning between levels of care, and referral for adjunctive treatment. Referrals will be tracked by Care Managers to promote follow-up and engagement in care. Alliance does not require referrals as a precondition for receiving any services at this time, and we inform our recipients that they can access the following services directly without needing a referral: emergency services and crisis service for behavioral health, and initial mental health or substance use assessment also does not require a referral.</p>

3.	BH /DD Tailored Plan’s procedures for disclosures and notices to recipients of the BH /DD Tailored Plan’s services and features.
	<p>Alliance will implement a multipronged approach to educate and provide timely updates to recipients regarding, services, benefits and features available to them under the Tailored Plan. Within 8 days of enrollment within Alliance, Alliance will send a Welcome Letter to all recipients that includes the following information:</p> <ul style="list-style-type: none"> • A link to our Member and Recipient Handbook which includes a detailed listing of covered benefits and how to access them, behavioral health crisis services, information and key phone numbers for: Member Services Line and the Behavioral Health Crisis Line and additional information related to recipient Rights. • A listing of the support lines that are also found in the Member and Recipient Handbook <p>Whenever Alliance makes a significant change to recipient benefits and services, following NC Department of Health and Human Services written approval, Alliance will send direct notice of the change to impacted recipients at least 30 days prior to the change and post these changes to our recipient facing website at least 30 days prior to the benefit change.</p>

4.	BH /DD Tailored Plan’s procedures for coordination and continuity of care.
	<p>In addition to developing and maintaining a sufficient, high quality and accessible network of care, Alliance understands the importance of ensuring effective coordination, continuity and transition of care. Alliance recognizes that recipients undergoing coverage transitions are at increased risk of adverse health outcomes and often experience unnecessary confusion when their needs are not effectively coordinated. Warm Handoffs are critical to best support recipients who have complex needs to ensure important information about their care is shared with all pertinent parties as appropriate.</p>

<p>5.</p>	<p>BH /DD Tailored Plan’s efforts to address the needs of all recipients, including those with limited English proficiency or illiteracy.</p> <p>Alliance evaluates recipient needs and provider capacity to address these needs through multiple approaches, including our annual network adequacy assessment as well as ongoing monitoring of network adequacy and service accessibility. Sources of information include community and service recipient demographics, grievance data, survey results, Language Line data, provider specialty and language capacity data, and other information as available. The most prevalent non-English language in each county is Spanish, and we have contracted with multiple providers who have the capacity to provide services through bilingual staff. Providers who do not have bilingual staff capacity are required to use interpreters or language translation services.</p> <p>As we prepare for Tailored Plan implementation and addition of Mecklenburg and Orange counties to our catchment area, we will continue evaluation of recipient characteristics and needs as well as provider capacity to address these needs, and will incorporate this information into network development and contracting plans. We will also be evaluating linguistic access for primary care, specialty, pharmacy and other medical providers that will be included in the scope of the Tailored Plan to identify potential gaps and resource needs.</p>
<p>6.</p>	<p>BH /DD Tailored Plan’s efforts to address the needs of historically marginalized populations;</p> <p>Our approach to addressing the needs of historically marginalized populations is multifaceted, including network adequacy evaluation, review of recipient characteristics and preferences, ongoing network development and training efforts, and provider recruitment and retention strategies that focus on alignment of network and recipient characteristics. Our Diversity, Equity and Inclusion plan will provide a structure for enhancing network capacity to serve historically marginalized populations, and we will also use data analytic approaches to understand and prioritize health access and outcome disparities for HMPs that are incorporated into network development strategic planning.</p>
<p>7.</p>	<p>BH /DD Tailored Plan’s efforts to ensure that State-funded Network providers provide physical access, reasonable accommodations, and accessible equipment for recipients with relevant physical, BH or I/DD needs;</p> <p>Alliance takes multiple steps to ensure that services are accessible for recipients who require assistance, accommodations or accessible equipment to access care. First, we require providers through our contract to comply with relevant legislation such as the Americans With Disabilities Act and Section 504 of the Rehabilitation Act of 1973, which prohibit discrimination on the basis of handicaps. Second, we identify providers that are ADA Compliant on our provider search to confirm that individuals who are searching for providers can confirm that selected providers and sites are accessible. Third, we review compliance with accessibility requirements through ongoing monitoring and review of grievances, and we provide technical assistance when indicated to improve adherence to accessibility requirements.</p>

8.	<p>BH /DD Tailored Plan’s efforts to assist the Department, as directed, to assess the capacity of select providers to ensure that recipients residing in these facilities have access to remote communication options and devices to be used for communication with family and providers, including Telehealth and telephonic options, in cases of emergencies, where in-person visitation is restricted. Select providers include:</p> <ul style="list-style-type: none"> • Behavioral Health residential treatment facilities licensed under 10A NCAC 27G.1300, .1700, .1900, .3100, .3200, 3400, .4100, .4300, .5600. • Adult Care Homes licensed under 10A NCAC 13F and 13G.
	<p>During the COVID-19 pandemic, we have worked closely with network providers to ensure that recipients have access to care, and have provided support for purchase of telecommunications equipment and data plans to enable access to behavioral health and medical care. We expect that telehealth access will continue to be a critical support for those who reside in licensed facilities post-pandemic, not only during emergency situations, but as an option for accessing healthcare when in-person visits are not required or when there are barriers to accessing services in person. In cases of emergencies that limit in-person visitation, we commit to assisting the Department to ensure that individuals who reside in nursing homes, ICF-IID facilities, residential treatment facilities and adult care homes have access to remote communication options and devices.</p>

9.	<p>BH /DD Tailored Plan’s efforts to support and sustain providers, in rural and other traditionally underserved areas as well as providers representative of Historically Marginalized Populations.</p>
	<p>Alliance serves four urban/metropolitan designated counties, which are not considered traditionally underserved, nor is there a state recognized tribe in our region. However, based on the geographical size of our region, there are areas with more rural characteristics that require a more specialized approach to network development and support. Our approach to addressing service accessibility includes addressing barriers to care such as transportation, stigma and cultural attitudes that shape healthcare seeking behavior. Alliance has implemented multiple strategies to address these issues. When Alliance is recruiting new providers to an area that are receiving start-up support, we require them to locate their office or facility along public transportation routes. Our two outpatient behavioral health urgent care centers are on public bus lines as are our contracted crisis facilities. We have further addressed transportation barriers by expanding the availability of in-home services, partnered with local school systems to co-locate behavioral health services, and have worked with our network providers to expand their service locations. We have also provided infrastructure funding to help providers expand office locations.</p> <p>Since the COVID 19 pandemic, large numbers of behavioral health practices have implemented telehealth. Additionally, Alliance has helped providers to purchase additional equipment to expand their telehealth capabilities. Should we identify an area that appears to be suffering from a lack of access to behavioral health care, we will facilitate the use of telehealth to promote service access and, if necessary, Alliance is able to provide initial infrastructure support to help cover preliminary connection costs and equipment needs to facilitate these connections.</p>

In the ongoing development and management of our provider network, Alliance has developed numerous supports for providers to promote adoption of evidence-based practices, increase service accessibility, improve quality of care and support effective and sustainable business practices. We provide regular technical assistance on billing and claims issues and ongoing training to providers through meetings, webinars, provider bulletins, communication on our website and through social media. We have also initiated a series of 11 Alliance network learning collaboratives, which Alliance either facilitates directly or contracts with subject matter experts to facilitate. These provider learning collaboratives draw an attendance of the majority of our network agency providers, including all of our largest providers.

We plan to maintain and expand these supports as a Tailored Plan to include the full range of providers participating in the network. We also recognize the importance of collaboration with community partners and stakeholders to support our provider network and will work closely with these systems to improve access, quality and effectiveness of care. Examples of these important relationships are agreements with local education agencies to support child and adolescent day treatment programs, partnerships with community agencies to address social determinants of health such as housing and transportation, and collaboration with criminal justice systems, recovery supports and community prevention efforts.

As we build and sustain our provider network, we will evaluate multiple domains of network adequacy, including geographic access, timeliness of appointments, and alignment with Alliance diversity, equity, inclusion and cultural competency goals. With assistance from the Barthwell Consulting Group, we have developed a Diversity, Equity and Inclusion Plan that will guide our collaboration with providers and stakeholders to implement a system-wide plan for enhancing diversity, equity, inclusion and cultural competency within the network. One element of this plan will be to identify substantive gaps impeding health equity through claims analysis, surveys and other approaches and to develop strategies for addressing inequities. We will also evaluate healthcare access for historically marginalized groups through our ongoing and annual review of network adequacy and accessibility, and will include identified strategies in our Network Access Plan. Our network adequacy review will also evaluate network capacity to serve historically marginalized populations through multiple approaches, including service recipient experience surveys, grievance data, claims analysis and comparison of provider characteristics and competencies to the characteristics and preferences of service recipients.

Alliance is embarking on a thoughtful approach to recruit, support and sustain providers that are representative of marginalized populations, hire staff that are reflective of the diverse communities that they serve and broaden access to welcoming, culturally competent care. We are interested in understanding the needs of underserved and marginalized populations in our community and have historically worked to build a more diverse network. An important first step has been a greater look inward. Alliance has launched a strategic initiative to develop a comprehensive Diversity, Equity, and Inclusion strategy with long- and short-term strategies to address identified issues. That strategy includes support for underutilized providers, utilization and access for recipients, and an internal cultural competency assessment. This will help ensure that unconscious bias is better identified so it does not inadvertently negatively impact network design and support. Goals of this initiative is

to assess, identify and address administrative components to promote an organizational culture of diversity, equity and inclusion and create a culture without racial inequities, institutional biases and social injustice that can lead to disproportionate impact on minority populations. It is important that we are recruiting and training our staff in a manner that supports diversity, equity and inclusion. An important aspect of this process is encouraging our leadership and staff to explore unconscious bias to ensure that that our internal hiring and advancement processes are not inadvertently denying opportunities to bring in a more diverse workforce and promote talented employees who are reflective of our community. This work is also important to ensure that unconscious bias is not impacting network decisions as we strive to build and support diverse and inclusive network. Prior to the launch of this initiative, Alliance Network Department leadership and management team participated in a serious of trainings on this topic.

We understand that marginalized populations tend to have a distrust for certain institutions and outside groups. We have continuously strived to develop partnerships with community-based organizations with deep connections to their communities and have historically sought to build and support a network that is reflective our diverse community. Alliance recently selected one of our network providers, ReNew counseling in Cumberland County, to conduct community outreach to increase use of the Hope4NC line during the COVID pandemic under a FEMA Crisis Counseling Program grant. Renew was selected because the owner and company have strong ties to the Latinx community in the county. Additionally, our network remains open for providers who can serve non-English speaking recipients and we have provided higher reimbursement rates to help sustain these providers. Alliance routinely shares network needs, such as the need for bilingual behavioral health service providers with our network to inform their staff recruiting efforts. Alliance is also re-evaluating our network selection and retention policies to ensure they do not overly prioritize certain infrastructure requirement which may dissuade smaller, providers are more deeply rooted in their communities from applying. Alliance is also seeking to better understand the needs of our recipients during our Annual Network Adequacy Assessment study. We are providing survey respondents the opportunity to include additional information related to physical access barriers, limited English proficiency, multiple ethnic and cultural backgrounds, and diversity with regard to gender, sexual orientation, and gender identity so we can better understand more specific network needs and priorities. This information will be incorporated in to our Network Plan, which will shape development activities in the coming year.

<p>10.</p>	<p>BH /DD Tailored Plan’s efforts for each service type outlined in <i>BH /DD Tailored Plan RFA Attachment F</i> to establish a Network that meets the State-funded Network adequacy standards.</p> <p>Alliance is committed to ensuring that recipients have broad access to an array of high-quality behavioral health (BH), intellectual and developmental disability (IDD), traumatic brain injury (TBI), and long-term services and supports (LTSS) services through a closed network of BH, IDD and TBI providers.</p>
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As described above (see Question 1), we have submitted our annual Network Adequacy and Accessibility Analysis and have identified service gaps in the following areas:

Location-Based:

- **Psychosocial Rehabilitation:** currently, 80% of recipients have a choice of two PSR providers within 30 minutes/miles, so we will be exploring options to improve choice in Cumberland and Durham counties, both of which currently have only one state-funded PSR provider.
- **SA Comprehensive Outpatient:** we have sufficient capacity to allow a choice of one provider for all state-funded individuals, but currently only 67% have a choice of two providers within 30 minutes/miles. We will be exploring options for expansion of choice in areas without a choice of two providers.
- **Opioid Treatment:** we are in the process of expanding contracts to meet this standard by adding state-funded contracts in Cumberland (Fayetteville Treatment Center) and Durham (Durham Treatment Center) counties
- **Partial Hospitalization:** we no longer meet LME-MCO network adequacy standards for this service due to changes in DHHS network adequacy standards that require a choice of two providers within 30 miles/minutes, and will need to add programs in Cumberland, Durham and Johnston counties to meet TP standards that require access to one provider within 30 miles/minutes. We will begin discussions with local hospitals as well as behavioral health providers in each community to assess interest in adding this service, and will pursue a competitive RFP if necessary.

Crisis Services:

- **Professional treatment services in facility-based crisis program:** although we meet current network adequacy standards for this service, the Tailored Plan requirements for one facility per 450,000 regional population will require us to increase capacity or seek a waiver from the Department. We currently have programs in Wake, Durham and Cumberland, and will be adding a child facility-based crisis facility within the region by the Summer of 2021. If funding is available to add additional facilities, priority areas will be development of a program in Johnston and an additional program in Wake.
- **Ambulatory Detoxification, ambulatory withdrawal management with extended on-site monitoring, and clinically managed residential withdrawal:** we currently do not have these services in our network, but we are working on network development of the SUD continuum in collaboration with current providers and community stakeholders. Since there are non-contracted physicians in our community who provide office-based opioid treatment and other SUD treatment within their practices, we will be reaching out to them as well as currently contracted behavioral health providers to identify additional providers of these services. If needed, we will pursue expansion through a competitive RFP process.

Residential Treatment Services: we currently do not meet TP standards for Residential Treatment Facility Services and have gaps for adolescent SA Halfway House as well as SA Non-Medical Community Residential Treatment for adolescents. We plan to work with current providers of residential care and possibly new providers to develop expansion plans for these services.

We are also preparing for additional service options to be developed this year as described in Section VII, Attachment F.2, Table 1. We will also be collaborating with our SUD provider network to expand services as new clinical coverage policies associated with the 1115 Waiver are released.

An important consideration in our future plans for state-funded services is the availability of sufficient state funds to support service expansion. Several factors that may limit funding availability are the impact of the financial downturn associated with the COVID-19 pandemic on number of uninsured seeking care as well state revenue that supports availability of service funding. Decisions about priority services for expansion will be made based on funding availability, service impact and the capacity for services to address needs of priority populations.

11. **BH /DD Tailored Plan’s quantifiable and measurable process for monitoring and assuring the sufficiency of the State-funded Network to meet the health care needs of all recipients on an ongoing basis, including the frequency of the monitoring. The frequency of monitoring shall be at least once a month.**

Evaluation and Monitoring of Network Adequacy

Alliance conducts an annual review of network adequacy and accessibility through a process that is informed by multiple sources of information, including community demographics, utilization trends, recipient and stakeholder feedback, and other relevant data regarding service gaps and network performance. In addition to geographic mapping of service availability and recipient choice, this analysis evaluates access for specific populations, specialized service needs, and the adequacy of the network in serving recipients with physical access barriers, limited English proficiency, multiple ethnic and cultural backgrounds, and diversity with regard to gender, sexual orientation, and gender identity. This analysis serves as the basis for our Network Access Plan, which includes plans for addressing network gaps, reducing access barriers, and improving access to high quality and effective care. This plan is updated as new service gaps are identified and as known access barriers are resolved.

Monitoring network adequacy and access to care: In addition to annual review of network adequacy and accessibility, we monitor network adequacy continuously to identify any significant changes that may affect recipient access to care. Information about changes in network capacity may come from multiple sources, including the Access & Information Center, care managers, Compliance Department, credentialing staff or recipient complaints. We have processes in place to respond quickly to identified gaps, including weekly Provider Network Management and monthly CQI Member Experience Subcommittee meetings, as well as the use of ad hoc meetings to evaluate the impact of service gaps and develop strategies for resolution.

Access standards are reviewed and updated annually in conjunction with renewal of Alliance contracts with DMA and DMH, and we include network access requirements in all provider contracts. Since network access is a critical performance measure for Alliance in our contracts with the Department, we monitor performance of our network providers on a continuous basis to ensure compliance with standards and to improve network service accessibility. The

monitoring process includes review and analysis of multiple sources of information, including claims data, grievances and incidents, provider monitoring results, surveys and other sources as available. The process is multi-departmental and includes regular reports and data analysis that quantify progress on targeted access goals, as part of a Quality Improvement Process overseen by the Quality Management Department.

Recipient access is monitored most closely for individuals who contact our Access & Information Center, since Alliance has information about the date and time of the service request and can track the timeliness of initiation of care. Individuals who call our Access to Care Line receive 24/7/365 live assistance by qualified Alliance staff who are able to provide information about service availability and can schedule appointments with providers directly through the “slot scheduler” online database of provider appointments. Alliance Access staff link recipients to the appropriate services requested, with a goal of meeting the timeframes specified by the state. Alliance has established protocols for screening and triaging callers in order to collaborate with the network of providers to meet this need. The Access Center uses an Appointment Availability Dashboard which provides a real time view of network appointment availability and capacity. In the event that there may be a limited number of timely appointments available, the Access Center outreach to providers to have them enter additional availability into the scheduler system.

For recipients who contact providers directly, which is most common, Alliance monitors timeliness of onset of care through provider monitoring and response to recipient complaints. The primary monitoring process for timely onset of care will be through regularly scheduled check-in calls by Provider Network Development Specialists (PNDS), who will contact a selected sample of providers each month. During these check-in calls, the PNDS will confirm provider directory access, status of referral acceptance, and appointment availability, including timeliness of intake appointments and follow-up appointments including medication management. Results of monitoring calls will be submitted to Provider Development Evaluation for further review, summary and comparison to other sources of data such as claims and grievance information. On at least a monthly basis, PDE will submit a summary report for review by the CQI Member Services Committee for further review and identification of potential access gaps. The team will identify and track follow up plans, including actions such as technical assistance, focused monitoring, network expansion or other strategies for reducing access barriers. Information about service access will be shared with Call Center and Care Coordination staff to inform referral decisions. Alliance also evaluates recipient access and develops quality improvement strategies through the Access to Care Quality Improvement Plan.

We have recently contracted with HealthCrowd, a digital communications platform that will enable us to improve communication with our recipients. We plan to use this technology to improve recipient input about network adequacy and accessibility and will review recipient feedback regularly as a critical component of our network access monitoring.

Alliance reviews additional sources of information to evaluate quality, utilization, and accessibility of care, including the following:

- **Recipient and provider satisfaction surveys**, including ECHO, Perception of Care, Provider Satisfaction, National Core Indicators, Staying Well, My Individual Experience, Call Center Recipient Experience, and Network Adequacy and Accessibility surveys of recipients, family, providers, stakeholders and staff.
- **Ad hoc surveys** allow us to ask specific questions. For example, during the initial rollout of telehealth services, Alliance called recipients to analyze the impact and satisfaction of our rapid telehealth rollout. We also gathered data about the provider perspective and were able to compare their experiences and identify additional needs for education.
- **Provider Dashboards**, which allow us to share performance data with providers. Data includes utilization management, HEDIS, and other quality measures with associated performance standards, as well as data on critical incidents and recipient grievances.
- **Executive walkthrough feedback** of provider sites to better understand recipient experience with providers and to give providers feedback about that experience.

Reporting. In addition to the annual submission of the network adequacy and accessibility analysis, we plan to ensure regular review and reporting of network adequacy, both internally and to the Department, as follows:

- We will monitor network adequacy on at least a monthly basis through review at the monthly CQI Member Experience Subcommittee meeting, and we will report any identified gaps to CQI Subcommittees as appropriate. We will identify a specific subcommittee based on the nature of the gap identified. For example, the Utilization Management committee may review concerns about service underutilization or overutilization, the Provider Quality Subcommittee may address gaps relating to clinical practice standards, the Member Experience Subcommittee will review trends in recipient grievances and satisfaction, and the Health Equity Subcommittee will address healthcare disparities.
- Within five (5) business days of identifying a significant change in network capacity or access, Alliance will notify the Department, and we will submit an updated Network Access Plan, network data file and as needed, network adequacy exemption requests, within thirty (30) days.
- We will provide regular progress reports on our Network Access Plan as requested by the Department.

12. Factors the BH /IDD Tailored Plan used to build the State-funded Network, including a description of the criteria used to select providers for the network.

Alliance has successfully developed and managed a robust network of behavioral health (BH), intellectual and developmental disability (IDD), and more recently traumatic brain injury (TBI) providers that have afforded our recipients a choice of high-quality and evidence-based services and service providers across a broad continuum of care.

	<p>The current State-funded behavioral health network consists of over 90 agencies within the Alliance catchment area. Practitioners include physicians, non-MD prescribers, doctoral level psychologists and masters level clinicians, with all disciplines being well-represented in each county. Our service array includes a breadth of service types, including services available within each county such as outpatient treatment, location-based ambulatory services, and community-based treatment options, as well as regionally available care such as crisis services, inpatient treatment and residential treatment.</p> <p>For the closed behavioral health network, Alliance evaluates network capacity and accessibility to identify specific service needs and adds services and contracted providers based on identified service gaps. Depending upon the specific need identified, we may approach current Medicaid-contracted providers to offer state-funded contracts, open our network for new provider applications, or solicit proposals through competitive bidding processes. The factors used for selection include provider geographic location, service capacity, quality of care, use of evidence-based practices, and alignment with diversity, equity, inclusion and cultural competency goals.</p>
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13.	<p>BH /DD Tailored Plan’s process and methodology to understand the distribution of Recipient health care needs against available providers and provider capacity to serve those needs.</p> <p>Identification of service needs. Alliance will use multiple factors to identify service needs and monitor network adequacy, including:</p> <ul style="list-style-type: none"> • Number of uninsured • Demographic, cultural, ethnic, racial and linguistic information for populations served • Characteristics and health care needs of covered populations • Historical and expected utilization of services • Number and types (specialty) of providers required to provide Covered Services • Provider characteristics, specializations and competencies to address identified population characteristics, including ability of providers to provide culturally competent services and to communicate with limited English proficient recipients in their preferred language • Network capacity to allow physical access, provide reasonable accommodations, culturally competent communications and accessible equipment for recipients with physical or intellectual disabilities • Provider availability, including ongoing monitoring of the number of network providers who are not accepting referrals • Recipient ability to access care within established benchmarks <p>Since all Alliance catchment counties are categorized as urban, we will ensure that our network meets the more stringent urban standard for service types that are subject to geographic and driving time standards. We will use multiple sources of data on a regular basis to monitor network sufficiency, including State-Funded Enrolled Provider data, service utilization reports, timely access to care reports, and recipient complaints.</p>
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<p>14.</p>	<p>BH /DD Tailored Plan’s plan to provide in-network access, compliant with the Department’s State-funded Network adequacy standards, to children to the full range of age-appropriate mental health, substance use, and I/DD providers.</p> <p>Alliance has extensive experience developing a system of care for children and adolescents for behavioral health and is committed to ensuring that the service continuum has adequate capacity to provide age-appropriate, evidence-based and accessible services for children and adolescents. We will reach out to providers with child-focused expertise as a component of our initial and ongoing network development efforts, and will include this priority in annual network adequacy analysis and ongoing network adequacy monitoring.</p>
<p>15.</p>	<p>BH /DD Tailored Plan’s method for ensuring children’s mental health, substance use, and I/DD needs will be met using appropriate child-focused specialty services that include supports and services from in-network providers who have special training in child health development.</p> <p>All counties in the current as well as planned Alliance catchment area are categorized as urban and have a relatively high ratio of providers per capita, compared to rural areas of North Carolina. With a few exceptions, our state-funded providers are a subset of our Medicaid contracted network, enabling Alliance to expand capacity for uninsured children by adding state-funded contracts. Within this network, we currently contract with a broad range of practitioners with specialized training to serve children and adolescents.</p> <p>We have also enhanced specialty care for children and adolescents through development and implementation of new service options, including evidence-based practices that are available through multiple service lines. For example, we require all Intensive In-Home providers to provide at least one of an identified set of EBPs with external fidelity review, such as Eco-Systemic Structural Family Therapy, Strengthening Families Program, or Trauma-Focused Cognitive-Behavioral Therapy. We work collaboratively with providers to identify service gaps for children and adolescents and opportunities for improving access to care and coordination of treatment with school systems, juvenile justice systems and other community stakeholders. Within the Child Enhanced Services Collaborative, Alliance supports providers through ongoing communication, training, education and technical assistance.</p>
<p>16.</p>	<p>BH /DD Tailored Plan’s approach to assure children’s access to child psychologists and child and adolescent psychiatrists (defined as having completed Accreditation Council for Graduate Medical Education (ACGME) accredited child/adolescent psychiatry fellowship and/or have board diplomat status as a child/adolescent psychiatrist).</p> <p>We will work both with network providers to ensure adequate capacity and access to child psychologists and child and adolescent psychiatrists throughout our network. We anticipate that the counties in our catchment area will have adequate representation of each specialty area, and we will evaluate network adequacy during the provider recruitment and contracting process to identify any areas in need of focused recruitment efforts.</p>
<p>17.</p>	<p>BH /DD Tailored Plan’s Quality Assurance Standards, consistent with the Department’s Quality Strategy and requirements, which must be adequate to identify, evaluate, and remedy problems relating to access, continuing care, and quality care.</p>

Monitoring network adequacy and access to care: In addition to annual review of network adequacy and accessibility, we monitor network adequacy continuously to identify any significant changes that may affect recipient access to care. Information about changes in network capacity may come from multiple sources, including the Access & Information Center, care managers, Compliance Department, credentialing staff or recipient complaints. We have processes in place to respond quickly to identified gaps, including weekly Provider Network Management and monthly CQI Member Experience Subcommittee meetings, as well as the use of ad hoc meetings to evaluate the impact of service gaps and develop strategies for resolution.

Access standards are reviewed and updated annually in conjunction with renewal of Alliance contracts with DMA and DMH, and we include network access requirements in all provider contracts. Since network access is a critical performance measure for Alliance in our contracts with the Department, we monitor performance of our network providers on a continuous basis to ensure compliance with standards and to improve network service accessibility. The monitoring process includes review and analysis of multiple sources of information, including claims data, grievances and incidents, provider monitoring results, surveys and other sources as available. The process is multi-departmental and includes regular reports and data analysis that quantify progress on targeted access goals, as part of a Quality Improvement Process overseen by the Quality Management Department.

Recipient access is monitored most closely for individuals who contact our Access & Information Center, since Alliance has information about the date and time of the service request and can track the timeliness of initiation of care. Individuals who call our Access to Care Line receive 24/7/365 live assistance by qualified Alliance staff who are able to provide information about service availability and can schedule appointments with providers directly through the “slot scheduler” online database of provider appointments. Alliance Access staff link recipients to the appropriate services requested, with a goal of meeting the timeframes specified by the state. Alliance has established protocols for screening and triaging callers in order to collaborate with the network of providers to meet this need. The Access Center uses an Appointment Availability Dashboard which provides a real time view of network appointment availability and capacity. In the event that there may be a limited number of timely appointments available, the Access Center outreach to providers to have them enter additional availability into the scheduler system.

For recipients who contact providers directly, which is most common, Alliance monitors timeliness of onset of care through provider monitoring and response to recipient complaints. The primary monitoring process for timely onset of care will be through regularly scheduled check-in calls by Provider Network Development Specialists (PNDS), who will contact a selected sample of providers each month. During these check-in calls, the PNDS will confirm provider directory access, status of referral acceptance, and appointment availability, including timeliness of intake appointments and follow-up appointments including medication management. Results of monitoring calls will be submitted to Provider Development Evaluation for further review, summary and comparison to other sources of data such as claims and grievance information. On at least a monthly basis, PDE will submit a summary report for review by the CQI Member Services Committee for further review and identification of potential access gaps. The team will

identify and track follow up plans, including actions such as technical assistance, focused monitoring, network expansion or other strategies for reducing access barriers. Information about service access will be shared with Call Center and Care Coordination staff to inform referral decisions. Alliance also evaluates recipient access and develops quality improvement strategies through the Access to Care Quality Improvement Plan.

We have recently contracted with HealthCrowd, a digital communications platform that will enable us to improve communication with our recipients. We plan to use this technology to improve recipient input about network adequacy and accessibility and will review recipient feedback regularly as a critical component of our network access monitoring.

Alliance reviews additional sources of information to evaluate quality, utilization, and accessibility of care, including the following:

- Recipient and provider satisfaction surveys, including ECHO, Perception of Care, Provider Satisfaction, National Core Indicators, Staying Well, My Individual Experience, Call Center Member Experience, and Network Adequacy and Accessibility surveys of recipients, family, providers, stakeholders and staff.
- Ad hoc surveys allow us to ask specific questions. For example, during the initial rollout of telehealth services, Alliance called recipients to analyze the impact and satisfaction of our rapid telehealth rollout. We also gathered data about the provider perspective and were able to compare their experiences and identify additional needs for education.
- Provider Dashboards, which allow us to share performance data with providers. Data includes utilization management and other quality measures with associated performance standards, as well as data on critical incidents and recipient grievances.
- Executive walkthrough feedback of provider sites to better understand recipient experience with providers and to give providers feedback about that experience.

<p>18.</p>	<p>Geographical location of providers in Network in relation to where recipients reside.</p>
	<p>The Alliance catchment area currently comprises Cumberland, Durham, Johnston and Wake counties, and we will be adding Mecklenburg and Orange counties later this year. All counties are classified as ‘urban’ and are required to meet network adequacy time/travel distance standards for urban counties in our evaluation of outpatient and location-based services. We have developed a behavioral health provider network that ensures availability of outpatient and location-based providers within these standards, and have recently completed our annual evaluation of network adequacy, which is available at: https://www.alliancehealthplan.org/wp-content/uploads/Network-Adequacy-and-Accessibility-Analysis.pdf</p> <p>As the network adequacy analysis shows, for State-funded services, we currently meet requirements for outpatient treatment, and 100% of service recipients have access to a choice of at least two providers within 30 miles driving distance or 30 minutes travel time.</p> <p>Location-based services are divided into two categories with different network access standards. For one group, which requires access to one provider within 30 miles/minutes, we meet network adequacy standards throughout the catchment area. For the other group, which has been changed to require a choice of two providers within 30 miles/minutes, we meet standards for SA Intensive Outpatient Program but no longer meet network adequacy requirements for the following location-based services:</p> <ul style="list-style-type: none"> • Psychosocial Rehabilitation • Child and Adolescent Day Treatment • Partial Hospitalization • SA Comprehensive Outpatient Treatment • Opioid Treatment <p>This list includes services that previously met network standards but no longer meet due to the change in standards, and we have requested an exception to network adequacy standards for FY22. We are expecting additional grant funding that may allow expansion of Opioid Treatment, and we are making plans to meet network adequacy standards for this service upon receipt of additional funding.</p>
<p>19.</p>	<p>Description of how the BH I/DD Tailored Plan will address Cultural and Linguistic Competency for specific populations, such as</p> <ul style="list-style-type: none"> • Recipients with TBI, • Recipients with disabilities,

	<ul style="list-style-type: none"> • Recipients who are blind or visually impaired, • Recipients who are deaf or hard of hearing, • Recipients who are in the Armed Services, veterans and their families, • pregnant women with SUD, • Recipients who identify themselves as LGBTQ+, • Recipients who are in jails or prisons, • youth in the juvenile justice system, • justice-involved populations more broadly, HMPs, and other vulnerable populations.
	<p>Accommodation of recipient needs. In addition to ensuring the sufficiency, capacity and accessibility of the provider network, Alliance is committed to addressing the individualized needs of our recipients. We recognize that the effectiveness of services often depends upon the degree to which recipient characteristics and preferences are included in care delivery, and we will prioritize the development of a network that is responsive to and respectful of these characteristics, with a special focus on addressing the needs of historically marginalized and vulnerable populations. Our annual and ongoing analyses of network adequacy will include review of recipient characteristics and preferences, as well as provider capacity to address factors such as the following:</p> <ul style="list-style-type: none"> • Racial, ethnic, and cultural background and preferences • Language and communication preferences and barriers, including service provision by bilingual/bicultural staff, access to translation, and services for deaf and hard of hearing • Barriers to service access for individuals who are blind, deaf or hard of hearing, or physically disabled • Population characteristics that warrant specialized services or cultural competence, such as military/veterans and their families, pregnant women with SUD, people who identify as LGBTQ, and people in justice-involved populations. <p>We will undertake network development efforts to align the characteristics of our provider network with those of our recipient population, including monitoring of provider characteristics and capacity, network cultural competency improvement efforts, and focused network recruitment when necessary.</p>

<p>20.</p>	<p>BH I/DD Tailored Plan’s strategies to ensure access and availability of services and build sufficient provider capacity, including but not limited to addressing Department priorities to increase clinically appropriate access to and utilization of:</p> <ul style="list-style-type: none"> • ambulatory detoxification, • substance abuse non-medical community residential treatment, • substance abuse medically monitored residential treatment, and • SUD residential recovery services and supports, • medication assisted treatment and adolescent SUD treatment services,
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including how the BH I/DD Tailored Plan shall

- **analyze and monitor utilization of these services,**
- **develop clinical practice guidelines related to appropriate utilization of these services,**
- **configure a continuum of access to these services,**
- **pursue other efforts to enhance access and**
- **develop provider capacity for these services;**

Alliance is committed to developing and enhancing our continuum of care for individuals with substance use disorders, including those with polysubstance use and co-occurring mental illness or I/DD. We have prioritized development of a comprehensive, recovery-oriented service array that aligns with ASAM criteria, and have made significant developments over the past five years, particularly with respect to expanded access to opioid treatment.

We are anticipating new opportunities in the upcoming year with the development of new service options available through the implementation of the 1115 SUD Waiver and the corresponding changes to both Medicaid and State-funded service requirements. The transition in SUD services will include modification of staffing requirements, updating language of service definitions, modification or addition of licensure rules, changes in payment approaches (e.g., bundled rates) and rate models, and establishment of new services such as Ambulatory withdrawal management with extended on-site monitoring. A critical support for implementation of these changes will be a process for communication, training and technical assistance for providers, and we approach this through a combination of approaches including training events, online information, and discussion in SUD Collaborative meetings.

For new services or service gaps, we plan to work collaboratively with our current SUD network providers to identify expansion opportunities and areas in need of focused provider outreach. We are also in the process of expanding our catchment area to cover Mecklenburg and Orange counties and will be reaching out to providers and stakeholders in both counties to develop an understanding of network capacity, service gaps and continuum expansion opportunities. An important consideration in development of new services will be the availability of state and local funding as well as the impact of changes in service rates, so our network expansion plans for the SUD continuum will be contingent upon funding availability.

We have been piloting several opioid treatment projects that focus on reducing barriers to care, promoting cross-systems collaboration to improve access, and incorporating peer supports into systems of care to promote engagement and retention. We have also worked collaboratively with DHHS, providers and stakeholders to develop evidence-based approaches to care that include harm reduction principles, promote recovery, address stigma, and emphasize low-threshold access to care. We are working with providers to develop and clarify standards of care and will work within our CQI Provider Quality Committee to develop and promote clinical

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	<p>guidelines for SUD treatment. We are developing metrics and processes for monitoring service utilization and clinical outcomes, and will review this information regularly through our CQI Committee structure.</p>
<p>21.</p>	<p>BH I/DD Tailored Plan’s strategies to ensure access and availability of services and build sufficient provider capacity, including but not limited to addressing Department priorities to increase clinically appropriate access to and utilization of the BH I/DD Tailored Plan’s First Episode Psychosis programs (FEP), including how the BH I/DD Tailored Plan shall</p> <ul style="list-style-type: none"> • analyze and monitor utilization of FEPs, • develop clinical practice guidelines related to appropriate utilization of FEP and educate and train providers, and • pursue efforts to enhance access and develop FEP capacity with a focus on recipients between fifteen (15) and thirty (30) years old who have or are at high risk of psychosis (e.g., build new programs, connect recipients to existing programs, conduct active surveillance of those at-risk) <p>Response: First episode psychosis (FEP) programs. Alliance currently contracts with FEP programs in Wake and Orange counties, both of which are operated by UNC using the team-based, multi-element Coordinated Specialty Care (CSC) model. We are interested in expanding awareness of the CSC model and the importance of early identification and appropriate treatment of first episode psychosis. As a Tailored Plan, we will have increased ability to increase awareness of FEP and will promote screening and early identification activities within crisis and inpatient facilities, medical and behavioral health practices, practices serving adolescents and young adults, and community stakeholders such as local education agencies. We will also identify FEP through care management and data analytic processes and will encourage referrals to FEP programs when appropriate. We have a strong partnership with UNC and plan to collaborate with them both on analysis of their program outcomes as well as opportunities for service enhancement, outcomes evaluation and expansion to underserved areas. We will also collaborate on review and adoption of clinical practice guidelines and potentially implementation of external fidelity review of the CSC model.</p>

<p>22.</p>	<p>BH I/DD Tailored Plan’s strategies to increase clinically appropriate access to and utilization of case management services for recipients with behavioral health conditions, including how the BH I/DD Tailored Plan shall</p> <ul style="list-style-type: none"> • analyze and monitor utilization of these services, • develop clinical practice guidelines related to appropriate utilization of these services, pursue other efforts to enhance access, and • develop provider capacity for these services <p>Alliance will undertake a dedicated care management approach in order to serve populations with low and modest incomes who need specialized services that are not otherwise available to them. Alliance will provide care management directly to individuals with I/DD and TBI and will develop, coordinate with, and oversee a network of providers that are able to provide case management to individuals with BH and SUD whose care is covered through State funds and meet priority criteria. Provider-based case management will be developed in anticipation of the</p>
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release of a State case management service definition for individuals with BH support needs. To promote the efficient delivery of BH State-funded case management, Alliance will only contract with BH entities that are contracted with Alliance to provide Tailored Care Management to our Medicaid Members. Providers offering Tailored Care Management will have the IT, clinical, and administrative infrastructure in place to deliver case management to Recipients. This infrastructure, coupled with Alliance support, including our Tailored Care Management Learning Collaborative and Practice Transformation support, will enable these entities to implement the new State service and provide it effectively. The majority of BH providers that are participating in the Alliance Care Management Learning Collaborative provide enhanced and residential services that contain case management elements, further bolstering their ability to deliver this service. Two of the providers in the Collaborative that are planning to seek Tailored Care Management certification have been trained and are already providing High Fidelity Wrap- Around in and around our region. Additionally, all providers that will offer Tailored Care Management will receive comprehensive training from Alliance and individualized supports from Alliance practice transformation specialists to further strengthen their abilities to deliver case management.

Recruiting providers to deliver State-funded case management from this subset of providers will enable Alliance to rapidly set up a case management network that leverages these providers' trained staff, extensive knowledge related to the local system of care, and existing clinical and IT infrastructure. Once the service definition is released, Alliance will dedicate a portion of the monthly Tailored Care Management Learning Collaborative that we have been facilitating since November 2019 to help orient providers to the service and expectations, as well as collectively address barriers and challenges to implementation. Our approach to develop case management capacity will also promote continuity of care. We will require entities that are contracted to provide case management to assist Recipients to apply for Medicaid, which will aid in a seamless transition from case management to Tailored Care Management if the Recipient becomes Medicaid eligible.

23.	Did the BH I/DD Tailored Plan submit separately with the Network Adequacy Annual Submission Report, the Annual Network Adequacy Results Tables Workbook File?
	<input type="checkbox"/> Submitted
	<input checked="" type="checkbox"/> Not submitted (add explanation below)
	Explanation for not submitting: These documents are not due for this submission. We did submit the Network Adequacy and Accessibility Analysis for 2020 and 2021 at the end of FY21.

24.	Did the BH I/DD Tailored Plan submit separately Network Data File Extract containing all currently contracted providers?
	<input type="checkbox"/> Submitted
	<input checked="" type="checkbox"/> Not submitted (add explanation below)
	Explanation for not submitting: This document is not due for this submission.

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25.	Confirm that the BH I/DD Tailored Plan has considered and demonstrated capacity to serve the expected enrollment in each region listed in <i>Section I.D.</i>
	<input checked="" type="checkbox"/> Confirm
	<input type="checkbox"/> Not confirmed
	Explanation for not confirming:

Submit this document and all additional pages and supplemental information as described in the current Inbound Job Aid (Job Aid). Refer to the Job Aid for file submission and file naming protocols.

VERSION

Date	Section Updated	Change
06/30/2021	Original (v1)	



Section A – Background

1. BH I/DD Tailored Plan Name: Trillium Health Resources
2. Submission Date: 8/25/21
a. Version Number (2021- 01)
3. Reason for Submission (select one): <input type="checkbox"/> Annual <input type="checkbox"/> Significant Change <input checked="" type="checkbox"/> At Request of Department <i>(provide explanation below)</i>
Explanation of significant change(s) triggering revision to the Plan. <i>(Complete only if Significant Change is selected above; add additional pages as necessary.)</i>
Response:

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Section B – Network Access Plan for State-funded Services (SFS)

The BH I/DD Tailored Plan shall develop a Network Access Plan for SFS and provide documentation that demonstrates that it has the capacity to serve the expected enrollment in its entire Region in accordance with the Department’s BH I/DD Tailored Plan Network Adequacy Standards (as found in *BH I/DD Tailored Plan RFA Section VII. Attachment F.2. BH I/DD Tailored Plan Network Adequacy Standards for State-funded Services*), state and federal law where applicable, and the terms of this Contract.

The Network Access Plan must be provided:

- Thirty (30) days after Contract Award
- As specified by the Department (i.e., at the request of Department)
- Annually
- Within thirty (30) days of a significant change, including merger or county disengagement
- Within forty-five (45) days of a significant change to the provider network

The Network Access Plan for SFS must address each of the following prompts. A Plan that includes any blank items will be deemed to not meet expectations, and the BH I/DD Tailored Plan may be subject to corrective action and/or other penalty as outlined in the BH I/DD Tailored Plan Contract.

The BH I/DD Tailored Plan shall add additional pages as necessary to provide a complete response to each item. The response should note if additional pages or supplemental information is attached to the report. All attachments should be labeled to align with the appropriate item by Section and number.

1.	<p>BH I/DD Tailored Plan’s plan to maintain State-funded Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of State-funded Services Recipients in the Region.</p> <p>Response:</p> <p>Sufficiency: Trillium currently manages a State-funded Network that provides services throughout Region 7 of the BH I/DD Tailored Plan Regions that is sufficient to meet the needs of our Recipients as measured from the Recipient’s residence for adult and pediatric providers in accordance with NCDHHS standards.</p> <p>Trillium maintains a restricted network for State-funded services that provides access to care while carefully managing the availability of funding to ensure continued access.</p> <p>Criteria for Provider Availability includes, but is not limited to:</p> <ul style="list-style-type: none"> • Number of Healthcare Professional(s) and facilities available per Recipient • Geographic Distribution of Providers • Availability or timeliness in which Recipients can access a participating provider <p>Adequacy Measures and Reporting: Trillium measures adequacy according to the Department’s standards annually or when significant changes occur and monitors network fluctuations on a regular basis. If a service category does not achieve the required benchmark, Trillium develops and implements a mitigation plan to remedy the gap, which may include, but is not limited to, provider recruitment via a Request for Proposal process.</p> <p>Trillium strives to correct any network gaps quickly to avoid limited access for Recipients. In addition to efforts to close any gaps, Trillium will notify the Department within five (5) business days of a significant change and update the Network Access Plan within thirty (30) days, which shall include an updated attestation of compliance with standards, updated Network Data File, and any updates or new requests for exception.</p> <p>Trillium has developed systems, strategies, and procedures to confirm quality assurance standards are met and Recipients have access and availability of services. Trillium uses a suite of advanced software and analytics tools to monitor the health of our provider network in near real-time. This capability gives Trillium the ability to quickly produce advanced geospatial analyses in response to emergent needs from our</p>
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	<p>Recipients. Trillium also assesses the impact of adding a specific site(s) on access prior to contracting with the provider, allowing Trillium to optimize site locations and maximize access.</p> <p>Provider Relations and Engagement: Trillium maintains long-lasting relationships with Network providers by solidifying strong working relationships to support Recipient care. Trillium will be available to assist network providers to answer questions or issues that a provider may potentially experience. Our “one-touch” issue/inquiry resolution approach provides immediate access and removes the unnecessary burden of transferring calls between departments. Trillium staff are trained on all relevant departments, including a deep dive into our geographic catchment area, department roles, access scripts, and communication tools. Providers may call the Provider Support Service Line for assistance Monday – Saturday: 7am to 6pm ET effective February 1, 2022. Prior to this date, Trillium launched the Provider Support Service Line to ensure that any needed adjustments are addressed prior to February 1, 2022. Trillium has skilled, compassionate, well-trained staff to consistently provide excellent customer service to providers that contact our Provider Support Service Line. To support a “no wrong door” philosophy and provide prompt customer service, providers also have an option to submit their inquiry into our Network Service Support Ticket System, which is a helpdesk tool that is supported by our Provider Network staff. Providers also have access to Claims Specialists to assist with timely filing of claims and reimbursement.</p> <p>Provider Communications: Other network engagement activities include but are not limited to posting frequently asked questions and answers, sharing Provider welcome packets, initiating surveys and interviews with providers to facilitate program evaluation and service delivery. All providers and their staff are invited to sign up to receive Network Communication Bulletins, Clinical Communication Bulletins, and Urgent Notifications. Trillium communicates, engages, and collaborates with providers through these provider communications.</p> <p>Provider Manual: Trillium’s Provider Manual provides detailed information on how providers should engage with Trillium. It is a resource guide for providers to ensure the delivery of quality health care services. It includes the processes and procedures we expect from providers and explains what providers can expect from Trillium in return. Trillium’s Provider Manual includes all required subject matter as identified by the Department.</p> <p>Provider Education and Training-My Learning Campus: Trillium has an extensive education and training program for providers on a platform called My Learning Campus. My Learning Campus offers providers online, on-demand trainings on a user-friendly platform. Network status is verified before user accounts are issued to ensure only our providers are able to access our robust training platform designed just for them. Upon entry into our Network, providers are required to complete the New Trillium Provider Orientation training. We also provide comprehensive trainings on this platform for Provider Direct, through which providers submit claims, clinical documentation, etc. We also include on our training site a host of other helpful trainings such as Medicaid Transformation, Recipient Benefits, and Cultural Competency.</p>
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2.	<p>BH /DD Tailored Plan’s procedures for referrals.</p> <p>Response: Trillium does not require formal written or electronic referrals to providers for specialty care services. Trillium assists in referral of our Recipients for services as needed to effectively coordinate care and non-health needs.</p> <p>Provider Directory: Trillium updates its online Provider Directory on a daily basis to promote easy and transparent access to providers. Our Provider Directory is available online and provides information on all participating providers. A Recipient may also download an English or Spanish Provider Directory from our website or contact our Member¹ and Recipient Service Line to request a paper copy of the directory to be mailed to them within five days. Visitors to the website can also print the full directory or results after completing a search.</p> <p>The Provider Directory is accessible 24/7/365 via our website. It is searchable and contains all required fields such as provider name, gender, discipline/provider type, specialties, accepting new referrals,</p>
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	<p>languages spoken/interpreters available, cultural competency (training completed), office address, phone number, organizational affiliations, board certification, website URLs, and ADA accessibility. The Provider Directory refreshes every 24 hours through direct links to our TBS provider database. Trillium provides a fully integrated, publicly accessible provider directory that includes all the required elements/filters.</p> <p>Member & Recipient Service Line: Recipients can call our Member & Recipient Service Line to connect with a Trillium Call Center Agent for assistance in determining the types of services needed and in connecting the Recipient to a Provider.</p> <p>¹ Member, unless otherwise specifically indicated in the Contract, refers to (1) a Medicaid beneficiary whose Medicaid eligibility arises from residency in a county covered by the BH I/DD Tailored Plan or who is currently enrolled in and receiving benefits through the BH I/DD Tailored Plan and (2) a Recipient who is actively receiving a State-funded Service or State-funded function, paid for by State Funds or Federal Block Grant Funds.</p>
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3.	<p>BH I/DD Tailored Plan’s procedures for disclosures and notices to Recipients of the BH I/DD Tailored Plan’s services and features.</p> <p>Response: Trillium communicates with State-funded Recipients in a variety of ways, including: Welcome Letters, Member and Recipient Handbooks, newsletters, communication bulletins, emails, texts, and Trillium’s website.</p> <p>Welcome Letter: When a person enrolls with Trillium, they will receive a Welcome Packet that includes a copy of our Notice of Privacy Practices/Rights and Responsibilities, and a letter that provides detailed information on requirements such as how to access our online provider directory and a summary of Benefits and Coverage. The Welcome Letter will also provide instruction on how to create an account in My Learning Campus, where additional information regarding the plan can be found. The letter informs the Recipient of how to access the Trillium Member and Recipient Handbooks which provides detailed information on numerous important topics such as their rights and responsibilities, how to find a provider, covered benefits, the Ombudsman Program, etc.</p> <p>Member and Recipient Handbooks: The Trillium Member and Recipient Handbooks includes important information that describes the plan. It explains the benefits for health care services, as well as applicable plan terms, conditions, exclusions, and limitations. The Member and Recipient Handbooks helps individuals to understand:</p> <ul style="list-style-type: none"> • Plan Benefits, Exclusions, and Limitations; • Which Services Require Prior Authorization; • Continuity of Care and Transition of Care • How Trillium contracts with providers and works with our providers to ensure delivery of quality health care; • How Emergency Care works within the plan; • Rights and Responsibilities of a Trillium Recipient; and • How to File a Complaint or an Appeal <p>Individuals and Families Webpage: Through the Trillium Individuals and Families Webpage and orientation, a Recipient can:</p> <ul style="list-style-type: none"> • Learn about health plan benefits, including viewing the Summary of Benefits & Coverage, Schedule of Benefits and Insurance Policy; • Find an In-Network Provider in the neighborhood; • Register for My Learning Campus; • Sign up for Newsletters; • Learn about Community Events; • Review archived Trillium News Releases.
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Recipient Communications Bulletins: Recipients who choose to provide their email addresses are sent information regularly to promote new opportunities, distribute new communications from NCDHHS, and remind Recipients of tools available on our website.

Text Message Campaigns: Trillium reaches out with occasional text messaging campaigns that encourages visits to our website, links to trainings on My Learning Campus, and promotes annual surveys. Recipients can opt out at any time or manually add themselves using the link on our website.

Consumer and Family Advisory Committee (CFAC): The Consumer and Family Advisory Committee is an advisory group for our communities devoted to enhancing care for individuals with mental health, I/DD, and substance use disorders. A person considering Membership can visit the Trillium website for more information.

Social Media: Our social media accounts (such as Facebook and Twitter) give us another outlet to share information and events, along with a way to build a sense of community and connection for our populations.

My Learning Campus: My Learning Campus is a value-added benefit that offers free, online trainings and tip sheets for anyone to access. Trillium helps our communities build the necessary foundations to help improve well-being, provide solutions, and recognize the potential we all offer. Courses will cover a wide range of topics including:

- Updates to service offerings such as the Innovations Waiver;
- An introduction to Trillium, behavioral health, and how we operate; and,
- Reducing stress.

Appeals and Complaints: If a Recipient has a question about their benefit plan, they can contact our Member Service Line. Trillium maintains a formal mechanism for the resolution of grievances and appeals. We handle grievances and appeals promptly, consistently, fairly, and in compliance with State and federal law and NCDHHS requirements. A Recipient may file a grievance and appeal verbally, electronically or in writing. If a Recipient has a complaint, they can speak to a Trillium representative by calling the Administrative line at (866) 998-2597, submit an online submission via the Trillium Website at <https://www.trilliumhealthresources.org/explore-trillium/contact-us/complaint-grievance-compliment-question>, or in writing to the Trillium office at 201 W. 1st Street; Greenville, NC 27858.

Trillium staff are available to reasonably assist a Recipient in filing their grievance and appeal. Trillium provides language services as necessary to assist during the grievance and appeal process. Complete information about Appeals and Complaints is provided in the Member and Recipient Handbooks and on our website. Anyone may download a copy of the Member and Recipient Handbooks and the Appeals Brochure or request a copy.

Recipients with Physical and Mental Disabilities: To ensure all Recipients have access to notices and disclosures, Trillium offers a full version of its website and print materials in both English and Spanish. All webpages are accessible on tablets and smart phones. We also added an accessibility filter to help improve readability for Recipients with certain disabilities.

Trillium employs the UserWay Accessibility Widget® that offers a broad selection of functions that users can mix and match to meet individual accessibility needs. Each of the functions can be turned on or off or set at an exact interim value. Settings for each user are automatically saved for future site visits. Features include; keyboard navigation (user can navigate the site without using a mouse), screen reader (to narrate the text aloud), increase text size, stop animations, convert to accessible fonts (that are easier to read), highlight links, large cursor, reading guide, dark mode, light mode, invert colors (switch from color to black and white), text spacing, color desaturation, and reveal page structure.

Trillium provides all printed materials produced for Recipient use including, but not limited to, the Member and Recipient Handbooks and Welcome Letter in a manner that accommodates the special needs of those Recipients with intellectual and/or developmental disabilities, who are visually limited and/or who have limited reading proficiency.

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	Trillium Member and Recipient Service Line representatives are available to assist Recipients who have physical or mental disabilities, or other special needs. Special assistance is available for the hearing impaired with our TTY service. Information regarding this service is available in the Member and Recipient Handbooks.
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4.	<p>BH /DD Tailored Plan’s procedures for coordination and continuity of care.</p> <p>Response: Trillium puts every person first, every time, bringing our decades of local care management, care coordination, and case management experience to our Recipients. We leverage our expertise to scale operations internally to meet the needs of our Recipients.</p> <p>Coordination Activities: Upon release of the service definition from the Department and availability of funding, Trillium will implement State Funded Case Management to ensure that Recipients receive synchronized coordination of care and to confirm appropriate referrals and connections are made for Recipients to needed providers and/or community resources, including services that may be outside of the required benefits or not available in Trillium’s network. Trillium will ensure that appropriate referrals and linkages are made for Recipients to the applicable provider or community resources. This includes the sharing of information with other insurance payers according to federal, state, and/or regulatory guidelines. In addition, Trillium will assist new providers in obtaining records as appropriate and in compliance with federal and state law.</p> <p>Continuity of Care: Trillium is well positioned and prepared to support transitioning Recipients when changes to providers occur. Trillium makes every attempt to ensure a seamless transition of Recipients to new providers. Staff will review all relevant information to coordinate care transitions and assure continuity of health care service. We monitor and track each Recipient by overseeing the completion of the Member Transition Plan. Network staff sends a written notice of the termination to all Recipients who have been receiving services from that provider as soon as possible, but no later than fifteen (15) calendar days. The written notice contains detailed instructions on how to choose a new provider, the necessary step to ease transition, link to the Provider Directory, and phone number to contact the Trillium services line to assist in selecting a provider.</p>
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5.	<p>BH /DD Tailored Plan’s efforts to address the needs of all Recipients, including those with limited English proficiency or illiteracy.</p> <p>Response: Trillium is committed to ensuring a network of providers and knowledgeable staff to address the needs of all Recipients, including those with limited English proficiency or illiteracy. Trillium ensures that internal staff complete Cultural Competency Training that focus on barriers that Recipients may face such as behavioral health/substance use concerns, unmet health needs, and resources for Recipients with Limited English Proficiency (LEP). In addition, Trillium’s network of providers are provided cultural awareness & competency training to include information, training resources, and agency assessment tools to support culturally competent communication. Providers have access at any time to cultural sensitivity information and cultural competency and health literacy training material via My Learning Campus, Trillium’s online Provider Portal. Cultural competency and health literacy training will include information on such topics as health communication, health literacy, cultural competency, limited English proficiency (LEP), auxiliary aids and interpreter services, ensuring compliance, disability sensitivity, and changing attitudes.</p> <p>Additionally, Network Communication Bulletins focused on the provider network are distributed throughout the year and are used to deliver information on emerging and effective best practice standards for diverse populations. Trillium’s network of providers are encouraged to identify resources utilizing focus groups or interviews with cultural or linguistic minority Recipients to determine how to meet their unmet health needs or for cultural engagement and interaction within their communities.</p>
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	<p>Trillium provides language assistance services, including the provision of qualified interpreters and translation services, and auxiliary aids and services to Recipients in accordance with translation and interpreter services requirements in the Contract to achieve effective communication. Trillium ensures that contacts with Recipients are culturally and linguistically competent and provide effective communication, including sign language interpreters, and occur in a timely manner that protects Recipient's privacy and independence.</p> <p>Trillium's Member and Recipient Service Line provides direct support in both English and Spanish. Access for other languages is provided through a translation service. Our provider search website allows Recipients to search by a variety of filters, including additional languages spoken.</p> <p>Trillium provides access to interpreter services and toll-free numbers with adequate TTY/TDD and interpreter capability via the 24-Hour Behavioral Health Crisis Line. Our website also has capability to view information in Spanish by the click of a button in order to view complex state policy topics such as Medicaid Transformation. Trillium also provides assistance in completing forms and taking other procedural steps related to a complaint or appeal including but not limited to auxiliary aids and services upon request.</p> <p>Trillium requires access to language assistance services at all times. These requirements are outlined in network provider contracts and the Trillium Provider Manual.</p>
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6.	<p>BH /DD Tailored Plan's efforts to address the needs of historically marginalized populations;</p>
	<p>Response: Trillium confirms that network providers are culturally competent and deploys strategies to reduce health inequities in regard to Historically Marginalized Populations that have historically and systematically been denied access to services, resources and power relationships across economic, political, and cultural dimensions because of systemic and persistent racism, discrimination and other forms of oppressions.</p> <p>Trillium System of Care staff engages and participates in local task forces aimed at discussing community needs that may be stigmatized or marginalized. Our staff is part of the discussion to find solutions and engage stakeholders. Trillium also embeds collaboration in multiple committees and over 400 meetings and task forces on an annual basis including but not limited to: Community Collaboratives, Juvenile Crime Prevention Council, School-based Mental Health, Opioid Coalitions, Council of Community Services, Child Advocacy Planning, Human Trafficking committee, Transportation Boards, Juvenile Justice Substance Abuse Mental Health Partnerships, and Churches Outreach Network.</p> <p>Trillium also maintains a webpage on Anti-Racism Efforts to underscore our stance and actions around antiracism efforts. Trillium collaborated with Historically Black Colleges and Universities to reach potential community collaborative partners and provides monthly awareness events to our annual calendar including Black History Month, Native American Heritage Month, and Hispanic Heritage Month. Trillium also provides resources for providers including Racial Equity Tools and data on disparities.</p> <p>Trillium prioritizes whole-person care with a focus on unmet health needs that affect health outcomes for Recipients. Trillium focuses on transportation, employment, food, interpersonal safety, and housing in alignment with statewide non-medical drivers of health priorities. Trillium is also focusing on social integration and community inclusion as an essential component of wellness.</p> <p>Trillium utilizes HOMES funds for individuals to request financial assistance for housing-related costs that could sometimes otherwise leave the individual without housing. Trillium's Neighborhood Connections Department has also been another resource for individuals when addressing non-medical drivers of health to promote healthy outcomes and reduce disparities.</p> <p>Trillium also continues all antidiscrimination efforts as part of our Credentialing and Contracting process so that providers applying to join Trillium's network are evaluated fairly and consistently. Trillium ensures that all staff and Provider Network Participation Committee Recipients review the meaning of discrimination and sign an antidiscrimination statement prior to participating and annually thereafter.</p>

<p>7.</p>	<p>BH /DD Tailored Plan’s efforts to ensure that State-funded Network providers provide physical access, reasonable accommodations, and accessible equipment for Recipients with relevant physical, BH or I/DD needs;</p> <p>Response: Trillium is committed to ensuring equal access to health care providers and services that are physically and programmatically accessible for Recipients with physical, developmental, or mental health disabilities. All network providers are required to provide physical access, reasonable accommodation, and accessible equipment for Recipients in their network contract.</p> <p>Trillium also ensures accessibility by implementing the following strategies:</p> <ul style="list-style-type: none"> • Verifying accommodations and access through provider monitoring and site visits; • Tracking Recipient and provider complaints/grievances to identify potential accessibility concerns; • Providing Cultural Competency training to providers, including topics related to caring for people with disabilities; • Connecting providers to community partners for additional training and resources related to cultural competency; • Resolving identified deficiencies via offering technical assistance and /or Plans of Correction with follow up to ensure compliance.
<p>8.</p>	<p>BH /DD Tailored Plan’s efforts to assist the Department, as directed, to assess the capacity of select providers to ensure that Recipients residing in these facilities have access to remote communication options and devices to be used for communication with family and providers, including Telehealth and telephonic options, in cases of emergencies, where in-person visitation is restricted. Select providers include:</p> <ul style="list-style-type: none"> • Behavioral Health residential treatment facilities licensed under 10A NCAC 27G.1300, .1700, .1900, .3100, .3200, 3400, .4100, .4300, .5600. • Adult Care Homes licensed under 10A NCAC 13F and 13G. <p>Response: Trillium will assess the capacity of the following providers to ensure that Recipients residing in these facilities have access to remote communication options and devices for use in cases of emergencies and/or where in-person visitation is restricted, as directed by the Department.</p> <p>Trillium will monitor the capacity of the following facilities for State-funded Recipients:</p> <ol style="list-style-type: none"> 1. Behavioral health residential treatment facilities licensed under 10A NCAC 27G.1300, .1700, .1900, .3100, .3200, 3400, .4100, .4300, .5600, 2. Adult care homes licensed under 10A NCAC 13F and 13G
<p>9.</p>	<p>BH /DD Tailored Plan’s efforts to support and sustain providers, in rural and other traditionally underserved areas as well as providers representative of Historically Marginalized Populations.</p> <p>Response: Trillium uses innovative methods to increase accessibility for remote/rural areas, including enhancing rates, developing mobile services, and partnering with providers to create telehealth and telepsychiatry offerings.</p> <p>Trillium supports providers via a responsive and available Network Management staff to assist providers in successful service delivery including those in remote or rural areas, including hospitals and those representatives of Historically Marginalized Populations. Trillium ensures providers receive technical assistance and support throughout all aspects of the care delivery process including obtaining authorizations, filing claims, obtaining contract amendments, and requesting rate changes to promote sustainability.</p>

	<p>In addition, Trillium's System of Care staff work to provide a link between providers and the local community to facilitate program awareness and drive referrals. Trillium's Neighborhood Connections staff also works with Recipients and providers to connect with community resources and decrease unmet health needs to support integrated care. Trillium utilizes innovative approaches to services in remote areas of our region to support provider sustainability and ensures that crisis services are available 24/7/365.</p> <p>Trillium also supports telehealth in rural areas. If a Trillium Network Provider offers Telehealth (including Tele-psychiatry or Tele-behavioral Health) services, Trillium will allow Recipients to use that service as if a Telehealth visit were a face-to-face visit with the Network Provider. Trillium may utilize Telehealth as tools for facilitating access to needed services in a clinically appropriate manner and does not require Recipients to utilize telehealth in lieu of a face-to-face out-of-network provider.</p> <p>Trillium's pilot programs, Value Based Programs, and rate enhancements address challenges of providers with smaller Recipient counts and lower volume of service need. Trillium also supports workforce retention strategies through increased rates to promote higher reimbursement for Direct Support Professionals.</p> <p>Trillium ensures accurate and timely claims payment and offers providers assistance with potential claims issues.</p>
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10.	<p>BH /DD Tailored Plan's efforts for each service type outlined in <i>BH /DD Tailored Plan RFA Attachment F</i> to establish a Network that meets the State-funded Network adequacy standards.</p>
	<p>Response: To provide Recipients with timely access to all covered health care services, Trillium confirms that its network will meet the quantifiable and measurable time and distance standards from the Recipient's residence for both adult and pediatric providers for all State Funded services as identified in the BHIDD Tailored Plan RFA when funding is made available and there is an identified Recipient need. Trillium shall utilize the standards as specified in Attachment F to measure adequacy and ensure standards are met as follows:</p> <ul style="list-style-type: none"> • Section VII. Attachment F.2 BH /DD Tailored Plan Time/Distance Standards for State Funded Services • Section VII. Attachment F.2. Table 2: Definition of Service Category for Behavioral Health Time for State Funded Services, • Section VII. Attachment F.2. Table 3: Appointment Wait Time Standards for State Funded Services through geo access mapping and regular monitoring of network changes. <p>Trillium strives to maintain a network of appropriately credentialed providers to assure availability that allows Recipients to choose their providers to the fullest extent possible, promotes strategies to increase involvement with treatment, provides services that focus and support of building natural resources and increase social determinants of health (SDOHs), and promotes stability for children and families.</p> <p>Trillium will ensure that each service type meets network adequacy standards or obtains an approved exception. Service Types, as outlined in Attachment F, include:</p> <ul style="list-style-type: none"> • Outpatient BH Services • Location Based Services • Crisis Services • Inpatient Behavioral Health Services • Community/Mobile Services • Residential Treatment Services, and • Employment and Housing Services <p>Potential Gaps and Mitigation Plan: Trillium reviews data reports measuring the performance of provider access against our goals to assist with establishing priorities regarding the recruitment of providers into our Provider Network at least monthly. Trillium monitors our Provider Network for any changes that would</p>

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	<p>affect Recipient ability to access services or compliance with the time/distance and appointment wait time standards. Where reports indicate that we are not meeting our objectives in a particular area, we will work to identify and contract with a provider for the identified services via Direct Recruitment and/or Request for Proposals, Request for Applications, or Request for Information as funding permits.</p> <p>Exceptions: If no provider type is available within the time and distance requirements, Trillium will request an exception for timely access. Such exceptions will be justified, documented, and submitted to the NCDHHS for approval per the required process.</p> <p>New Services: Trillium will also confirm that new services added to the State Funded Benefit Plan are added to the Trillium Benefit Plan, recruited for, and contracted in a timely manner as funding permits.</p>
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11.	<p>BH /DD Tailored Plan’s quantifiable and measurable process for monitoring and assuring the sufficiency of the State-funded Network to meet the health care needs of all Recipients on an ongoing basis, including the frequency of the monitoring. The frequency of monitoring shall be at least once a month.</p>
	<p>Response: Trillium will meet the BH, SU, I/DD, and TBI needs of State-funded Recipients and meet all standards for State-Funded services or obtain approved exception as required by the Department taking into consideration funding availability.</p> <p>Trillium Business Solutions: One of the key components to managing the network of State-funded Providers is through technology. Our Trillium Business Solutions (TBS) platform drives our integration efforts to offer a holistic view of our provider network. To maintain network adequacy and high-quality standards, we actively validate the diversity, capacity, and impact of providers from across the geography we serve through TBS.</p> <p>Trillium will monitor the provider network of State-Funded Services at least monthly to observe and ensure the sufficiency of the Network to meet the health care needs of our Recipients. Trillium utilizes Recipient data and provider contract data to quantify and measure the adequacy of the network.</p> <p>Annual Network Adequacy Analysis: In accordance with the information published by the state regarding Network Adequacy and Accessibility requirements, Trillium conducts an annual analysis of the State-Funded provider network that incorporates data analysis of practitioners/providers for language, access to and choice of providers, as well as input from Recipients, family members, practitioners/providers and other stakeholders. Trillium reviews all services, including crisis services, and identifies service needs and will prioritize strategies to address any network needs 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 practitioner/provider community, local public agencies, and other local system stakeholders. The state requirements include quantifiable and measurable standards for the number of each type of behavioral healthcare practitioner and provider.</p> <p>Upon completion of the assessment, Trillium creates a mitigation plan to meet identified community needs. The plan includes identification and analyses of gaps and requests for approval of exceptions. Trillium meets the requirements to obtain exceptions for any identified gaps. Trillium may utilize existing approved statewide alternative service definitions or In Lieu of Service Definitions or develop and request approval for new alternative service definitions to fill network adequacy and accessibility service needs not met with current service definitions.</p> <p>Network Development reviews the results of the annual report and develops a specific Network Development Plan. This plan is reviewed and updated regularly in addition to monthly reviews of network fluctuations and internal feedback during the Recruitment and Retention Workgroup (a cross-functional workgroup including Care Management, Call Center, Finance, Network Management, System of Care, Quality Management, and Utilization Management, and Medical Affairs).</p>

To monitor and assure sufficiency, Trillium utilizes a suite of advanced software and analytics tools to monitor the health of the provider network in near real-time, and established access to care standards to ensure there are a sufficient number of participating health care professionals. Trillium dedicates specialized staff and software/analytics tools that allow it to assess its provider and Recipient locations using a variety of geospatial analysis techniques. Trillium calculates the percentage of Recipients within a specified distance (miles or driving time) of a Trillium provider and has the ability to calculate this data using state and federal standards for access, or more stringent standards, as needed. Geospatial maps allow Trillium to visualize Recipient drive times and distances to a provider, as well as the geographic distribution of Recipients who have special language or other needs. Network Development staff use these maps to discover areas for improvement related to network adequacy.

12.	<p>Factors the BH /IDD Tailored Plan used to build the State-funded Network, including a description of the criteria used to select providers for the network.</p> <p>Response: Trillium currently maintains a robust network of providers offering services covered in the State-funded Benefit Plan.</p> <p>Provider Network Data: Trillium, in partnership with the Department, and via the Provider Network Participation Committee (PNPC) shall monitor all enrolled providers and assess for approval to join the Trillium Provider Network. Trillium shall review any newly enrolled providers of BH /IDD services in comparison to Trillium’s network needs to determine acceptance into the network. Trillium maintains a restricted network for all State-funded BH, IDD, and TBI services to ensure appropriate use of limited funding and equitable distribution across the benefit plan.</p> <p>Recruitment and Retention Workgroup: Trillium’s Recruitment and Retention Workgroup will meet on a monthly basis to review ongoing changes to the network. The workgroup will consist of representation across multiple departments including Network Development, System of Care, Program Integrity, Utilization Management, Medical Affairs, and Quality Management. Trillium will evaluate new requests to join the network for BH, IDD, and TBI services and approve expansion as Member needs or gaps are identified.</p> <p>Provider Recruitment: If a need is identified for a specific State-funded service, Trillium utilizes several recruitment strategies to ensure gaps are filled when funding permits. Recruitment strategies include, but are not limited to, issuing Open Enrollment, Request for Proposals, Request for Information, Request for Applications, and/or Direct Recruitment of qualified providers.</p> <p>Quality Determination: Trillium’s Credentialing and Re-credentialing Policies adhere to all federal and State requirements. Trillium currently holds URAC and NCQA Managed Behavioral Healthcare Organization accreditation and follows all standards to ensure that Network providers are of the highest quality and meet all requirements to provide services to Trillium Recipients.</p> <p>Provider Network Participation Committee (PNPC): The PNPC, which is chaired by Trillium’s Chief Medical Officer (CMO), will evaluate the credentials of network applicants and make quality determinations based on state, federal, and accreditation standards. The PNPC will meet monthly and include representation from network practitioner’s types and providers who demonstrate an understanding of provider requirements.</p> <p>Trillium accepts verified provider credentialing information from the Department or Designated Vendor and does not request additional credentialing information from the provider. Upon receipt of the provider file from the Department or Designated Vendor, Credentialing staff will prepare provider files and present “clean files” as established by procedure to the CMO. A list of providers based on clean files will be presented to the PNPC at each meeting. The PNPC will review all “unclean files” to determine eligibility for provider network participation with Trillium.</p>
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13.	<p>BH /DD Tailored Plan’s process and methodology to understand the distribution of Recipient health care needs against available providers and provider capacity to serve those needs.</p> <p>Response: Trillium takes a very broad and extensive approach to providing the necessary tools required for Trillium’s Network Management to quantifiably monitor and assure the sufficiency of the Network.</p> <p>As mentioned previously, Trillium uses a suite of software and analytics tools to monitor the health of its provider Network in near real-time. Trillium has a dedicated core group of staff with a deep knowledge of geospatial analysis and has disseminated the value of this kind of analysis throughout the organization. This unique in-house capability also means that Trillium can rapidly produce advanced geospatial analyses in response to emergent needs from Trillium Recipients.</p> <p>Using these tools and skillsets, Trillium utilizes a menu of capabilities that permits Trillium to transform complicated data down into usable and informative visualizations that assist Network Management in quantifiably monitoring and measuring the provider network. Some of this functionality includes the ability to calculate drive-time and drive-distance as well as create static and interactive network health maps.</p> <p>Trillium also reviews regular reports as requested via our internal reporting platform (SSRS) for internal departmental needs, contractual reporting (i.e. NCDHHS), and for quality improvement activities. Reports can be run daily, weekly, monthly, quarterly, annually, or as needed, via a request to Informatics or by accessing a range of reports via the reporting platform.</p> <p>Trillium prides itself on building a diverse ingestion, analytical, and reporting platform that allows it to report and monitor using just about any data that is available and in a usable format to provide strong decision support based around the need and specifications provided. We continue to strive to onboard leading industry tools and practices that maintains Trillium at the forefront of reporting and monitoring capabilities.</p>
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14.	<p>BH /DD Tailored Plan’s plan to provide in-network access, compliant with the Department’s State-funded Network adequacy standards, to children to the full range of age-appropriate mental health, substance use, and /DD providers.</p> <p>Response: Trillium will ensure that children and adolescents have access to a full range of age-appropriate health care providers, subspecialists, and facilities. Trillium focuses on prevention and early intervention approaches as well as increasing quality of residential programs for children with BH needs. Trillium utilizes the network adequacy measuring processes described above to ensure that children’s services are available and Recipient needs are met using appropriate services that are available from in-network providers who have training in child health development. Trillium continues to maintain partnerships with in-network providers to communicate specific Recipient needs to providers and generate recruitment when needed to fill potential gaps or increase services in areas where population changes occur.</p> <p>Trillium manages a network of psychologists and psychiatrists that specialize in child and adolescent needs. Trillium confirms that child and adolescent psychiatrists have completed the Accreditation Council Graduate Medical Education (ACGME) accredited child/adolescent psychiatry fellowship and/or have board diplomat status as a child/adolescent psychiatrist. This information will be available to Recipients and families on the Provider Directory.</p> <p>Preferred Psychologist Program: Trillium utilizes a Preferred Psychologist Program to increase timely appointment wait times for Trillium Recipients. This program ensures that Recipients needing psychological assessment have access to an appointment within 7 days of referral. The Preferred Psychologist Program incentivizes providers to complete Level of Care Eligibility Determination, increase access for referrals made from Trillium, and timely completion of testing.</p> <p>Multi-systemic Treatment (MST): Trillium contracts with providers to offer intensive, evidenced-based interventions to youth between the ages of 7 to 17 experiencing antisocial behaviors, aggressive or violent acting out, school-related truancy, substance use, and juvenile criminal offenses. MST further addresses the needs of youth at-risk for out-of-home placement or youth returning from out-of-home placement. MST</p>
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	<p>is delivered through a team approach that provides face-to-face therapeutic interventions 24-hours-a-day, 7-days-a-week.</p> <p>Trillium continues to develop innovative approaches to increase utilization of evidenced based practices and integrated care among child providers including Value Based Programs.</p>
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15.	<p>BH /DD Tailored Plan’s method for ensuring children’s mental health, substance use, and I/DD needs will be met using appropriate child-focused specialty services that include supports and services from in-network providers who have special training in child health development.</p>
	<p>Response: As stated above, Trillium will ensure that children and adolescents have access to a full range of age-appropriate health care providers, subspecialists, and facilities. Trillium utilizes the network adequacy measuring processes described above to ensure that children’s services are available and Recipient needs are met using appropriate services that are available from in-network providers who have training in child health development.</p> <p>Trillium will also ensure that psychologists and psychiatrists that specialize in child and adolescent needs have completed the Accreditation Council Graduate Medical Education (ACGME) accredited child/adolescent psychiatry fellowship and/or have board diplomat status as a child/adolescent psychiatrist. This will be verified in the Provider Data File provided by the Department.</p> <p>Trillium has available to Providers Clinical Practice Guidelines for Child Mental Health Disorders, Intellectual/Development Disabilities, and Autism Spectrum Disorders to ensure that requirements and expectations are well known to providers.</p> <p>In addition, the Network Auditing staff conducts provider auditing and monitoring activities to ensure provider compliance including but not limited to post payment reviews, initial and annual site visits.</p>

16.	<p>BH /DD Tailored Plan’s approach to assure children’s access to child psychologists and child and adolescent psychiatrists (defined as having completed Accreditation Council for Graduate Medical Education (ACGME) accredited child/adolescent psychiatry fellowship and/or have board diplomat status as a child/adolescent psychiatrist).</p>
	<p>Response: Trillium manages a network of psychologists and psychiatrists that specialize in child and adolescent needs. Trillium confirms that child and adolescent psychiatrists have completed the Accreditation Council Graduate Medical Education (ACGME) accredited child/adolescent psychiatry fellowship and/or have board diplomat status as a child/adolescent psychiatrist. This information will be available to Recipients and families on the Provider Directory.</p>

17.	<p>BH /DD Tailored Plan’s Quality Assurance Standards, consistent with the Department’s Quality Strategy and requirements, which must be adequate to identify, evaluate, and remedy problems relating to access, continuing care, and quality care.</p>
	<p>Response: Trillium has well established internal procedures and protocols to manage and oversee quality improvement activities such as those associated with access to care, continuation of care, and quality of care. The procedures are cross-functional, and activities are focused on access, clinical quality, satisfaction, service, qualified providers, and compliance. Activities are designed to address health care settings; evaluate the quality and appropriateness of care and services provided to Recipients; pursue opportunities for improvement; and to, resolve identified problems. Detailed processes and methodology are used to determine the overall efficacy of quality improvement activities. The monitoring of specific indicators is designed, measured, and assessed by all appropriate departments to reveal trends and opportunities in an effort to improve organizational performance.</p>

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These indicators are objective, measurable, based on current scientific literature, knowledge, and clinical experience, broadly recognized in the industry, and structured to produce statistically valid performance measures of care and services provided. The effectiveness of the quality strategies are assessed through the recommendations provided by the External Quality Review Organization (EQRO), a review of our performance on HEDIS measures, and survey results. Additional information is gleaned from reviews of complaints/grievances, appeal logs, Recipient experience, out-of-network request and utilization, and quality improvement activities (QIAs) to determine opportunities.

In addition, the Network Auditing staff conducts provider auditing and monitoring activities to ensure provider compliance including but not limited to post payment reviews, initial and annual site visits. Network Contract staff reviews and addresses areas of concern regarding access to care standards and availability site concerns.

18. Geographical location of providers in Network in relation to where Recipients reside.

Response: Trillium will ensure that the geographical location of providers of State Funded services in the Network provide Recipient access to needed services through our Region.

Trillium shall measure distance from Recipient residences calculating drive time and mileage to ensure easy access to services.

19. Description of how the BH I/DD Tailored Plan will address Cultural and Linguistic Competency for specific populations, such as

- **Recipients with TBI,**
- **Recipients with disabilities,**
- **Recipients who are blind or visually impaired,**
- **Recipients who are deaf or hard of hearing,**
- **Recipients who are in the Armed Services,**
- **veterans and their families,**
- **pregnant women with SUD,**
- **Recipients who identify themselves as LGBTQ+,**
- **Recipients who are in jails or prisons,**
- **youth in the juvenile justice system,**
- **justice-involved populations more broadly, HMPs, and other vulnerable populations.**

Trillium recognizes the cultural diversities woven through the communities we serve and that our communities are only as strong as their people. Trillium strives to ensure that all Recipients have equal access to services provided by a network of culturally and linguistically competent providers. Accordingly, Trillium endeavors to contract with providers who recognize that providing efficacious services requires meeting the unique cultural needs of our Recipients.

Trillium has maintained a Cultural Competency Plan in accordance with state regulations to promote the delivery of services in a culturally competent manner to all Recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Trillium offers staff and network provider’s cultural competency training, with the goal that they understand that cultural competence reaches beyond race, color, national origin, age, disability, sex, creed, and/or language identifiers. Trillium has chosen to implement the use of national Culturally and Linguistically Appropriate Standards (CLAS). It is our desire to promote equity, reduce health disparities, and improve quality of care.

Traumatic Brain Injury (TBI): Trillium aims to support Recipients with a TBI diagnosis and ensure that the needs of each Recipient are adequately met while waiting for waiver services. Trillium utilizes the Registry of Unmet Needs to ensure the Recipients who desire waiver services are identified and able to receive

waiver slots when available. Recipients with a TBI diagnosis may be eligible to receive appropriate services in the benefit plan for Recipients with Intellectual and/or Developmental Disability (IDD). If the Recipient has a co-occurring Mental Health (MH)/Substance Use (SU) diagnosis, appropriate MH/SU services are available.

When appropriate, and when funds are available, Trillium utilizes an alternative service definition called TBI Long Term Residential. When funds are available, Recipients can access assistive technology, vehicle modifications, home modifications through Choose Independence funding from Trillium or from a special allocation of TBI funds. Recipients may also be eligible for services additional services such as Medicaid Personal Care and services covered under the CAP-DA waiver.

Trillium is currently partnering with The Arc of North Carolina, Easter Seals UCP, and The Autism Society of NC to implement Family Navigators for Recipients with I/DD/TBI. This new option leverages the powerful lived experiences of family members to support other Recipients and families with I/DD/TBI. Family Navigators are a part of the care team for Recipients. Also, Recipients on the TBI Waitlist are eligible for Tailored Care Management which enables Trillium to coordinate whole-person care, link Recipients to formal and information services/support, and ensure Recipients receive the appropriate care, including primary care and specialty care as needed.

Trillium also provides access to online training modules for TBI-related topics, from the Brain Injury Association of NC. We post TBI training opportunities on our social media. There are numerous links to resources on the Trillium website for Recipients with TBI and Providers.

People who are blind/ visually impaired/ Deaf/ hard of hearing: Trillium ensures that Recipients are provided with all printed materials produced for Recipient use including, but not limited to, the Member and Recipient Handbooks and Welcome Letter in a manner that accommodates the special needs of those with intellectual and/or developmental disabilities, who are visually limited and/or who have limited reading proficiency.

To support Recipients who are deaf/hard of hearing, Trillium provides access to interpreter services and telecommunications relay services. Language interpretation services are available by telephone and/or in person; enabling Recipients to effectively communicate with Trillium and Providers. TDD (telecommunication devices for the deaf) is also available for persons who have impaired hearing or a communication disorder.

Trillium also ensures that the Recipient-facing Provider Directory is accessible to Recipients as needed.

Armed services/ veterans & families: Trillium has an identified point of contact for military affairs and trained staff to provide services for military and their families. These individuals work to connect Veterans to housing and homelessness programs, domestic violence support and employment opportunities. Trillium offers Mental Health First Aid – Veterans, focusing on the unique experiences and needs of the military, veteran, and family populations. Trillium’s website provides an extensive list of regional, statewide, and national resources, including the Give an Hour Program, The Lighthouse Project, and Veteran’s Crisis Line, among others.

Trillium’s Access Point Screening Program is also available online 24-hours a day providing evidence-based, self-conducted screenings for depression, post-traumatic stress disorder, alcohol use disorders and more.

Pregnant women with SUD: Trillium has dedicated Care Managers whose primary focus is pregnant women with substance use disorders. Trillium partners with Local Health Departments to conduct outreach and education with local OB/GYN and NICUs as well as education on the CMARC program. All pregnant women with an active opioid use or SUD are automatically assigned a specialized care manager to assist with connecting to recovery resources. Trillium Care Managers have worked with Community Care of NC, specifically Community Care of the Lower Cape Fear and Access East, about enhancing collaboration and referrals for pregnant women with opioid use disorders and Care Coordination in general. A Trillium representative is also participating in the Child Welfare & Substance Use/Plan of

Safe Care Policy Meeting. There is a list of local groups working with Trillium to address opioid and substance use issues in their communities that can be found at: <https://www.trilliumhealthresources.org/for-individuals-families/mental-health-substance-use/opioid-epidemic-substance-abuse/other-resources>

People who are Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ): Trillium continues to develop a network of Providers with specialized training to service Recipients who identify as LGBTQ. To support youth in Foster Care, Trillium developed Project OUTreach to share LGBTQ information with community stakeholders, providers, faith-based organizations, and more. Trillium works with North Carolina Families United to help educate all communities with the skills needed to address the specific health concerns of and abuse toward LGBTQ youth. Research shows that between 2-7% of all adults are lesbian, gay, or bisexual, and the average age that youth realized they were gay was a little over age 13. OUTreach is available in all Trillium counties.

Trillium is developing a cohort of Trillium Staff trainers and In-Network Foster Care Provider trainers to achieve certification in the All Children All Families model to provide ongoing education that is clinical in nature to community stakeholders and Therapeutic Foster Families.

The purpose of OUTreach is to:

- Improve health and mental health outcomes of LGTBQ youth in Eastern NC.
- Help ethnically and religiously diverse families and caregivers to decrease rejection and increase support for LGBTQ children, youth, and young adults.
- Support the critical needs of youth in foster care related to LGBTQ health.
- Facilitate systems change to address needs by increasing awareness and support of LGTBQ youth.

Additional information can be found at <https://www.trilliumhealthresources.org/outreach>

Jails/ prisons: Recipients who are in jails or prison can experience barriers in accessing much needed care, including behavioral health services, while incarcerated which limits successful outcomes. Trillium's contract with DMH in the Care Coordination for High Risk Consumers requires care coordination assignment to be prioritized for persons in need of MH/DD/SA services who are transitioning from jails and prisons.

Trillium has continued implementation of a two-year, Department of Justice (DOJ) diversion grant to work with law enforcement agencies in Onslow and Carteret Counties. The funds have been used to provide Mental Health First Aid and CIT Training, in addition to initiating the use of the evidence-based Brief Mental Health Screener tool (BMHS) for police officers to identify those individuals better served by connecting to crisis and treatment services rather than take into custody or to the hospital emergency department.

Trillium is also piloting two Medication Assisted Treatment in County Jail programs, one in New Hanover and the other in Pitt County. This program aims to reduce Opioid Overdose and engage Recipients in Opioid Treatment upon release.

In addition, Onslow County has been awarded a 3-year DOJ grant to pilot the above-mentioned BMHS tool in an electronic version for all officers and the implementation of a case management program in the Onslow County Jail.

Youth in juvenile justice: Adolescents and their families involved with the Department of Juvenile Justice (DJJ) experience difficult in maintaining treatment in MH/SU services. Trillium has two dedicated new positions which included the Head of Department of Social Services' (DSS) Engagement and the Director of Care Coordination. These positions provide support for systems of care involving children and youth as well as to assure the best care for Recipients throughout the entire Trillium coverage area. Both positions bridge the systems that support care management and community resources in many different types of settings for Recipients. They collaborate with various community-based agencies such as juvenile justice stakeholders and department of social services stakeholders to improve health outcomes and increase access to care for Recipients and their families.

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The Director of Care Coordination position is dedicated to supporting providers and stakeholders who are directly connected to the DJJ-involved youth and families across our catchment. This position functions as a channel of support between external stakeholders and Trillium as it assists in navigating Trillium's processes and service array. The position also relays fluid communication when there are gaps and needs in services for children and youth, linking very closely with our Network Management Department and provider network. The Director of Care Coordination position is a function of Care Management department to provide a warm transition when DJJ or related stakeholders and providers make contact about questions or needs related to a Recipient's care. This allows Recipients to avoid higher levels of care or interruption in service as the Recipient is connected to the services best suited for their individual needs, at the right time.

Each county in the Trillium area has a designated System of Care Coordinator. System of Care Coordinators are knowledgeable about their counties and the services and supports available in that particular geographical area. As important resources in their local communities, they serve on various teams and committees such as:

- Juvenile Crime Prevention Committees (Department of Public Safety)
- Juvenile Justice Behavioral Health Committees (formerly known as JJSAMHP)

Juvenile Justice Behavioral Health (JJBH) is a partnership among juvenile justice stakeholders and providers to deliver services for youth involved with the juvenile justice system who may experience challenges such as using substances, anger, traumatic events, difficulties in school, aggression and other areas. Currently there are partnerships in all the regions of the Trillium catchment.

Juvenile Crime Prevention Council (JCPC) sparks collaboration among community leaders, locally and statewide, to reduce and prevent juvenile crime. Funding is used to subsidize local programs and services. These are Councils in each of the 26 Trillium catchment counties. Through JCPC Trillium is able to work in partnership to address assessment and treatment barriers.

Trillium recognizes the Department of Social Services as a critical external stakeholder. The Department of Social Services (DSS) is tasked with many responsibilities, one of which being the protection of all children and adolescents in their respective counties. This, unfortunately, does result in DSS assuming custody of children and often require assistance in obtaining the appropriate treatment/setting for those youths. The Head of Department of Social Services Engagement serves as a conduit of communication between Trillium Health Resources and the DSS's in our catchment area. Often the focus of discussions revolves around foster children and how to best meet their complex needs. Having an identified position to assist both DSS and Care Managers facilitates communication towards effective and efficient treatment.

- 20. BH /DD Tailored Plan's strategies to ensure access and availability of services and build sufficient provider capacity, including but not limited to addressing Department priorities to increase clinically appropriate access to and utilization of:**
- ambulatory detoxification,
 - substance abuse non-medical community residential treatment,
 - substance abuse medically monitored residential treatment, and
 - SUD residential recovery services and supports,
 - medication assisted treatment and adolescent SUD treatment services,
- including how the BH /DD Tailored Plan shall**
- analyze and monitor utilization of these services,
 - develop clinical practice guidelines related to appropriate utilization of these services,
 - configure a continuum of access to these services,

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	<ul style="list-style-type: none"> • pursue other efforts to enhance access and • develop provider capacity for these services; <p>Response: Trillium has a well-established State-funded provider network that will ensure access and availability of State-funded Substance Use Disorder (SUD) services. Trillium also builds and maintains provider capacity pending funding availability to increase clinically appropriate access to and utilization of ambulatory detoxification, substance abuse non-medical community residential treatment, substance abuse medically monitored residential treatment, and SUD residential recovery services and supports, medication assisted treatment and adolescent SUD treatment services.</p> <p>Trillium will monitor utilization of State-funded Substance Use Services to ensure practitioners and providers remain within clinical guidelines and that Recipients are utilizing services available. Trillium will also monitor data related to access to care to ensure that Recipients can schedule appointments and receive treatment within appropriate timeframes.</p> <p>Trillium continues to develop and maintain clinical practice guidelines related to the continuum of access to State-funded SUD services based on the most recent clinical research and evidenced based practices including SAMSHA.</p>
<p>21.</p>	<p>BH I/DD Tailored Plan’s strategies to ensure access and availability of services and build sufficient provider capacity, including but not limited to addressing Department priorities to increase clinically appropriate access to and utilization of the BH I/DD Tailored Plan’s First Episode Psychosis programs (FEP), including how the BH I/DD Tailored Plan shall</p> <ul style="list-style-type: none"> • analyze and monitor utilization of FEPs, • develop clinical practice guidelines related to appropriate utilization of FEP and educate and train providers, and • pursue efforts to enhance access and develop FEP capacity with a focus on Recipients between fifteen (15) and thirty (30) years old who have or are at high risk of psychosis (e.g., build new programs, connect recipients to existing programs, conduct active surveillance of those at-risk) <p>Response: Trillium will ensure that Recipients have access to and have sufficient provider capacity to First Episode Psychosis programs (FEP). Trillium will increase access and utilization of FEP by increasing training and support with a focus on Recipients between the ages of fifteen (15) and thirty (30) years old who are at high risk of psychosis. This will be achieved through program development and active surveillance for the identified at-risk population as additional funding becomes available.</p> <p>Through partnerships with FEP providers, Trillium maintains and provides up to date clinical practice guidelines related to the appropriate utilization of FEP to guide providers and shall provide educational and training opportunities for FEP providers around Trillium’s clinical practice guidelines.</p> <p>Trillium analyzes and monitors utilization of FEPs utilizing claims data to monitor Recipient access and utilization of this service.</p>
<p>22.</p>	<p>BH I/DD Tailored Plan’s strategies to increase clinically appropriate access to and utilization of case management services for Recipients with behavioral health conditions, including how the BH I/DD Tailored Plan shall</p> <ul style="list-style-type: none"> • analyze and monitor utilization of these services, • develop clinical practice guidelines related to appropriate utilization of these services, pursue other efforts to enhance access, and

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	<ul style="list-style-type: none"> • develop provider capacity for these services
	<p>Pending release of the new Case Management service definition for child and adult Recipients with mental health and/or SUD needs for the State Funded service array, Trillium will ensure that Recipients have access to and utilize Case Management services. Trillium will partner with experienced providers to develop a network of State Funded Case Management services pending funding availability. Trillium plans to leverage the existing network of Care Management Agencies and Advanced Medical Homes providing Care Management to Medicaid Recipients to provide high quality case management services to both child and adult State Funded Recipients. Trillium will also partner with High Fidelity Wrap-Around providers to expand this case management intervention for children and families.</p> <p>Trillium will ensure key personnel are in place along with all new policies, practices, and systems to support the provision of case management services as detailed in Section V.A.1.i. Staffing and Facilities for Medicaid and State Funded Services.</p>

23.	<p>Did the BH /DD Tailored Plan submit separately with the Network Adequacy Annual Submission Report, the Annual Network Adequacy Results Tables Workbook File?</p>
	<input type="checkbox"/> Submitted
	<input checked="" type="checkbox"/> Not submitted (add explanation below)
	<p>Explanation for not submitting: Trillium is capable of supplying the designated information upon release of specifications of report by DHHS or intended recipient.</p>

24.	<p>Did the BH /DD Tailored Plan submit separately Network Data File Extract containing all currently contracted providers?</p>
	<input type="checkbox"/> Submitted
	<input checked="" type="checkbox"/> Not submitted (add explanation below)
	<p>Explanation for not submitting: Trillium is capable of supplying the designated information upon release of specifications of report by DHHS or intended recipient.</p>

25.	<p>Confirm that the BH /DD Tailored Plan has considered and demonstrated capacity to serve the expected enrollment in each region listed in <i>Section I.D.</i></p>
	<input type="checkbox"/> Confirm
	<input checked="" type="checkbox"/> Not confirmed
	<p>Explanation for not confirming: We are unable confirm what is being requested; Section I.D. unknown. We have submitted an inquiry to the Department to receive further clarification on this question.</p>

Submit this document and all additional pages and supplemental information as described in the current Inbound Job Aid (Job Aid). Refer to the Job Aid for file submission and file naming protocols.

VERSION

Date	Section Updated	Change
08/25/2021	Original (v1)	

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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:

Improved integration of healthcare

Strategies to attain the goal:

1. Promotion of integrated healthcare in OTPs, other SUD treatment provider agencies and FQHCs
2. 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 SFT21, 11,291 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: FY22 will demonstrate a 1% increase in the number of individuals with a substance use disorder who receive improved physical health care, as evidenced by claims for E&M codes.
Second-year target/outcome measurement: FY23 will demonstrate an additional 1% increase in the number of individuals with a substance use disorder who receive improved physical health care, as evidenced by claims for E&M codes.

Data Source:

NCTracks
 Reports on service utilization from FQHCs

Description of Data:

Paid claims of E&M codes for individuals with a substance use diagnosis.

Data issues/caveats that affect outcome measures:

The addition of services delivered by FQHCs is a new and additional component to this indicator. The methods for actual data collection are still being determined.

Priority #: 2
Priority Area: Community Ingration
Priority Type: SAT
Population(s): Other (Criminal/Juvenile Justice, Homeless)

Goal of the priority area:

Access to recovery supported housing

Strategies to attain the goal:

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. 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. 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 SFY21, there were 1709 federally-funded beds available for men, women and women with children.

First-year target/outcome measurement: No less than 1745 SABG NC Oxford House beds will be available to adults with substance use disorders at the end of SFY22.

Second-year target/outcome measurement: No less than 1781 SABG NC Oxford House beds will be available to adults with substance use disorders at the end of SFY23.

Data Source:

North Carolina Oxford House Activity, NC Project Status, Attestation Reports and Contractor Progress Reports (submitted monthly).

Description of Data:

Monthly Activity and Project Status Reports are submitted to the Division Contract Administrator to include cumulative and geographic information on each house to include the; number and type of beds, vacancies and location. The Attestation Forms and submitted with picture within 30-days of occupancy for newly opened houses, and the Contractor Progress Report gives a snapshot of progress made during the reporting period, because they consist of cumulative data from Monthly reports.

Data issues/caveats that affect outcome measures:

The COVID-19 pandemic has had a major impact on the housing market, which has negatively impacted the contractor's ability to sustain existing houses, and adversely effected their ability to obtain new potential Oxford Houses.

Indicator #: 2

Indicator: In SFY21, there were 2041 total beds available for men, women and women with children, in which 1709 were federally funded beds and 332 were state funded beds.

Baseline Measurement: At the end of SFY21, 60 SABG new re-entering individuals in recovery were served and mentored through a combination of SABG funds (60 individuals) and SOR funds (180 individuals) for a total of 240 individuals

First-year target/outcome measurement: No less than 62 persons will be mentored and transitioned from incarceration into a NC Oxford House at the end of SFY22 with SABG funds.

Second-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 SFY23 with SABG funds.

Data Source:

NC Ex-Offender Reentry Programs data and Contractor Progress Report (submitted quarterly)

Description of Data:

Cumulative data (non-personally identifiable information) on the number of individuals Reentry Staff interviewed and those that were mentored and housed; along with the geographic info for correctional institutions where Staff have established and maintained programs are identified.

Data issues/caveats that affect outcome measures:

The outcome for SFY21 was attained by a combination of SABG funds that fostered (60) transitions and State Opioid Response funds which supported the additional (180) individuals to transition for a total 240. The COVID-19 pandemic has had a major impact on the housing market, which has negatively impacted the contractor's ability to sustain existing houses, and adversely effected their ability to obtain new potential Oxford Houses.

Priority #: 3
Priority Area: Persons Who Inject Drugs
Priority Type: SAT
Population(s): PWID

Goal of the priority area:

Increased in the number of people who access treatment for injection drug use.

Strategies to attain the goal:

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 funding is targeted towards and contracts are initiated with OTPs, OBOTs and FQHCs, with a focus on under-served areas and historically marginalized communities.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of PWID with an opioid use disorder participating in treatment.
Baseline Measurement: According to the Client Data Warehouse (CDW), in SFY20, 15,003 individuals who identified as injecting drugs participated in treatment services.
First-year target/outcome measurement: In SFY22, increase by 2% the number of individuals injecting drugs that access treatment.
Second-year target/outcome measurement: In SFY23, increase by an additional 1% the number of individuals injecting drugs that access treatment.

Data Source:

Client Data Warehouse (CDW)

Description of Data:

Data issues/caveats that affect outcome measures:

None anticipated.

Indicator #: 2
Indicator: Increased availability of naloxone
Baseline Measurement: In SFY21, 150,240 units of naloxone (110,520 IM units and 39,720 nasal units) were distributed.
First-year target/outcome measurement: In SFY22, purchase and distribute a minimum of 400,000 units of naloxone.
Second-year target/outcome measurement: In SFY23, purchase and distribute a minimum of 100,000 units of naloxone.

Data Source:

Purchase orders and distribution logs

Description of Data:

Staff track availability of funds, requests for naloxone, actual purchases and agencies to which naloxone is distributed.

Data issues/caveats that affect outcome measures:

None anticipated

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

Strategies to attain the goal:

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 Specialist 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 on Veterans, Servicemembers and their Families.

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: 391 Veterans and/or family members contacted ADCNC during FY21 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:

Deployments and COVID disruptions to the traditional drill schedule

Priority #: 5
Priority Area: TB
Priority Type: SAT
Population(s): TB

Goal of the priority area:

Tuberculosis screening and referral

Strategies to attain the goal:

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. (Due to COVID-19 and imposed travel restrictions for state employees, clinical

monitoring activities that collect this information and data were not conducted this past state fiscal year. It is unknown at this time if this was achieved or not. Plans for conducting monitoring are currently being finalized due to the increase in coronavirus cases in our state.)

First-year target/outcome measurement: A compliance rate of 98% will be achieved in SFY22.

Second-year target/outcome measurement: A compliance rate of 98% will be achieved in SFY23.

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:

Monitoring will be conducted in SFY22, although it may be desk audits, or a combination of desk audits and site visits, depending on the status of the current State of Emergency and travel restrictions due to COVID-19.

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 SFY22, 100% of individuals who screen positive for TB symptoms will be referred follow up services

Second-year target/outcome measurement:

In SFY23, 100% of individuals who screen positive for TB symptoms will be referred follow up services

Data Source:

Annual SABG monitoring reviews

Description of Data:

A sample of provider 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:

Again, due to COVID-19 and imposed travel restrictions for state employees, clinical monitoring activities that collect this information were not conducted this past state fiscal year. Monitoring will be conducted in SFY22, although it may be desk audits, or a combination of desk audits and site visits, depending on the status of the current State of Emergency and travel restrictions due to COVID-19.

Priority #: 6

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

Strategies to attain the goal:

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 DSS, DPH 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 women of child-bearing age with an opioid disorder participating in treatment.

Baseline Measurement: During SFY21, 5644 women of child-bearing age, 18-45, accessed SUD treatment for an opioid use disorder. (341 of the 5644 women were pregnant.)

First-year target/outcome measurement: In SFY22, increase by 1% the number of women of child-bearing age of child bearing age with an opioid use disorder receiving SUD treatment services

Second-year target/outcome measurement: In SFY23, increase by 1% the number of women of child-bearing age of child bearing age with an opioid use disorder receiving SUD treatment services

Data Source:

NCTOPPS & Client Data Warehouse (CDW)

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 Client Data Warehouse: Unduplicated number of pregnant women and women of child-bearing age with an OUD served in the system. This would be added as an additional data source.

Data issues/caveats that affect outcome measures:

None anticipated

Priority #: 7

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.

Strategies to attain the goal:

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 SF21, 786 pregnant women and women with dependent children received referrals (155 of the 786 women were pregnant.)

First-year target/outcome measurement: Increase the number of treatment referrals by 1% in SFY22.

Second-year target/outcome measurement: Increase the number of treatment referrals by an additional 1% in SFY23.

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 #: 8
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.

Strategies to attain the goal:

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 SFY21, a total of 961 individuals were referred by county CPS offices for a SUD assessment.
First-year target/outcome measurement: Maintain the number of individuals referred for SUD assessment in SFY22.
Second-year target/outcome measurement: Increase the number of individuals referred for SUD assessment by 1% in SFY23.

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:

1. The number of referrals by county DSS had decreased during the COVID pandemic although it appears they are stabilizing at this time.
2. Potential data issues include transition of a large LME-MCO in SFY22 that may impact reporting, but staff are working with the LME-MCO to mitigate any data collection issues.

Priority #: 9
Priority Area: Youth Initiatiion and Tobacco Access
Priority Type:
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.

Strategies to attain the goal:

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: Underage tobacco sales retail violation rate

Baseline Measurement: SFY20, 12.2% of retail establishments sold tobacco to an underage person.

First-year target/outcome measurement: In SFY22, demonstrate a 2% decrease in the percentage of retail establishments that sold tobacco to an underage person.

Second-year target/outcome measurement: In SFY23, demonstrate a 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:

None anticipated, merchant visits are planned.

Priority #: 10

Priority Area: Justice - Treatment Accountability for Safer Communities (TASC)

Priority Type: SAT

Population(s): Other (Criminal/Juvenile Justice)

Goal of the priority area:

To support people with substance use and co-occurring conditions under criminal justice supervision through the provision of appropriate care management and connections to services

Strategies to attain the goal:

DMHDDSAS will collaborate with the Department of Public Safety, Administrative Office of the Courts, TASC providers, and other key stakeholders to identify and maximize resources for people under criminal justice supervision who have substance use and co-occurring disorders.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of TASC participants discharged from TASC having successfully completed the program

Baseline Measurement: TASC participants successfully completed TASC at a rate of 59.3% during SFY 20-21.

First-year target/outcome measurement: TASC Participants will complete treatment at a rate of 60% or higher.

Second-year target/outcome measurement: TASC Participants 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 NCTOPPS 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:

The COVID-19 pandemic has disrupted several processes relevant to TASC, including jail releases, court proceedings, and the safe provision of in-person services to TASC Participants

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Footnotes:

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 2022/2023. ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	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	H. COVID-19 Relief Funds (MHBG) ^a	I. COVID-19 Relief Funds (SABG) ^a	J. ARP Funds (SABG) ^b
1. Substance Abuse Prevention ^c and Treatment	\$69,352,995.00		\$50,000,000.00	\$56,353,330.00	\$302,265,698.00	\$0.00	\$0.00		\$30,993,144.00	\$12,456,884.00
a. Pregnant Women and Women with Dependent Children ^c	\$15,745,000.00			\$729,260.00	\$20,265,698.00				\$1,500,000.00	\$0.00
b. All Other	\$53,607,995.00		\$50,000,000.00	\$55,624,070.00	\$282,000,000.00				\$29,493,144.00	\$12,456,884.00
2. Primary Prevention ^d	\$17,998,475.00		\$0.00	\$2,470,207.00	\$0.00	\$0.00	\$0.00		\$9,838,696.00	\$3,895,232.00
a. Substance Abuse Primary Prevention	\$17,998,475.00			\$2,470,207.00					\$9,838,696.00	\$3,895,232.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services	\$0.00								\$0.00	\$0.00
5. Early Intervention Services for HIV	\$0.00								\$0.00	\$0.00
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	\$2,640,904.00								\$1,339,440.00	\$0.00
10. Crisis Services (5 percent set-aside)										
11. Total	\$89,992,374.00	\$0.00	\$50,000,000.00	\$58,823,537.00	\$302,265,698.00	\$0.00	\$0.00	\$0.00	\$42,171,280.00	\$16,352,116.00

^a The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

^b The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

^c Prevention other than primary prevention

^d The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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Footnotes:

Total ARP award is \$36,420,651, the numbers in the table above reflect expected expenditures for the period 09.01.21 - 06.30.23. Column D includes funds from the following SAMHSA grants: SOR 2, Emergency COVID and Emergency COVID Supplement, PPW and SPF-RX.

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	10,032	1,102
2. Women with Dependent Children	17,606	22,656
3. Individuals with a co-occurring M/SUD	317,643	32,202
4. Persons who inject drugs	27,151	15,003
5. Persons experiencing homelessness	1,018	4,950

Please provide an explanation for any data cells for which the state does not have a data source.

For Women with Dependent Children, the calculation of number estimated in need is women in poverty. However, the number of women with dependent children in treatment is derived from NCTOPPS, which may not be limited to women in poverty. Therefore the number in treatment may be inclusive of women not in poverty.

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Footnotes:

Data sources and methodology for the above are as follows:

1. Pregnant Women aged 15-44 in NC estimated to have a SUD in 2021: 10,032.

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 2020 would estimate 67.0% 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. 70, No. 2, March 23, 2021 Table 8. Birth rates, by age of mother: United States, each state and territory, 2019. Fertility rates reported are births per 1,000 women aged 15–44 years. In the US = 58.3. In NC = 57.8

Applying the 2020 estimated live birth rate of 67.0% of pregnancies resulting in a live birth to the 57.8 births per 1,000 women for NC in 2019, the expected pregnancy rate would = 86.3 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 (2000-2050). <https://www.osbm.nc.gov/demog/county-projections>. Last updated 2/15/21. Downloaded 4/7/21.

In NC as of July 2021, there were 2,113,634 women ages 15-44.

- Prevalence Rates. SAMHSA, Center for Behavioral Health Statistics and Quality, Results from the 2019 National Survey on Drug Use and Health: Detailed Tables, August 2020. <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>. Published 9/11/20.

Table 5.5B Substance Use Disorder in Past Year among Persons Aged 12 or Older, by Age Group and Demographic Characteristics: Percentages, 2018 and 2019.

Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse.

State-specific rates by gender for NC not published. Used US rates applied to NC population. Prevalence in 2019 for persons ages 12 and older with a SUD in the past year: Total 7.4%, Males 9.4%, Females 5.5%.

Calculations:

Applied the most current available national SUD prevalence rate for women (5.5% of women aged 12 and older) to the number of women in NC aged 15-44 years as of July 2021:

$2,113,634 \text{ women} \times 5.5\% = 116,250 \text{ women aged 15-44 in NC estimated to have a SUD.}$

Divided this number by 1,000 and multiplied by 86.3 pregnancies per 1,000 women aged 15-44 = 10,032 pregnant women in NC estimated to have a SUD in 2021.

2. Women in Poverty with Dependent Children in Need of SUD Treatment: 17,606.

Women with Dependent Children In SUD Treatment: 22,656.

Data Sources:

- Number In Treatment. Per the North Carolina Treatment Outcomes and Program Performance System (NCTOPPS) as of 9/22/21, the number of women in the SUD population with dependent children in NC receiving treatment in SFY2021 = 22,656.

- 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, 2020 Poverty Report: Persistent poverty demands a just recovery for North Carolinians, by Logan Rockefeller Harris, Senior Policy Analyst, Budget and Tax Center, published October 29, 2020 <https://www.ncjustice.org/publications/2020-poverty-report-persistent-poverty-demands-a-just-recovery-for-north-carolinians/>. In 2019, 1.4 million North Carolinians, or about 1 in every 7 people in the state, lived in poverty. In 2019, the state had the 13th highest poverty rate in

the country, and at 13.6%, the poverty rate was 3% higher than the U.S. rate of 10.5%. The poverty rate among North Carolina women is more than 20% higher than for men. 786,000 women, or 14.9%, experienced poverty, compared to 600,000 men, or 12.2%, experienced poverty.

- 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.
- Per the US Census Bureau publication Income and Poverty in the United States: 2020, September 14, 2021, Report Number P60-273, Emily A. Shrider, Melissa Kollar, Frances Chen, and Jessica Semega, <https://www.census.gov/library/publications/2021/demo/p60-273.html>, the poverty rate for families with a female householder in 2020 was 23.4%. This increased from 22.2% in 2019. Prevalence Rates. SAMHSA, Center for Behavioral Health Statistics and Quality, Results from the 2019 National Survey on Drug Use and Health: Detailed Tables, August 2020, published 9/11/20, <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>.

Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse. State-specific rates by poverty level and gender 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, 2018 and 2019. Prevalence in 2019 for persons ages 18 and older with a SUD in the past year by poverty level: Less Than 100% = 9.8%

Table 5.5B Substance Use Disorder in Past Year among Persons Aged 12 or Older, by Age Group and Demographic Characteristics: Percentages, 2018 and 2019. Prevalence in 2019 for persons ages 18 and older with a SUD in the past year by gender: Total 7.7%, Males 10.0%, Females 5.6%.

Population data. NC Office of State Budget and Management (NC OSBM), Population Estimates/Projections Data - Sex and Single Years of Age (2000-2050). <https://www.osbm.nc.gov/demog/county-projections>. Last updated 2/15/21. Downloaded 4/7/21. In NC as of July 2021, there are 4,361,183 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, 14.9% of women in NC in poverty (2019) x 4,361,183 women ages 18 and older in NC (July 2021) = 649,816 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 649,816 women in poverty in NC (July 2021) = 246,930 women in poverty with dependent children in NC.

Per the NSDUH 2019 results, 9.8% of persons in the US less than 100% of poverty have a SUD. This is 27.3% higher than the 7.7% of persons ages 18+ in the US who have a SUD.

Per the NSDUH 2019 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 27.3% higher than the total population, then one might expect 7.13% 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 7.13% x 246,930 women in poverty with dependent children in NC = 17,606 to have a SUD.

3. Individuals with co-occurring MI/SUD in NC in 2021:

Adults Ages 18+ with Any MI + SUD 317,643

Adults Ages 18+ with SMI + SUD 117,026

Adolescents Ages 12-17 with MDE + SUD 14,040

Adolescents Ages 12-17 with MDE with severe impairment + SUD 11,563

Data Sources:

- Prevalence Rates. Substance Abuse and Mental Health Services Administration. (September 2020). Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP 20-07-01-001, NSDUH Series H-55). 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

3.8% of Adults Ages 18+ have co-occurring AMI + SUD

1.4% of Adults Ages 18+ have co-occurring SMI + SUD

7.6% of Adults Ages 18-25 have co-occurring AMI + SUD

2.8% of Adults Ages 18-25 have co-occurring SMI + SUD

5.2% of Adults Ages 26-49 have co-occurring AMI + SUD

2.0% of Adults Ages 26-49 have co-occurring SMI + SUD

1.5% of Adults Ages 50+ have co-occurring AMI + SUD

0.5% of Adults Ages 50+ have co-occurring SMI + SUD

1.7% of adolescents ages 12-17 have co-occurring MDE + SUD

1.4% 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 (2000-2050). <https://www.osbm.nc.gov/demog/county-projections>. Last updated 2/15/21. Downloaded 4/7/21.

In NC as of July 2021:

Population ages 18+ = 8,359,026

Population ages 12-17 = 825,898

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 2021 in the relevant age group:

3.8% x 8,359,026 adults ages 18+ = 317,643 have co-occurring AMI + SUD

1.4% x 8,359,026 adults ages 18+ = 117,026 have co-occurring SMI + SUD

1.7% x 825,898 adolescents ages 12-17 = 14,040 have co-occurring MDE + SUD

1.4% x 825,898 adolescents ages 12-17 = 11,563 have co-occurring MDE with severe impairment + SUD

4. Estimated persons aged 13+ who inject drugs in NC in 2021: 27,151 .

Data Sources:

- Prevalence. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, 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 Crepez. Published May 19, 2014. PLoS ONE 9(5): e97596. doi:10.1371/journal.pone.0097596. Published: May 19, 2014.

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 (3.6% for males, 1.6% for females).
- Past-year PWID was 0.30% (95% confidence interval: 0.19 %–0.41%) of the U.S. population aged 13 years or older (0.36% for males, 0.21% for females).

- Prevalence. SAMHSA, Center for Behavioral Health Statistics and Quality, Results from the 2019 National Survey on Drug Use and Health: Detailed Tables, August 2020, published 9/11/20, <https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables>.

Table 1.97B Specific Hallucinogen, Inhalant, Needle, Heroin, and Other Drug Use in Lifetime among Persons Aged 12 or Older, by Age Group: Percentages, 2018 and 2019.

Needle Use (Heroin, Cocaine, Methamphetamine) Ages 12+ in the US population in 2019 = 1.7% (Lifetime).

- Population data. NC Office of State Budget and Management (NC OSBM), Population Estimates/Projections Data - Sex and Single Years of Age (2000-2050). <https://www.osbm.nc.gov/demog/county-projections>. Last updated 2/15/21. Downloaded 4/7/21.

Population in NC as of July 2021: Ages 12+ = 9,184,924 Ages 13+ = 9,050,268

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 2021: $0.30\% \times 9,050,268$ adolescents and adults aged 13+ = 27,151 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: $2.6\% \times 9,050,268$ adolescents and adults aged 13+ = 235,307 estimated persons aged 13+ who inject drugs during their lifetime in NC.

NSDUH: $1.7\% \times 9,184,924$ adolescents and adults aged 12+ = 156,144 estimated persons aged 12+ who inject drugs during their lifetime in NC.

5. Persons experiencing homelessness in NC in 2021 that have a SUD: 1,018.

Data Sources: (Note: It is often necessary to cross-reference these sources to obtain complete and consistent data to create the big picture)

- Homeless Count: NC Coalition to End Homelessness (NCCEH) January 2020 Point-In-Time (PIT) count, 11/2/20. 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) Data for 2021 is not yet available on-line.

- Homeless Count: HUD Exchange website. Continuum of Care (CoC) Homeless Assistance Programs Homeless Populations and Subpopulations Reports: 2020 CoC Homeless Populations and Subpopulations Report – North Carolina.pdf, 12/15/20. 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). Data for 2021 is not yet available.

- Homeless County: a HUD companion report 2020 AHAR: Part 1 - PIT Estimates of Homelessness in the U.S. Date Published: March 2021.

<https://www.hudexchange.info/homelessness-assistance/ahar/#2020-reports> provides comparative state counts of homeless persons.

- The 2020 Annual Homeless Assessment Report (AHAR) to Congress, Part 1: Point-In-Time Estimates of Homelessness, January 2021.

<https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf>

NC 2020 PIT Count: 9,280 people experienced homelessness. 17.6% were children ages 17 and younger = 1,634. 82.4% were adults ages 18+ = 7,646. 973 (10.5%) had chronic SA. 1,281 (13.8%) had SMI. According to the AHAR, 8.8 in every 10,000 people experienced homelessness.

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. 1,041 (11.2%) had chronic SA. 1,348 (14.5%) had SMI. Using this snapshot and data indicating the frequency of new episodes of homelessness, NCCEH estimates 27,900 people will experience homelessness in 2019.

NC 2018 PIT Count: According to data for NC posted on the HUD Exchange website, 9,268 people experienced homelessness. 7,506 adults + 1,762 children. 993 (13.2%) adults had SUD. 1,207 (16.1%) adults had SMI. SUD and SMI data for children was not provided.

NC 2017 PIT Count: 8,962 people experienced homelessness. NCCEH provided a data table for 2017 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.

NC 2016 PIT Count: 9,559 people experienced homelessness. 15% had a SUD. 17% had SMI. (Source: NCCEH)

Calculations:

Data for 2021 is not yet available on any of the sources websites. More complete data was available for 2020 and prior years, so I used that data to estimate 2021. I applied the 2020 HUD AHAR's 8.8 per 10,000 estimated to be homeless in NC to the NC OSBM July 2021 estimated population of 10,658,717 to calculate an estimate of 9,380 people who are homeless. Because the percent of homeless reported to have chronic SA has been decreasing over the past 5 years, I applied the average rate for the most recent 2 years (2019 and 2020) to the 2021 estimated number of people who are homeless to estimate the number of persons with chronic SA in 2021. The result is $10.9\% \times 9,380 = 1,018$ persons with chronic SA. This represents a PIT number rather than an annualized number.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award ¹	ARP Award ²
1 . Substance Use Disorder Prevention and Treatment ³	\$34,676,498.00	\$30,993,144.00	\$14,155,550.00
2 . Primary Substance Use Disorder Prevention	\$8,999,237.00	\$9,838,696.00	\$2,183,836.00
3 . Early Intervention Services for HIV ⁴	\$0.00	\$0.00	\$0.00
4 . Tuberculosis Services	\$0.00	\$0.00	\$0.00
5 . Administration (SSA Level Only)	\$1,320,452.00	\$1,339,440.00	\$0.00
6. Total	\$44,996,187.00	\$42,171,280.00	\$16,339,386.00

¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

³Prevention other than Primary Prevention

⁴For the purpose of determining which states and jurisdictions 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 (SABG); 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 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 required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services 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'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 be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:

The figures in the table above for the COVID supplemental funds equal the entire award. The numbers for the ARP funds represent expected expenditures for the first 25 months of the total award period. Total ARP award for NC is \$36,420,651.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Strategy	A		B	
	IOM Target	SA Block Grant Award	FFY 2022	
			COVID-19 ¹	ARP ²
1. Information Dissemination	Universal	\$679,016	\$610,220	\$1,091,918
	Selective			
	Indicated			
	Unspecified			
	Total	\$679,016	\$610,220	\$1,091,918
2. Education	Universal	\$1,018,523	\$763,830	
	Selective	\$594,139	\$445,568	
	Indicated	\$84,877	\$63,652	
	Unspecified			
	Total	\$1,697,539	\$1,273,050	\$0
3. Alternatives	Universal	\$103,550	\$77,656	
	Selective	\$59,414	\$44,557	
	Indicated	\$6,790	\$5,092	
	Unspecified			
	Total	\$169,754	\$127,305	\$0
4. Problem Identification and Referral	Universal			
	Selective	\$67,901	\$50,922	
	Indicated	\$158,437	\$118,818	
	Unspecified			
	Total	\$226,338	\$169,740	\$0
	Universal	\$1,414,616	\$1,082,092	

5. Community-Based Process	Selective			
	Indicated			
	Unspecified			
	Total	\$1,414,616	\$1,082,092	\$0
6. Environmental	Universal	\$1,471,200	\$1,787,093	
	Selective			
	Indicated			
	Unspecified			
	Total	\$1,471,200	\$1,787,093	\$0
7. Section 1926 Tobacco	Universal	\$404,175	\$430,000	
	Selective			
	Indicated			
	Unspecified			
	Total	\$404,175	\$430,000	\$0
8. Other	Universal			
	Selective			
	Indicated			
	Unspecified			\$1,091,918
	Total	\$0	\$0	\$1,091,918
Total Prevention Expenditures	\$6,062,638	\$5,479,500	\$2,183,836	
Total SABG Award³	\$44,996,187	\$42,171,280	\$16,339,386	
Planned Primary Prevention Percentage	13.47 %	12.99 %	13.37 %	

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

³Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award ¹	ARP Award ²
Universal Direct	\$3,969,007	\$841,486	\$1,091,918
Universal Indirect	\$1,122,073	\$3,909,405	
Selective	\$721,454	\$541,047	
Indicated	\$250,104	\$187,562	\$1,091,918
Column Total	\$6,062,638	\$5,479,500	\$2,183,836
Total SABG Award³	\$44,996,187	\$42,171,280	\$16,339,386
Planned Primary Prevention Percentage	13.47 %	12.99 %	13.37 %

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

³Total 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 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award ¹	ARP Award ²
Targeted Substances			
Alcohol	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Cocaine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bath salts, Spice, K2)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Targeted Populations			
Students in College	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Military Families	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
LGBTQ	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
American Indians/Alaska Natives	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
African American	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Homeless	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Asian	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Rural	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Planning Tables

Table 6 Non-Direct Services/System Development

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated ¹	D. COVID-19 ²	E. ARP ³
1. Information Systems	\$400,769.00	\$1.00		\$1,550,000.00	
2. Infrastructure Support	\$2,699,901.00	\$184,317.00		\$2,463,000.00	
3. Partnerships, community outreach, and needs assessment	\$339,257.00	\$1,240,070.00		\$2,510,346.00	
4. Planning Council Activities (MHBG required, SABG optional)	\$0.00	\$0.00			
5. Quality Assurance and Improvement	\$746,129.00	\$275,234.00		\$400,000.00	
6. Research and Evaluation	\$101,282.00	\$407,885.00		\$1,067,500.00	
7. Training and Education	\$3,098,910.00	\$829,093.00		\$2,333,350.00	
8. Total	\$7,386,248.00	\$2,936,600.00	\$0.00	\$10,324,196.00	\$0.00

¹Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

²The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

³The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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Footnotes:

In the SABG Prevention column, no funds will be spent for Information Systems, but the table requires an amount other than 0 in order for the other line entries to be saved.

At the time of submission, NC's ARP proposal had not been approved; therefore that column will be updated once approved and methods for deployment of funds are determined.

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 homes³¹ and ACOs³² 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.

²² BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102-123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52-77

²³ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/million-hearts-initiative>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁴ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <https://www.samhsa.gov/find-help/disorders>

²⁵ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchstp/socialdeterminants/index.html>

²⁶ <https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development>

²⁷ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

²⁸ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

²⁹ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁰ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, <https://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/home>; National Telehealth Policy Resource Center, <https://www.cchpca.org/topic/overview/>;

³¹ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

³² New financing models, <https://www.integration.samhsa.gov/financing>

³³ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

³⁴ What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

³⁵ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

³⁶ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

³⁷ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

³⁸ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

³⁹ Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf; Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

⁴⁰ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>;

⁴¹ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

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.

The SAMHSA-HRSA framework conceptualizes physical and behavioral health integration as a continuum of six levels within three categories: coordinated care, co-located care and integrated practice structures. In coordinated care, collaboration can be described as minimal, where patients are merely referred to another setting (level 1) or basic where primary and behavioral health care providers share and communicate with each other about them (level 2). In co-located care, providers serve patients in the same site with regular communication about their shared patients, but have different treatment plans for their patients (level 3). Level 4 of co-located care has a closer collaboration between providers with records shared between them. The levels of integrated care are characterized by close collaboration (Level 5) for shared patients, but separate treatment plans still exist for some patients. Full collaboration occurs in Level 6, for all patients; both types of providers develop the treatment plan at this level. (<https://www.milbank.org/wp-content/uploads/2016/05/Evolving-Models-of-BHI.pdf>).

Providers awarded funding by federal agencies such as SAMHSA and HRSA and by private local institutions such as the Kate B. Reynolds Charitable Trust and Duke Endowment offer integrated care through the co-location of a medical provider at a specialty clinic or a behavioral health care provider at a medical facility. For instance, the recently-concluded SAMHSA-funded NC Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant funded a licensed clinician (often dually-licensed for mental health and addiction) to screen and provide brief intervention to patients coming in for their annual health visit. Some schools and community centers also practice integrated care through the co-location of primary and behavioral health care providers. 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 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 benefits to offer the complete ASAM continuum, waive IMD exclusion for SUD services, ensure providers 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.

Additionally, through the COVID-19 Supplemental SABG funding, North Carolina will begin initiatives with federally qualified health centers (FQHCs) and community health centers for individuals with opioid use disorders. Primary objectives of these pilots include the provision of medication assisted treatment in non-traditional, less stigmatized settings in conjunction with physical and medical health care for this uninsured population.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring

capability.

The state provides services and supports towards integrated care for individuals families with co-occurring mental health and substance use disorders through federal funds (i.e., Medicaid, Block Grant, discretionary grants) and state funds. Clinical Coverage Policy 8-C requires that all comprehensive clinical assessments include information on an individual's chronological general medical health history and current issues, as well as current medications for physical conditions. These assessment requirements are applicable consumers and adherence is reviewed and monitored annually through block grant monitoring reviews. Additionally, Evaluation and Management (E&M) codes have been approved by the Division for many years and allow various levels and types of health screenings. These services are particularly critical for individuals participating in medication assisted treatment and as such are provided by physicians, PAs and NPs in all opioid treatment programs.

On a smaller scale, North Carolina recently ended a pilot program in three FQHCs that focused on the administration of naltrexone for an opioid use disorder, while also meeting participants' medical and physical health needs. The state also has continued the integration of mental health, SUD and physical health needs under the Promoting Integration Primary Behavioral Health Care (PIPBHC) grant. As stated above, North Carolina will also begin another initiative based in FQHCs and community health centers to treat opioid use disorders through medication assisted treatment, as well as medical needs for uninsured individuals.

3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? Yes No

b) and Medicaid? Yes No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

The seven LME/MCOs that manage public behavioral health funds for all 100 counties in North Carolina are responsible for monitoring access to SUD services. Additionally, the Division's Quality Management section monitors access and timeliness to care through reporting from the LME/MCOs.

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 (1) an absence or inadequacy of information about parity provisions, and (2) the stigma that still exists specific to SUD that prevents many people from seeking treatment or help for their problems. The final and perhaps most critical factor is the large number of uninsured residents in North Carolina, which is about 10% of the population or roughly 1.1 million people.

10. Does the state have any activities related to this section that you would like to highlight?

Integrated is one of the priorities of the 1115 demonstration waiver.

Please indicate areas of technical assistance needed related to this section

Development of a payment model or reimbursement for integrated care for uninsured individuals.

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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 status⁴⁷. 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 populations⁴⁸. 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>

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?

While the Prevention and Wellness team does not have a formal data-driven plan to address and reduce disparities, the team 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. Additionally, the prevention and wellness team has supported local prevention providers in addressing disparities by providing administrative data for all 100 counties for the completion of a needs assessment in FY20. The data was dis-aggregated to support providers in identifying disparately impacted populations by age, race, gender and sexual orientation. Lastly, the team is in the process of transitioning the prevention system to a focus on results-based outcomes over the next two years. The transition plan includes the identification of and planning for health disparities.

Additionally, there are initiatives underway to better assure a workforce that is illustrative of our population demographics through scholarship opportunities in Criteria A schools for students of color pursuing a career in SUD counseling, as well as targeted growth of collegiate recovery programs in Historically Black Colleges and Universities (HBCUs). Efforts to develop resources in marginalized and traditionally under-served communities are also planned, particularly through expansion of medication assisted treatment opportunities in OBOT and FQHC and community health center settings.

Please indicate areas of technical assistance needed related to this section

None at this time.

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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:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

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.

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 https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.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 focused on consumer outcomes rather than care processes.
 - g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, 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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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 monitoring requirements for the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) provide methods to ensure that State and Block Grant dollars are utilized appropriately, in accordance with statutory and regulatory framework, and in support of programmatic goals. The procedures and practices include requirements for the completion of annual performance and financial audits, in addition to the active monitoring that occurs throughout the fiscal year. Any identified risks or issues are addressed via technical assistance, plans of correction and/or other elevated action.

Please indicate areas of technical assistance needed related to this section

None at this time.

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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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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) Data on consequences of substance-using behaviors
 - b) Substance-using behaviors
 - c) 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)
 - Children (under age 12)
 - Youth (ages 12-17)
 - Young adults/college age (ages 18-26)
 - Adults (ages 27-54)
 - Older adults (age 55 and above)
 - Cultural/ethnic minorities
 - Sexual/gender minorities
 - 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)

Archival indicators (Please list)

NC Report Card, NC Courts, NC DETECT, Department of Public Health (DPH) Alcohol Data Dashboard, DPH Opioid Dashboard, Division of Mental Health Drug Control Unit (opioid prescribing rates), FDA, NC Department of Motor Vehicles prescribing rates), FDA, NC Department of Motor Vehicles, NC Department of Public Instruction YRBS

National survey on Drug Use and Health (NSDUH)

Behavioral Risk Factor Surveillance System (BRFSS)

Youth Risk Behavioral Surveillance System (YRBS)

Monitoring the Future

Communities that Care

State - developed survey instrument

Others (please list)

NC Youth Tobacco Survey

5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds? Yes No

If yes, (please explain)

The state utilizes statewide data to identify consumption and consequence issues, as well as key intervening variables to address through primary prevention services. To support direct services prevention providers complete their local needs assessment and planning efforts, the state provided administrative data for all 100 counties. Prevention providers 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. The state also provides training in assessment, including data collection methods and follow-up technical assistance.

If no, (please explain) how SABG funds are allocated:

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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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

Yes, the North Carolina Addictions Specialist Professional Practice Board is the certifying body for substance use disorder professionals in NC including SUD prevention workforce. The became a duly chartered corporation in August 1984, and was granted statutory status by N.C.G.S. 90-113.30 of 1994. It was reorganized under the NC General Assembly in January 2020. The mission of the Board "to protect the public health, safety, and welfare; to protect the public from being harmed by unqualified persons; and to assure the highest degree of professional care and conduct on the part of credentialed substance use disorder professionals".

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. The state has formed a Statewide Prevention Consortium (SPC) that consists of training and technical assistance agencies, discretionary grant leads, prevention evaluation center, and other statewide prevention resources. The consortium ensures the effective implementation of high-quality prevention services, delivered in alignment with state business policies for the prevention system. Partners within the consortium supports the state and local providers through the provision of training in evidence-based programs, policies and practices; developing CSAP Six strategies best practice guidance; training and technical support in conducting local needs assessment and strategic planning; supporting process and outcome evaluation efforts; workforce development that supports credentialing and local capacity building efforts.

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, the state works 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.

Narrative Question

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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.

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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.

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:
 - Health fairs and other health promotion, e.g., conferences, meetings, seminars
 - Prevention focused websites, email blasts, and newsletters
 - Radio & TV public service announcements
 - Speaking engagements/community presentations
 - b) Education:
 - All Stars
 - All Stars Jr
 - AVOID
 - Catch My Breath
 - Celebrating Families
 - (Will be discontinued in FY 2022)
 - Guiding Good Choices
 - HALO (Healthy Alternatives for Little Ones)
 - Life Skills Training (LST)
 - Media Detective

Media Ready
 Mentoring Support
 Parent & Family Management Planning
 Parent and Family Management Support
 Prime For Life
 (Will be discontinued in FY 2022)
 Project ALERT
 Project SUCCESS
 Project Towards No Drug Abuse
 Project Venture
 Reconnecting Youth
 Safe Dates
 Second Steps
 STEP
 Storytelling for Empowerment
 Strengthening Families (10-14)
 Strong African American Families
 Too Good for Drugs
 Triple P Level 4
 Unique You

c) Alternatives:

Drug free dances and parties.
 Recreation Activities
 Youth Leadership Development

d) Problem Identification and Referral:

Educational interventions primarily for youth referred due to school alcohol and drug policy violations.

e) Community-Based Processes:

Coalition/Task Force/Collaborative/Meetings
 System Needs Assessment and Strategic Planning
 State Level Workgroup
 Sustainability Planning/Leveraging Resources
 Communities Mobilizing for Change on Alcohol

f) Environmental:

Communication Campaigns: Social Norms
 Communication Campaigns: Support for Prevention
 Environmental Strategies Planning
 Establishing, reviewing, or changing community and/or workplace ATOD policies
 Establishing, reviewing, or changing school ATOD policies
 Youth environmental management strategies
 Publicized sobriety checkpoints
 Responsible Beverage Service Training
 Retailer alcohol compliance checks
 Secure Alcohol Storage
 Social Host
 Talk it up. Lock it up.?
 Festival/Event ATOD Restriction
 Safe Stores
 Lock Your Meds
 Safer Prescriber Training
 Secure Medication Storage and Safe Disposal
 Synar

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.

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) Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b) Includes evaluation information from sub-recipients
- c) Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d) Establishes a process for providing timely evaluation information to stakeholders
- e) 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) Numbers served
- b) Implementation fidelity
- c) Participant satisfaction
- d) Number of evidence based programs/practices/policies implemented
- e) Attendance
- f) 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) 30-day use of alcohol, tobacco, prescription drugs, etc
- b) Heavy use
- Binge use
- Perception of harm
- c) Disapproval of use

- d)** Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e)** Other (please describe):

Footnotes:

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

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; and
 6. Weekly Program Managers COVID Check In Conference Calls since April 2020.

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. 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.
- Weekly conference calls with statewide perinatal, maternal & CASAWORKS program managers to address COVID cases, protocols, resources, policies and other technical assistance. This call is also utilized for programs to update the State on a weekly basis regarding any programmatic challenges or technical assistance needs.

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, if applicable 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 activities 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's 24/7/365 crisis, screening, triage and referral helpline. LME/MCOs are also required 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 opioid treatment programs across North Carolina. All (currently 86) are required participate in a 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 86 programs, individuals who elect to receive clinical 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. Bi-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 HIV in areas that have the greatest need for such services and monitoring the service delivery? Yes No

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.C.Â§ 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, please provide a brief description of the elements and the arrangement

SABG treatment funds have been used to purchase naloxone be distributed to individuals at risk for opioid overdose. Naloxone has been deployed to various organizations, including opioid treatment programs, syringe service programs and other community organizations that have contact with or provide services to 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 members, 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 including 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, which is typically about 10% of the total number 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 opportunity 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) Performance-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%20Mental%20Health,%20Community%20Facilities%20Services>

Footnotes:

Environmental Factors and Plan

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 2020-FFY 2021? Yes No

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma⁵⁷ 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 Trauma⁵⁸ 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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Footnotes:

Environmental Factors and Plan

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, McNeil, 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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Footnotes:

Environmental Factors and Plan

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], 49 [4], and 63[5].

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.

TIP 40 - <https://www.ncbi.nlm.nih.gov/books/NBK64245/> [ncbi.nlm.nih.gov]

TIP 43 - <https://www.ncbi.nlm.nih.gov/books/NBK64164/> [ncbi.nlm.nih.gov]

TIP 45 - <https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf> [store.samhsa.gov]

TIP 49 - <https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf> [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

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) Buprenorphine, 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 continues to increase in NC; as September 2021, there were 86 programs serving over 22,000 individuals daily with capacity for over 27,000. Although monthly calls have traditionally been held with the Medical Directors of all OTPs, since the onset of the COVID pandemic, weekly calls have been conducted to better assure access to care is maintained in a safe manner. NC has three state-run facilities and 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*

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15. Crisis Services - Required for MHBG

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](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)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>

⁶²Practice 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 Community Mental Health Block Grant 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 NC 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 2.0. 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, titled the Consumer Policy Advisor, served on the Executive Leadership Team. That position has evolved into the Assistant Director for Community Engagement and Empowerment who oversees staff that work closely with the Consumer and Family Advisory Committees throughout the state (local and state-level), as well as stakeholders and advocates statewide to promote recovery-oriented principles and ensure the voices of individuals in recovery and family members impacted by substance use are heard at high levels of policy development.

DMHDDSAS and the Division of Health Benefits worked together to develop a statewide Peer Supports service definition. The state-funded service definition became effective August 1, 2019, while the Medicaid-funded peer support definition became effective the following year. Having an approved peer support service definition provides an additional mechanism of funding, and helps with the sustainability of those services.

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.

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 09/16/2021, the number of Certified Peer Support Specialist in North Carolina is 3,824. Of the 3,824 Certified Peer Support Specialists, 3,741 reside in NC, and 83 reside in other states. Only three counties out of 100 do not have a peer support specialist residing there. Of the total, 1433 have expertise in substance use and an additional 995 are certified under both substance use and mental health experience. 424 certified peers have military experience and nearly 2100 of the total are employed as a peer support specialist, volunteer as such or are employed in a related field.

The Division has supported collegiate recovery programming since 2015 when the initiative was first established by then Governor McCrory due to concerns over alcohol consumption by college students and the need to provide a college atmosphere that was not "recovery hostile." These collegiate wellness and recovery programs focus on the issues related to substance use on college campuses by providing enhanced and expanded prevention, intervention, treatment referral and particularly recovery-oriented services to address the growing needs of students on college campuses. Although the project began with six universities, there are currently 13 funded campuses. Each school submits an annual plans to develop, continue, expand or enhance services and programs; four campuses have very recently been identified and are more in the development phase. Additionally, efforts will be focused on identifying two more historically black colleges and universities (HBCUs) interested in developing or enhancing their collegiate recovery programs in SFY22. Five of the 13 current schools are HBCUs. Schools currently funded include: (1) East Carolina University, (2) NC A&T, (3) UNC-Charlotte, (4) UNC-Chapel Hill, (5) UNC-Greensboro, (6) UNC-Wilmington, (7) NC Central University, (8) Appalachian State, (9) NC State University, (10) Fayetteville State University (11) Elizabeth City State University, (12) UNC-Pembroke, and (13) Winston-Salem State University.

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. A continuing 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.

5. Does the state have any activities that it would like to highlight?

The Division has chosen to continue efforts to more fully develop a true recovery-oriented system with funding from the COVID-19 Supplemental SABG funds. Specific initiatives under this funding will include the following:

- Creation of a Recovery Policy Center. Over the past several years, North Carolina has gradually tried to shift funds to build and support a recovery-oriented environment or system of care. But this has been difficult because it has involved shifting some funds from treatment to recovery services and supports. The federal opioid grants have helped with this, as we have increased treatment capacity, especially for opioid use disorder. And the influx of federal funding has also strengthened recovery supports like peer services and recovery supported housing. These federal opioid funds also made it more feasible for us to expand recovery community centers and collegiate recovery programs with other dollars. While these are positive accomplishments, the issue is these services and supports are like pieces of a puzzle that aren't quite connected.

The Recovery Policy Center would allow us to focus on all this – to identify and establish the framework for existing recovery supports, assess the current system from both policy and services perspectives, determine needs and gaps, and utilize these additional funds to fully develop and embrace a true recovery oriented system of care. Other functions of the Recovery Policy Center would include research to identify and implement evidence-based and promising practices specific to recovery services and training to advance recovery-oriented thinking in clinical and primary care settings, as well as justice and re-entry settings.

- Expansion of Recovery Community Organizations and Centers. North Carolina currently provides funding to two recovery community organizations that operate recovery community centers and also act as mentors to additional recovery community centers (that also receive funding) across the state. These centers provide various types of recovery services and supports for individuals seeking or in sustained recovery. Additional funds will support the development of a process to identify and select communities primed for the development of recovery community centers in historically marginalized or under-served areas that can offer culturally appropriate services.

- Expansion of Collegiate Recovery Programs. North Carolina currently provides funding for 13 collegiate recovery programs. These programs offer a supportive environment, services and opportunities within the campus culture that reinforce the decision to engage in a lifestyle that does not include substance use. Supplemental funding will focus on the expansion to additional schools, specifically Historically Black Colleges and Universities (HBCUs).

- Expansion of Recovery Supported Housing and/or Targeted Housing. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services provides funding support for various levels of recovery supported living. Additionally, as of March 2020, there were 281 Oxford Houses in North Carolina with more than 2100 beds for individuals in recovery, including women and men with children. We plan to utilize some of the COVID-19 Supplemental funds to support the expansion of recovery supported housing, through funding to the LME/MCOs to provide this service for uninsured individuals, as well as potentially offer funds for start-up of new recovery supported homes.

- Expansion of Services Provided by Certified Peer Support Specialists. Peer Support Specialists are people living in recovery with mental illness and/or substance use disorder and who provide support to others who can benefit from their lived experiences. The North Carolina Certified Peer Support Specialist Program provides acknowledgment that the peer has met a set of requirements necessary to provide support to individuals with mental health or substance use disorder. Through the use of funds from federal discretionary grants, a more deliberate focus on embedding peers in non-traditional settings has occurred, including in emergency departments, prisons and jails. Emphasis will be placed on furthering the co-location of peers in these settings, opioid treatment programs, recovery community centers, etc.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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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

- 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
- Does the state have a plan to transition individuals from hospital to community settings? Yes No
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 Congress⁶⁸ 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).

⁶³Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁴Kessler, 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.

⁶⁵Centers 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.

⁶⁶The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁶⁷Department 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>

⁶⁸http://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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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: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
No Data Available				

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Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
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.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

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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:
tbd
 - c) Other (e.g. public service announcements, print media) Yes No

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Footnotes:

DMHDDSAS staff meet monthly with the SABG Advisory Committee of the SUD Federation for input, review, feedback and more global distribution of the plan to SUD providers, stakeholders and other organizations across the state.

Upon approval for submission to SAMHSA, the plan will be posted on the NC DHHS website for review and comment.

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction^{1,2} on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the [Consolidated Appropriations Act](#), 2018 (P.L. 115-141) signed by President Trump on March 23, 2018³.

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers⁴. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs⁵: These documents can be found on the Hiv.gov website: <https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs>,

1. [Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016](https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf) from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy <https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf>,
2. [Centers for Disease Control and Prevention \(CDC\) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016](http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf) The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention <http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf>,
3. [The Substance Abuse and Mental Health Services Administration \(SAMHSA\)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs](http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf) <http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf>,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
 - Include proposed protocols, timeline for implementation, and overall budget
 - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

¹ Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds **only** and is consistent with guidance issued by SAMHSA.

² Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C. § 300x-31(a)(1)(F)) and 45 CFR § 96.135(a) (6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the [Federal Register](#) (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

³ Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

⁴ Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

⁵ ***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a [description of the elements of an SSP](#) that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

As of July 11, 2016, North Carolina (G.S. 90-113.27) allowed for the legal establishment of hypodermic syringe and needle exchange programs. Any governmental or nongovernmental organization “that promotes scientifically proven ways of mitigating health risks associated with drug use and other high risk behaviors” can start a syringe exchange program (SEP). Included in the law is a provision that protects SEP employees, volunteers and participants from being charged with possession of syringes or other injection supplies, including those with residual amounts of controlled substances present, if obtained or returned to a SEP. SEP employees, volunteers and participants must provide written verification (including a participant card or other documentation) to be granted limited immunity. Although NC has over 40 SEPs, these are community-based organizations not financially supported by the SABG. We do work collaboratively to better assure SEPs have accurate and up-to-date information for referring individuals to treatment and accessing care coverage through the LME-MCOs, as well as provide naloxone for distribution to participants and their families.

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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Footnotes:

N/A